Behavior Management Manual: procedures for psychosocial problems in rehabilitation

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Finally, we thank all of those rehabilitation professionals who attended our workshops, presented the behavioral problems, tried the interventions which we suggested, and gave us feedback on their successes and sometimes failures.

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Introduction

The average rehabilitation worker encounters more behavior problems in a year than most psychologists or psychiatrists meet in a decade. Not only is the rehabilitation worker (whether instructor, evaluator, recreational therapist or counselor) in daily contact with those demonstrating behavioral problems, but he or she is also presented with the opportunity to help these clients. Rehabilitation workers, regardless of job title, are in a position to be helpful to people with behavioral problems.

The purpose of this manual is to provide structured and systematic methods of dealing successfully with behavior problems for rehabilitation personnel who are **not** trained in behavioral treatment procedures. However, training in behavior management via short term workshops or formal courses is recommended.

The rehabilitation personnel who spend the greatest amount of time with clients should find this handbook of most value. They observe the greatest number of behavioral difficulties and also have the greatest opportunity to aid clients to develop more adaptive patterns of behavior. It is hoped that vocational instructors, recreational workers, and evaluators as well as counselors who have contact with clients in settings most like the "real world" will find these methods helpful. It is in these work and social settings that adaptive/maladaptive behavior can best be evaluated and modified.

Rehabilitation personnel are not merely teachers, evaluators, or recreational personnel. They are rehabilitation teachers, rehabilitation evaluators, and rehabilitation recreational personnel. The goals of rehabilitation are comprehensive in terms of client adjustment. We are responsible not only for teaching vocational skills, but also for preparing clients to obtain and hold jobs. We must prepare clients not only to be financially independent, but also to live effectively as contributing members of social and work groups.

Catch 26

Many people in rehabilitation are severely threatened when charged with dealing with behavioral problems. Their reaction is, "I'm not trained to be a psychologist." The catch is that you are **already doing something** when you are faced with behavioral problems in your situation, and what you are doing either serves to maintain or to modify the behavioral problems. As rehabilitation workers, we are either part of the problem or part of the rehabilitation program. It is suggested that with the structure offered in this handbook, you can more effectively meet your responsibility as a rehabilitation worker.

Behavior Change

There are three basic areas that must be considered in order to bring about behavioral change.

I. Language - Professional helpers are trained to label behavior within a standardized classification scheme. You may refer to a client as extremely shy whereas the psychologist or psychiatrist may refer to him or her as a schizoid personality. Neither of these labels is very helpful in bringing about a behavior change.

Therefore, the first task of this handbook is to provide behavioral definitions of psychological problems. If you see a person who is unable to make decisions, seeks constant reassurance, comes to the counselor very often for help in deciding what he/she should do, and so forth, the manual provides a description of these behaviors under the trait of "dependency behaviors." By studying the behaviors listed under this trait, you may decide that a particular client has a problem in this area. This section of the manual teaches the rehabilitation worker a means of describing the problem in a more specific manner than just giving a label of shy or schizophrenic. Instead, the problem is identified in terms of observable behavior.

II. Quantifications - The second area of concern is quantification of behavior. Psychologists are trained to recognize the normal range of behavior and deviations from this "norm." They know when a person is too dependent or not dependent enough. The psychologist, based on sufficient information from his tests and interviews, can tell you whether or not the person in reality has a "problem" in this particular area. Most rehabilitation workers do not have the training in testing but they do have another advantage. They are in close daily contact with the client. Vocational instructors, recreational personnel, houseparents, etc., are able to tell someone pretty quickly if the client has mild, moderate, or severe behavioral problems.

The methods of recording behavior that are described will give an accurate estimate of the severity of the problem. These methods of measurement will allow you to evaluate whether or not your efforts are helping the client.

III. Treatment - The majority of this handbook is devoted to "what to do." The treatment procedures are based on the principles of social-learning theory and behavior modification. This approach to behavior treatment is one of the simplest to use, yet one of the most effective. The companion manual, Behavioral Modification: Principles, Procedures, and Token Economies for Rehabilitation Practitioners (Marr and Krauft, 1980) explains many of the practices that have been developed from learning theory and gives definitions of terms used in the manual.

Using the Manual

I. Who Should Use It

The manual is primarily addressed to the rehabilitation person who spends the most time with handicapped clients and consequently has the greatest opportunity to modify client behavior. It is designed for the vocational instructor to use in the classroom or training area, the recreational therapist to use in the recreational area, the housemother to use in the dorm, etc. If you are a rehabilitation worker and are not formally trained to treat behavior problems but have the opportunity and desire, read on.

II. How To Use It

A. Read the Manual

Familiarize yourself with the different sections of the manual:

1. Identification of the Problem
2. Measurements
3. Treatment.

Note: At the first opportunity, read these sections. This will teach you the basic principles, get you oriented, and prepare you to use the manual as a handbook.

B. Get Consultation

The concepts and principles may be a little foggy at first. It will help to discuss the handbook with others who are attempting to learn the method. You can figure it out by yourself, but it will help to work with another person. You may have a psychologist or counselor in your situation who is familiar with this type of treatment.

C. **Try** It

You must get your feet wet sometime. Select a client who has one of the behavioral problems discussed in the manual, and start your first treatment program. During this period, use the manual as a handbook to insure that you are following the appropriate procedures. Accurate behavioral records will tell you whether or not the treatment plan is working.

D. Try Again

Hopefully, your first treatment program was successful. If it wasn't, check your procedure and correct it or choose another treatment from the handbook. Even the most experienced behavioral therapist makes corrections in his or her treatments with each client and learns something new from each case.

E. Evaluate Your Success

Within each treatment section, you will find a section entitled "Recording - Graphing." The purpose of this section is to prepare you to determine "how often" the undesirable behavior occurs. As you read this section, you may consider it to be unnecessary or just an added chore. But the record is very important because it serves as a measure of rehabilitation progress with the client. It is the method by which the rehabilitation professional holds the treatment program accountable.

F. Learn a New Word or Two

As you read the treatment sections, you will encounter a sprinkling of new words. You have probably heard most of them used in some context or will be able to understand how they are used. It would be ideal if there were no new terms used in this manual, but regretfully there just aren't any everyday words to replace some that are used in the language system of learning theory. The companion Manual (Marr and Krauft, 1979) defines and explains these terms.

Cautions

I. On Patience

Don't expect miracles. You may have a few miracles, but generally, well-ingrained behaviors change slowly over long periods of time. A client doesn't become a proficient mechanic overnight, so don't expect him or her to covert from dependent to independent overnight.

II. On Negative Consequences

Although the treatments are primarily based on positive reinforcements, some of the treatment procedures require you to administer some consequences which the client does not like, such as negative practice or time out. These consequences must be presented in a nonpunitive manner. If you "loose your cool" or communicate that there is pleasure for you in the consequences (which there sometimes will be), at some level a personal "battle" will start and the treatment program is doomed for failure. All negative procedures should be administered in a "matter-of-fact" manner. You must show neither positive nor negative personal reactions when you administer punishment. We want the client to associate the consequences with his or her behavior and not with our emotional reactions.

III. On Freedom

There are occasions and situations in which it is appropriate for you and client to be dependent, to act immature (to be silly), and to be aggressive. You have a responsibility to prepare clients to more effectively deal with **their world.** You must exercise caution not to let your personal biases influence your identification of client "problem areas." If you identify the same type of problem in different students over and over again, it may be that you are attempting to mold clients to fit your personal preferences. If there is any question, expand your knowledge of yourself by checking out the problems you have identified with others to insure that you have identified a "problem" which will hinder the client's adjustment or interfere with adjustment and which is not just a habit that bothers only you.

Other Applications

I. The Group Counselor or Personal Adjustment Instructor

At the end of chapters on specific behavioral problems, there are suggestions for treatments in groups. These are designed primarily for the rehabilitation worker who works with clients in groups designed to improve clients' personal adjustment.

II. Coordinators of Behavior Management Programs

Although this manual is designed to allow rehabilitation workers to employ treatment procedures with rehabilitation clients in their individual area of responsibility (e.g., the training area, dorm) it is ideal to have a coordinated effort throughout the facility. If a student is being treated for being overly dependent only in the training dorm, the chances for maximal client improvement are decreased. It is, therefore, advantageous for behavior management to be implemented on a facility-wide basis, with someone appointed as a coordinator. The coordinator can teach, give advice, and facilitate implementing behavioral programs.

Problem Identification and MIeasurement

Identification of the Problem

Introduction

The first step in treating the behavior problem of any particular student is to define what problem behavior you are going to treat. Terms such as "immature" have their purpose, but they do not tell us what the client does or does not do that leads us to call him or her "immature." If the client was not **doing** something wrong, we would not use the label "immature." Therefore, we must only identify what it is that the client **does** that suggests to us that he/she is immature. This is the first step of any behavior treatment problem.

Deficits and Surpluses

The specific behavioral problem will be one to two types: either he/she does **too much** of something—a **behavioral surplus;** or **too little** of something— a **behavioral deficit.** Asking too many questions is an example of behavior surplus and a client screaming in the training area is another. It is a behavior that should not be there or should only infrequently occur; therefore, it is a surplus. An example of a behavior deficit is when a client does not bathe. It is a behavior that should occur frequently but does not; therefore, there is a deficit. We want behavior surpluses (fighting, screaming) to occur less often. We want behavior deficits (bathing, being on time) to occur more often.

Steps for Behaviorally Defining the Problem

The rules that follow should be helpful as you behaviorally define the client's problem:

1. Know what you are looking for; you are looking for an observable behavior (i.e., something that can be seen) that constitutes, or is, the client's problem.
2. Observe clients in the situation you expect to treat them in.
3. Behaviorally define the problem behavior.

Example

Good	Bad
a. Frequently asks for advice on routine matters. b. Screams loudly.	a. Is indecisive, b. Acts immature.

4. Specify where he/she inappropriately behaves.

Example

Good	Bad
a. Frequently asks for advice on routine matters in the recreation hall. b. Screams loudly in the training area.	a. Is indecisive around the Center, b. Acts immature in certain situations,

5. Specify to whom the client behaves this way when possible.

Example

Good	Bad
a. Frequently asks the recreational staff for advice on routine matters in recreational hall.	a. Is indecisive with people around the Center.
b. Screams loudly at other students in the training area.	b. Acts immature around people in certain situations,

The end result should be a problem behavior statement that other rehabilitation professionals can understand. After reading your description, two other people could observe the client and count the same number of times the behavior occurs with little or no difficulty.

As you behaviorally define the problem, you may often identify more than one maladaptive behavior. In these cases, you must select the most important behavior to treat or treat more than one behavior at a time.

Measurement

Why Record

The purpose of this section is to prepare you to determine "how often" the undesirable behavior occurs. As you read this section, you may consider it to be unnecessary or just an added chore. Please establish the baseline first (i.e., how often the behavior occurs) before beginning your treatment program. This is important for the following reasons:

1. During the process of establishing the baseline, you will be testing how well you behaviorally defined the client's behavior. Without this step, it is too easy to start your treatment procedure too early or to direct it toward the wrong goal. If you can't count it, you didn't behaviorally define it.

2. You need reinforcement, too. One of the greatest problems in making a success of this approach is to keep yourself motivated and actively helping clients to develop more adaptive behaviors. The process of changing behavior often occurs slowly. If you have baselines available for comparison as you work with clients, it enables you to see the small changes which are occurring. This feedback may make the difference between the continuation or the dropping of a program.

3. Basically, these treatment programs are based on the principle that a behavior followed by a "reward" will increase, whereas a behavior followed by a "punishment" will decrease. You are going to make mistakes—one person's pleasure is another's poison. The baselines will allow you to tell if you have a client's pleasure and poison confused. When a particular treatment doesn't work, the record will show no improvement when compared to the baseline measurement. We can then hold the treatment accountable and replace it.
4. The gains which show at different times during the program, when compared to the baseline, may also be used to reinforce the client. Clients can see their progress in the record.
5. Finally, the baseline is helpful at the conclusion of programs to demonstrate the success of the program and to document the attainment of the rehabilitation goals.

Methods of Recording

Recording is basically counting. There are different ways of approaching the task of figuring out how many times something happened or didn't happen. One method is not appropriate for all types of behavior problems. For example, take the case of a client who comes to the training area, goes to the corner and sits there all day at the beginning of a treatment program. At the end of the program he also goes to the corner when he first arrives at the training area, but only stays there for one minute or less. The client's behavior problem has obviously improved tremendously, but if you merely counted the times **he/she went to the comer,** no improvement would be shown. Listed below are some suggested methods of counting and recording problem behaviors. In most cases it will be obvious which method should be utilized.

A. Frequency Counts

The simplest method of recording in many instances will be to simply count the number of times the behavior occurs. This will give you the frequency of the behavior for the specified time period. This is the best method to use when the behavior is infrequent.

Examples

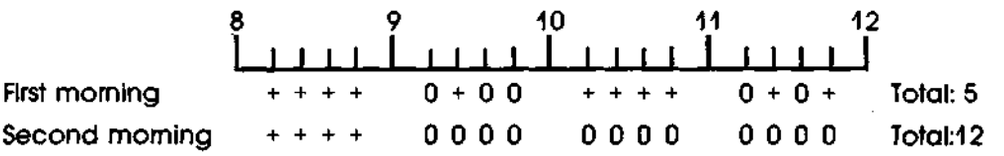
1. Count the number of times the client argues with other students in the training area per day.
2. Count the number of minutes the student is late per day, based on morning arrival and returns from breaks and lunch.
3. Count the number of times the client stands within 5 feet of the instructor during the training period.

It is important that the frequency counts are done during a certain period of time. For example, we may decide to count the number of times the client argues with other students in the training area. This is done between 8 AM and 4:30 PM every day. Or we could count those behaviors between 10 AM and 2 PM every day. The time period that we choose should depend upon our knowledge of the client and when he or she is most likely to show the problem behaviors.

B. fixed Interval Counts

Sometimes frequency counts do not accurately show the problem. For example, some clients stop working and just sit watching others. One morning the client may stop working at 9:02 AM and go back to work at 9:05. Again from 9:33 to 9:39; 9:42 to 9:52; 11:01 to 11:04; and 11:42 to 11:46. That morning he/she stopped five times and did not work for 26 minutes. On another morning, he/she stops work at 9:07 and doesn't resume work (no matter how many times the supervisor tells him/her) until 11:52. He/she stopped working only once but did not work for 165 minutes. Our frequency count of 5 vs 1 would show that her/his problem is worse on the first morning but we can be certain that the supervisor found the problem to be more severe on the second morning. To measure the problem in a way that will show the severity, we can use fixed interval counting.

We break the time period (morning work hours from 8 AM to 12 Noon) into a number of equal intervals, such as 15 minutes. Using a kitchen timer that rings every 15 minutes or a 15 minute beep on a cassette tape, we mark down whether or not the client was working at any time during the 15 minute interval. For the client described above, his/her record would look like this if we marked a 0 if he/she stopped work at any time during a 15 minute interval.



The fixed interval count would more accurately show on which morning her problem work behavior was more severe. Notice that although he/she stopped work twice during the 9:30 - 9:45 interval, we only give one zero because we are counting whether or not the problem behavior occurred during the 15 minute fixed interval.

C. Time - Sample Counts

Another way to measure behaviors that occur for different durations is the time sample count. Like the fixed interval count, we must use some means of breaking the time period for measurement into fixed intervals or segments of time. A kitchen timer or a sound such as a beep occurring at regular intervals on a cassette tape are often used. Whenever the instructor or evaluator hears the beep, her or she looks to see if the client is doing the problem behavior. For example, a person in a sheltered workshop had the habit of rocking her body in a manner that was disturbing her work and was disturbing to the other clients. The workshop supervisor was advised to measure the behavior for one hour in the morning, 9-10, and one hour in the afternoon, 2 - 3. The cassette tape was turned on at 9 AM and 2 PM. Every 10 minutes a beep sounded from the cassette. Whenever the supervisor heard the beep she looked to see if the client was rocking. If rocking was occurring, the supervisor marked an X on the record sheet. If rocking was not occuring, the supervisor marked a 0. The record looked like this for the 12 time samples of each observation period.

9-10 observation period	X X O O X X X O X X X O	Total X: 8
2 - 3 observation period	X O O O X O X X X X O X	Total X: 7

A baseline period of five or ten days would be used to determine the severity of the problem. After treatment was started, measurements could be taken 2 or 3 times a week at 9 AM and 2 PM to judge the effect of treatment. The major advantage of time sample counting is that it doesn't require a lot of time. The supervisor in the example only has to watch the client for a moment whenever the beep sounds to see if the client is rocking or not. Time sample countings are popular measures for such behaviors as crying, thumb sucking, talking, and on-task (doing the assigned activity).

D. Rating Measure

Ratings of client behavior are generally not recommended for behavioral treatment programs but sometimes there is no other way. This is often the case when one person such as a counselor must get an evaluation of a client from somebody else such as a teacher. The teacher says she does not have time to measure the behavior but is willing to make a daily rating. A form that has been used in behavioral programs with some success is the daily work report that can be quickly filled out by a person who is familiar with the daily work of the client.

Daily Work Report

(Client Name) (Date)

Please Rate	**Very Good**	**Satisfactory**	**Poor**
1. Promptness in arriving and returning from break			
2. Cooperation in working with others			
3. Work rate			
4. Quality of work			

Any comments:

(Rater's signature)

Note:

You may be able to devise different methods of counting which are particularly suited to the specific behavior you plan to treat. You should make sure that the method of counting will reflect any improvement that occurs. The smaller the segment of time selected in B. and C. above, the more sensitive the measurement will be to any changes in behavior.

Your counting method should occur in a particular situation and for a specified length of time. If you have the client in a particular training area regularly for six hours a day, you should have little problem with this concern. But if the client is also on a medical program and his or her time in the training area may vary considerably from day to day, it would not be accurate to take a total count of occurrences for daily time in the training area—he or she may be there two hours one day and six hours the next. Also, consider the situation in which the behavior occurs. If your training area is divided into classroom learning for the first two weeks and shop experience for the next five months, you have two entirely different situations. This would significantly influence the frequency of occurrence of some types of behaviors. Horseplay would be more common in the shop than in the classroom setting.

Although the most sensitive record is obtained by a daily measure, this is often not possible for some rehabilitation settings. The once-a-week measure should be obtained since it will show the changes in behavior that are occurring weekly as a result of the treatment. The more frequent recording is better, however. Some rehabilitation professionals have been very successful in teaching other clients to take the daily measure. It saves staff time and teaches clients how to make accurate and reliable time measures.

Records

Introduction

The first step in preparing to treat a behavior problem is **behavioraliy defining the problem.** The second step is **measurement** or being able to accurately and appropriately determine the number of times the behavior occurs in a specified length of time. After we are prepared to know what to measure and how to measure it, we must then put this information into useable form. This is referred to as **graphing—**the third step of behavioral treatment. Graphing is nothing more or less than putting the frequency of the program behavior on a graph to allow you to see the changes that occur as a result of your treatment program.

The Baseline

If we are trying to determine whether or not the treatment program is working or how much the treatment program helped the client, we must know "how bad" the problem was to begin with. This process is called establishing the **baseline.** You establish **how many** times the problem behavior occurs during a specified length of time (i.e., the baseline period) before treatment starts.

You obtain the measure during the baseline and treatment periods by using one of the methods described in the previous section. In most cases you cannot get an accurate reading of the extent of the problem during the baseline period based on one measure. As a general rule, you need to establish the baseline over a period of one to two weeks. Here again, you will need to use your judgement. Your guiding principle should be whether or not your baseline accurately reflects the severity of the problem behavior prior to treatment.

The Graph

Once you have recorded your baseline measure.you are ready to go to the graph. Look at Figure 1. On each of the graphs, the vertical line represents the level of behavior. The horizontal line represents the **time dimension** (usually days). You will notice that the level of behavior column, the vertical column, for each of the three types of behavior is different. Aggressive behavior was measured using interval counts, on-task behavior was measured using time sample counts and on-time behaviors were measured using frequency counts.

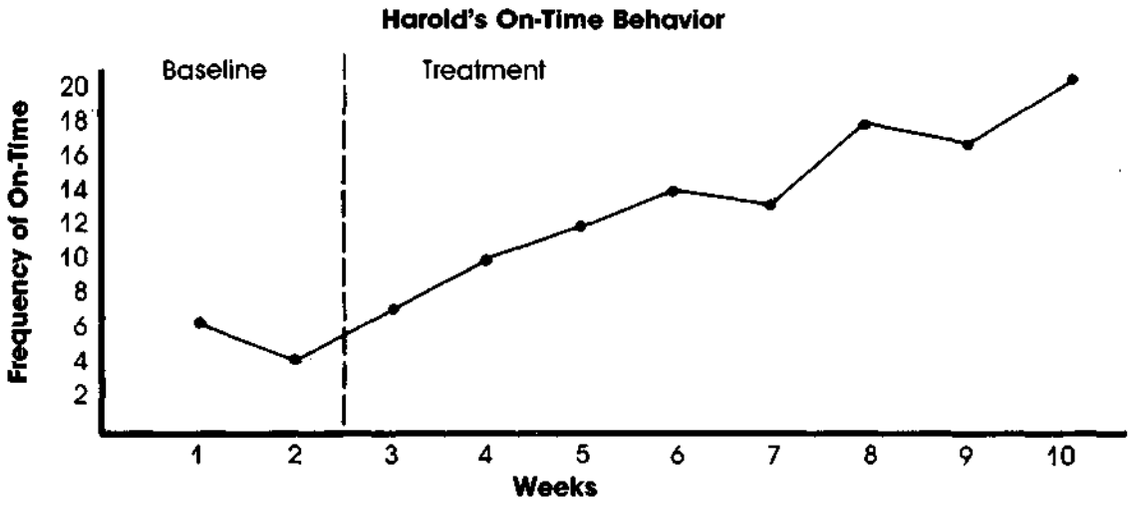
Measurement is the mark of the professional.

The simple but frequent measures of blood pressure and temperature that the public sees the medical professional doing in the hospital is impressive and probably contributes to the status of that profession. Yet those measures are not taken frequently just to gain status but to reveal the effect of the medical treatment. In the profession of rehabilitation, measurement also allows us to discover the effect of treatment. We no longer have to rely on judgement. We can hold our treatments accountable.

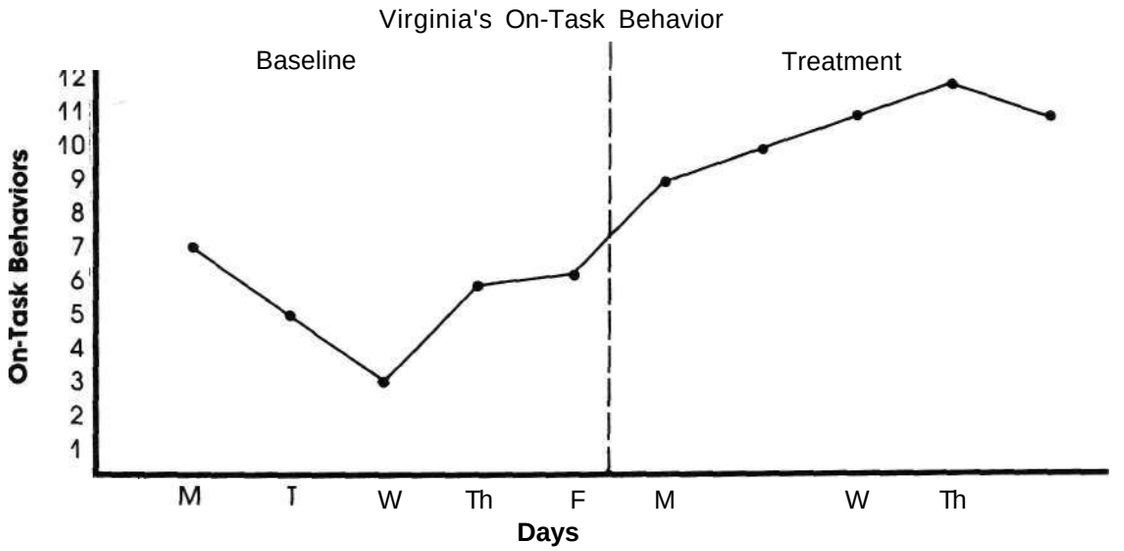
Footnote

More measurement methods showing durations and quality rating methods are presented in the book by Martin and Pear (1978). An excellent manual for training staff to make graphs is also available (See Koortand and Martin, 1975).

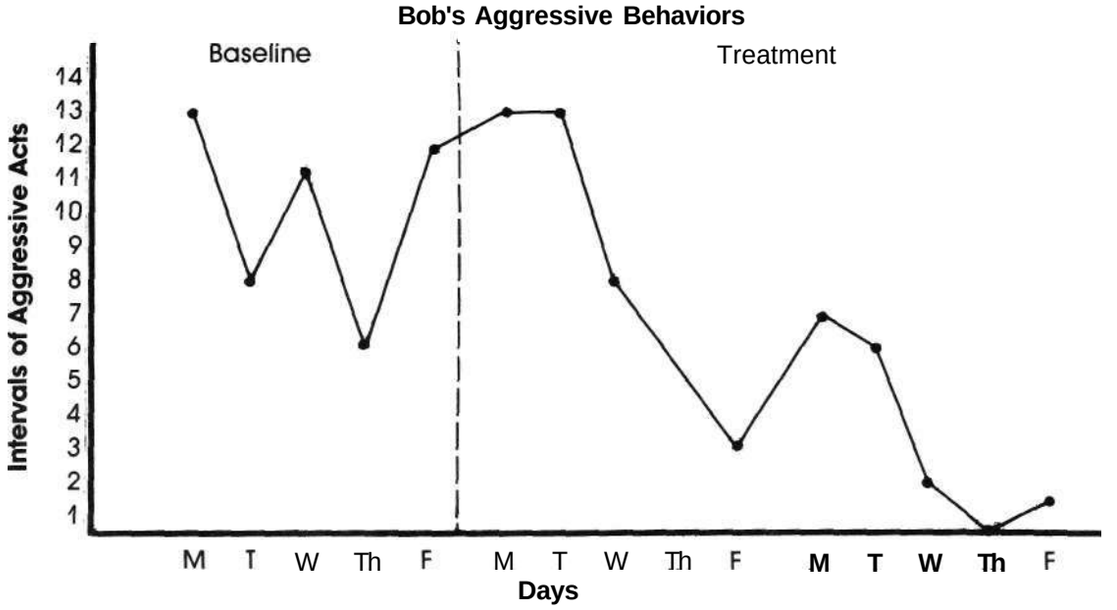
Figure 1



On-Time Behavior: Number of times in a week that Harold was at work at 8:15 AM, 10:15 AM, 1:00 PM, and 2:45 PM. (Frequency Count)



On-Task Behavior: Number of 15 minute time samples in which Virginia was doing the work assigned between 9:00 AM and Noon.



Aggressive Acts: Swearing at another, physical fights, throwing objects or shouting.
Measure: One-half hour interval samples between 8:30 AM and 4:30 PM.

Work Problems

Work Problems

General Definition

Broadly defined, work related behavior problems are those that prevent the organization where the individual works from reaching its goals. Generally, these include anything that the individual does (surpluses) or does not do (deficits) that results in a reduction in productivity and that is not necessary for the well-being of the individual. In rehabilitation, the organization is usually a rehabilitation facility that has a sheltered workshop, vocational training programs or a work-adjustment center. In these facilities clients work or learn to work, and it is the task of the staff to decrease surplus behaviors that would interfere with their ability to keep jobs or to increase deficit behaviors that are necessary to obtain and maintain jobs.

Rationale for Treatment

It is important that we distinguish between (1) those behaviors that interfere with the individual's productivity or other workers' productivity, (2)those hat are for the convenience of the rehabilitation facility, and (3) those that are incompatible with our value system.

1. Those behavior surpluses or deficits that must be changed so that the individual can obtain and maintain work are the primary targets of vocational rehabilitation. These would include showing up on time; wearing clean, safe clothes; staying on task; not drinking on the job; etc.

2. Those behaviors that will not interfere with obtaining or maintaining a job but are necessary to operate the rehabilitation facility are secondary targets. They are also important because every work organization must have rules, and rehabilitation clients must learn to follow rules of society. Although these are secondary targets of rehabilitation, sometimes they must be among the behaviors that are treated first so that the individual won't be discharged from the rehabilitation unit. Playing a radio at work is acceptable in many occupations but probably won't be acceptable in a vocational training workshop where instruction is on-going.

3. Those behaviors that are incompatible with the values of the rehabilitation staff generally should not become targets of rehabilitation. The staff are hired to prepare the individual for the world of work and not to make an individual conform to their own rules of "right" and "wrong." The style of hair, for example, should not be modified unless the way it's worn would create a safety or health hazard. The style of dress is of concern only if the client's present habitual dress is not acceptable by the type of employers the client will encounter. Whistling at girls/boys while working would be acceptable in a factory job but a probably wouldn't be acceptable as a salesperson.

Common Descriptions

Some of the problems that have been listed by supervisors of rehabilitation workshops are: Too many work breaks, returns from breaks late, poor quality of work, poor production, doesn't show up for work, poor task attention, frequent bathroom trips, doesn't clean up, doesn't follow safety rules, doesn't put tools away, breaks equipment, misuses equipment or tools, no initiative, lazy.

There are other problems that occur in work settings such as "horsing around," "goofing off," sarcasm, hostility, aggression, shyness, etc., which are not included in this chapter because they are described in the chapters on Dependency, Aggression, and Immaturity. The problems listed above and discussed in this section would fit many of the clients seen in rehabilitation work settings. Rehabilitation staff may feel that some clients have all of these problems but others have only one or two. Regardless of the number of problems, it is difficult to bring about change unless the problem is translated into specific behaviors. For example, if I tell the client that one of his/her problems is that he/she doesn't follow the safety rules in the shop, the client may argue with me or think I am picking on him/her. The client believes that he/she does follow the safety rules because he/she always wears goggles when working with a machine, but I am thinking of the number of times the clients' sleeves are left unbuttoned (when wearing long sleeved shirts) or the number of times the client fails to wear a hard hat when working under scaffolding. Thus, to bring about change, we must be specific in identification of the problem. Table 1 shows some examples of specific behavioral definitions of work problems.

Action Steps

If you are preparing to develop a treatment program for a client with work-related problems, follow the steps below.

Step I - Familiarize Yourself With the Client's Work Behaviors

Sometimes an interview with the client will reveal difficulties he or she has had in the past in employment, in school, or in performing routine household tasks and odd-jobs. Sometimes the referral source can supply information. But it is also important to observe the client in a work situation during a work evaluation period that may vary from 3 days to 2 weeks. Observe deficits and surpluses that interfere with work. If any of these behaviors are aggressive, immature, dependent, or withdrawn, turn to the chapter by that title. The remainder of this section deals with quantity and quality of work, care of materials, appropriate dress, and on-time behaviors.

Table 1

Examples of Redefinition of Work-Related Surpluses and Deficits

Behavioral Surpluses	Measurement of Behavior Specification
Work Break	
Complaints: "goofs off," "easily distracted," "poor task attention," "poor work endurance" (Also see **Deficits** below)	Number of minutes away from the work desk in activities not related to production, i.e., drinking beverage, eating, talking at another worker's area, standing at window. Includes sitting in chair at work area doing nothing or reading comic book or magazine.
Quality of Product	
Complaints: "doesn't care," "irresponsible," "unmotivated," "careless," "no pride"	Number of chips in whetstone plus number of corners missing, plus number of square inches on stone which are not buffed.
Care of Materials	
Complaints: "careless," "irresponsible," "lazy"	Number of tools left in work area, number of tools and machines broken.
Clean Area	
Complaints: "irresponsible," "poor attitude," "immature"	Number of papers on floor in work area or number of square feet of floor in work area containing dirt and debris.
Behavior Deficits	
Work Quantity	
Complaints: "lazy," "unmotivated," "goofs off"	Number of finished products produced in a day (or in an hour, two hours, etc.), number of 15-minute time samples in which he was not working or not on-task.
Personal Appearance	
Complaints: "poor grooming," "inappropriate dress"	Number of checks for appropriate work appearance: hair combed, shaved, nails clean, shirt buttoned, slacks or skirt closed, shoes tied, shoes appropriate (no sandals or slippers), socks on.

Step II - **Behavorally *Define*** the Problem(s)

Specify what the client does or does not do. Write it so clearly that the client and others can understand it and so that other staff can tell what to watch for, what to measure and what to treat. See Table 1 for examples of behavior supluses and deficits that have been redefined for measurement.

Step III - Select the Problem You will Work On

If there is only one behavioral problem that you wish to treat, proceed to Step IV. If there are more than one, you may want to treat them all at the same time or to treat them one at a time. You will need to measure each and select a treatment plan for each. The priority of treatment should be based on the considerations discussed in **Rationale for Treatment,** above.

Step IV - Establish the Baseline

Generally the baseline period before treatment or work-related problems needs to be long enough to determine the usual level of the behavior. This may be three observation days or two weeks. It should be long enough to allow the client to familiarize himself with the work environment and to act in his usual manner. If the baseline graph shows a lot of ups and downs in the first week, as in the letter "M," two weeks baseline maybe necessary.

Next decide on what type of measure (see Measurement Methods, pp. 3-7) and what period of the day to measure. A few examples are given below.

If the client's problem is tardiness, the number of minutes late in arriving at work in the morning plus the number of minutes late in returning to work after morning break plus the number of minutes late in returning to work after lunch and after his/her afternoon break are totaled and put on the graph for that day. Another measure of tardiness might be a weekly count of the number of times the client is late coming to work or returning to work after a break.

If the problem is one of work production, then the number of products (pieces assembled, inches of yarn, garments pressed, etc.) are counted and this count is recorded on the graph for that day. If the problem is quality, then some count of errors in each finished product might be taken, such as described in Table 4 (See also Martin and Pear, 1978, pp. 287-289 for other methods of measuring quality).

If the client seems to be taking too many breaks from work, we can either count the number of minutes or if that is inconvenient, take a time sample (See Measurement Methods, pp. 3-7). A sample observation might be every half hour. At the start of each half hour, the instructor simply notes whether or not the client is working. The total number of periods in which he or she was working or not working is recorded and graphed. If the client was not working at 8:30, 9:00,10:00,11:30,1:00, 2:00, 2:30, and 4:00, we would record 8 occurrences of the problem on the graph. A treatment plan would then be selected from the Cafeteria, below, for decreasing this problem of too many work breaks.

Step V - Graphing

Make a graph as described in Records, pp. 7-9. Some ideas on graphing are presented in Figure 1 and a number of actual cases of work-related problems are described and graphed in the book by Sanders (1975). You may find a way to include more than one behavior problem on the same graph or you may need a graph for each. Do not put so many behaviors on the same graph that it becomes difficult to detect a change when treatment begins.

Step VI - Select the Treatment

Review the Behavior Treatments described in the Cafeteria for Work Behaviors section below, and select a treatment for each of the problems that you have graphed. Instructors may want to discuss the selection with other staff. It is usually helpful if staff practice the procedure on each other in a role-playing situation before using the procedure with a client.

Step VII - Treatment, Review and Program Revision

Begin treatment and continue measurement. If the graph is not showing a change in the level of behavior after two or three weeks, the procedure is not being carried out consistently by all staff in the program or the treatment is not effective in this setting for this client. First observe the program in action to see whether there is consistency across staff, notice the client's immediate reaction to staff action, and correct any staff errors if necessary. Next consider revising the procedure by making small changes as shown in the graph. If the program is being carried out properly and the revised program is not effective, return to the Cafeteria section below and choose another treatment.

Behavior Treatment Cafeteria for Work Behaviors

I. - Consistent Positive Reinforcement

Inappropriate work behaviors are often due to the individual's failure to make a discrimination between the world of work and the world of socializing, recreation, and relaxation. In addition, these individuals have usually had very little work practice and therefore little opportunity to be reinforced for appropriate work behaviors and little exposure to significant and appropriate work models. In those cases where the rehabilitation client seems to be very much aware of the fact that he is doing poor quality work when he is capable of doing good quality work, or where the client knows that his work rate is much lower than is desirable, he may be testing the supervisor's limits. In a sense, he is asking, "What are the contingencies for doing poor quality work or for working slowly?" This limit-testing behavior is more characteristic of clients who have had very inconsistent supervision of chores, jobs, school assignments, and work activities by parents, teachers, or previous work supervisors. Sometimes they were punished or criticized for not doing a chore, sometimes nothing happened, or maybe sometimes when they worked very slowly somebody would come along and help them or even do the job for them. Thus, their strategy upon starting any new work assignment is to test the system.

Whatever the reason for the inappropriate work behavior, the client will need positive reinforcement for improvement. The rehabilitation professional must be willing to start with where the client is. If we withhold reinforcement until he is demonstrating acceptable work rates and quality performance, we are likely to produce little change in him/her. But if we are quick to give sincere verbal approval for slight gains even though the work is still unacceptable, we will get slow, steady improvement. Eventually we will need to give positive reinforcement to him only as frequently as any effective foreman gives reinforcement to his quality workers.

It is important that all clients learn that when they work, they will get attention and praise. If a client hears the staff praise others for being "on-task," often that will trigger his/her trying it out. If the workshop staff or instructor quickly responds to slight increases in on-task behavior, the client will increase work. If the instructor ignores these small increases or is late in reinforcing, the client is liable to resume old behaviors of using the work station to socialize instead. Quick reinforcement of improvement will lead to further improvement.

Varying the reinforcement is also important. Tell the client in different ways that he/she is doing well. Tell other staff to do the same. Call the client's counselor so that the counselor can praise him/her for the improvement. Let the client discover that work pays by earning praise, attention, better work stations, special privileges, or whatever can be arranged to reinforce workers for production.

These same guidelines should be applied to improvements in dress, returning from breaks earlier, cleaning up work areas, following instructions, etc.

II. - Modeling Appropriate Work Behaviors

A considerable body of research has now been collected on the effects of modeling on the behavior of the observer (Bandura, 1971). The evidence from this research suggests three procedures by which modeling might be used in teaching appropriate work behaviors in rehabilitation settings.

A. General Graphic and Video Instruction

Video tapes or films of workers working at a satisfactory rate and doing quality work are shown to all new workers. The video material should, whenever possible, show these workers being rewarded for their work. In some cases, inappropriate work habits might also be shown provided that negative contingencies such as accidents, verbal reprimands, loss of status, or the need to do a job over again are included. Cartoons, posters, or other graphic materials posted in conspicuous places in work training areas can be helpful but are not as effective as live models.

Apprenticeship Assignment

Here each new trainee is assigned to an experienced worker for on-the-job instruction. Care must be taken to prepare the experienced workers to demonstrate not only the technical aspects of the job, but also tool care, clean up, rates of working, work break termination, etc. In addition the learner should see and hear the experienced worker being reinforced for quality, etc. by the supervisor.

Coworker Models

Whenever possible, trainees should be assigned to work in a team with workers who model appropriate work behaviors. These models should be selected on the basis of their leadership abilities, work habits, and willingness to let the trainee experience all aspects of the team assignment (Some effective workers are not effective models because they would do all the work themselves while allowing the trainee to stand around and watch).

It is a common observation in various work settings that some new workers will gravitate to the worst workers in forming friendships. Some of this may be due to the fact that the best workers take the least time to become acquainted with new employees. Some of it is due to the "poor" worker seeking company and attention in his frequent work breaks. This is why it is essential that work-training programs include planned modeling procedures. The new trainee is given a companion who shields him/her from an inappropriate model while presenting an appropriate set of work standards. Even when the modeling program is limited to video tape programs or film presentations of ideal work behaviors, there is a standard with which the trainee can compare his/her own habits or those of the friendly co-worker who does little work. Regardless of whether the modeling plan includes film presentations, apprenticeship programs, or co-worker assignments, the reserach on modeling (Bandura, 1971b) has revealed a number of procedures that encourage imitation in the trainee. Imitation is more likely to take place if:

1. models are warm and nurturant, and have prestige, power and competence,
   This means that they are friendly and helpful, and are admired by others, are very capable of doing their work and sometimes are known to be very skilled at activities outside work. Their power is shown by the fact that others follow them and listen to them. Usually their approval of a new worker determines whether or not the new person is accepted.
2. models are observed to be reinforced for their work behaviors,
   This means that models are praised publicly by the supervisor or instructor and often are seen to have a preferred work station.
3. the models' status is enhanced as a result of their work behavior,
   This means that one of the reasons that models have prestige is because of their ability to do their work activities.
4. the modeled work activities clearly spell out when appropriate behavior can result in reinforcement, and
   This means that others can clearly see that their work earns praise and attention—not personality, good looks, stories, or jokes.
5. the modeled work activity is rehearsed by the trainee in a non-threatening atmosphere.
   This means that the new person must get an opportunity to practice the behavior he/she is trying to model without criticism or sarcasm but with frequent praise for improvement from the model and staff. Thus, the client discovers that he/she too can do it and that it pays to do it.

III. - **Token Economy—Work Behaviors**

The general description of token and point economies is presented in **The Behavior Modification Manual for Rehabilitation Practitioners** (Marrand Krauft, 1980). These programs can be very effective in teaching a client to report to work on time, to go immediately to his work station, to get the proper tools and materials, to work at a productive rate, to produce quality products, to limit breaks to one or two in the morning and afternoon, to use proper safety procedures while working or moving about in a shop, to care for and put tools and equipment away, and so on.

Points on the clients' point cards are punched or they are given tokens whenever they show one of the selected work behaviors during the training phase. It is very important that the supervisor, foreman, or instructor carry tokens or a point punch whenever moving through the shop so that he or she can give immediate reinforcement for appropriate work behaviors. One of the most common reasons for token economies to fail is due to the supervisor's delay in awarding tokens or points for appropriate behaviors.

In addition, in order that a token economy be effective in producing appropriate work habits, the supervisor must be prepared to shape the desired behaviors. For example, cleaning one's work area at the end of the work day might include putting all tools away in the proper storage area, putting unused materials in proper bins, cleaning off and wiping dirt from work desk or bench, sweeping floor so that no scraps, dirt, or dust are visible, and putting sweepings in trash bin. If the supervisor waits for every trainee to do all of that before reinforcing each one, he/she will end up with a lot of workers who never do a thorough job of cleaning. However, if the supervisor quickly reinforces trainees who have put some tools away with a couple of tokens, and at the same time, informs them that they will earn more tokens when they put all tools away each time, the trainees will show improvement. When putting tools away is a habit, the tokens can be discontinued. Similarly, clients will become much better at cleaning up their area if they are quickly reinforced for initiating sweeping. The next day they are reinforced with more tokens for sweeping and cleaning off their bench, and so on. Once the trainee is reliably doing all the clean-up tasks, the tokens need to be given only at completion of clean-up.

Tokens can be used to improve both quality and quantity in production. If a client has been producing about five whetstones in an hour, the workshop foreman tells that client that he/she can earn a token for each whetstone that does not have a chip in it or a corner missing and that is completely buffed. After one hour, the supervisor returns, counts the number of completed stones and pays the client in tokens for those that are of good quality. The supervisor should not pay for those that are improperly buffed, but should set these aside, telling the client that he/she can receive tokens for those when the buffing is complete. To avoid complaints about not receiving tokens for the chipped stones, much praise should be given for the quality products. At first, it may be necessary to pay every hour but gradually payment should be given only every two hours, then only for morning and afternoon work, and finally for daily work. In addition, the client should be told how much he or she is improving. Compliments should be given for being a better worker so that the client sees that efforts receive praise as well as the tokens and the back-up reinforcements on the token menu.

A client who has been shaped into doing a complete clean up at 'the end of the work day and has shown a consistent pattern of earning the maximum number of tokens for clean up for a number of days and who has shown a large improvement in production could be considered for promotion into the next category of the token economy where he/she receives a salary in tokens at the end of the week instead of being paid on a piece rate daily (tokens for each job or clean up period). Of course, promotion would not be considered if the client has not attained the other behavioral goals in his/her individualized work adjustment program.

Since a token economy program is dependent on the value of the tokens, it is essential that the reinforcement menu contain powerful incentives. A careful choice of backup reinforcement menus are listed in the **Behavior Modification Manual for Rehabilitation Practitioners** (Marr & Krauft, 1980).

Another aspect of token economy programs that make them particularly helpful in changing inappropriate surplus work behaviors is the Response Cost procedure. Surplus behaviors such as taking extra work breaks, returning from lunch late, throwing a tool, leaving a machine running, not wearing safety goggles, and misuse of a piece of equipment are listed separately on the Reinforcement Menu. Each response has its cost listed next to it. When the client fails to wear safety goggles when operating a lathe, he pays the listed cost in tokens. The work supervisor deducts the cost from the individual's account or collects the tokens in the same neutral manner he or she assumes when collecting tokens for one of the other menu activities such as seeing a movie, getting a pass recommendation from the instructor or buying a shirt patch. This procedure is used to emphasize to the client that it was his or her decision to spend tokens on not wearing goggles instead of saving tokens for the shirt patch; the client must stop spending them for safety violations. Thus, response cost procedure is built on the value of the tokens to the client. The token's value comes from an attractive menu.

IV. - Self Observation and Behavioral Goals in Work

The use of daily feedback to the client coupled with behavior incentives has proven useful in changing inappropriate work behaviors in work adjustment centers. This procedure includes specification of the behavior surplus or deficit, measurement of the behavior and feedback to the client, setting the behavioral success criterion, and the behavioral incentive.

A. Behavioral Specification

Surplus behaviors such as excess work breaks, arguing or fighting with co-workers, or poor product quality are defined so that the client can recognize the occasions when his/her work behavior is being judged as inappropriate. Similarly, work deficits such as low rates of production, improper cleaning of work area, or improper dress for work are redefined so that the client can identify the behavioral goals. For example, proper dress: shirt buttoned and tucked in, trousers, socks, and hard-top shoes tied.

B. Measurement and Recording

Once the behaviors have been specified in a way that both client and supervisor can agree on their occurrence or nonoccurrence, they can be counted and graphed. This can be done by either the client or supervisor, but research on accuracy of self-observation indicates that most individuals are not accurate self observers without training (Thoresen & Mahoney, 1974). If the client agrees to keep a record of the number of work breaks and the number of minutes away from his or her work area, the supervisor should also keep such a record. At first this duplicating should be daily but after the client has been trained in self-observation, only an occasional check is made of his or her accuracy. Many studies of self-control procedures have indicated that the daily feedback provided by self-observation can by itself bring about the desired change in behavior (Thoresen & Mahoney, 1974). Notice in Figure2 that feedback on frequency of occurrence without self-observation was sufficient to produce change. (The instructor-evaluator recorded and graphed the behavior and showed it daily to the client.)

C. The Behavior Success Criterion

After the client and counselor or supervisor have specified the behavior and agreed on the method of measurement and training in self-observation, the target line of success is drawn on the graph (see Figure 2). For example, (not counting the work break in the morning of 15 minutes and one in the afternoon of 15 minutes) the target line might be set on the graph to show 0 or 1 minute. Thus, if the present behavioral surplus is 36 minutes a day, the client would need to decrease the number of breaks or length of breaks to obtain a decrease of 35 minutes to reach the target line of success. This procedure works faster if there are intermediate goals. For example, intermediate target lines 24,12, and 6 minutes would also be drawn. When the client shows an improvement by reaching an intermediate target, he or she is reinforced.

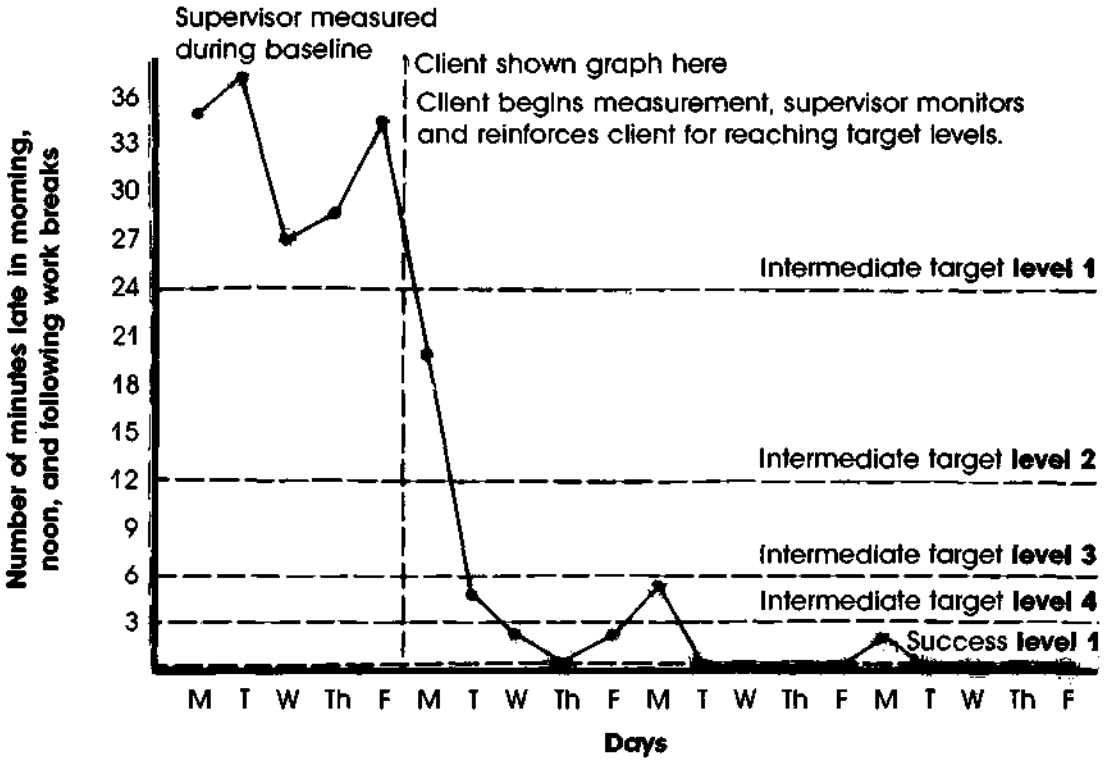
Similarly, if the behavioral deficit of productivity of whetstones in the work adjustment center is presently two finished stones an hour or 12 in a day, the target line of success might be set at 30 a day on the graph, with intermediate targets of 14,18, 22, and 26.

D. The Behavioral Incentive

It should be made clear to the client that once he/she has reached the criteria of success for each behavioral deficit or surplus and has maintained these successful levels of behavior for a specified period of time (one to four weeks), he/she is then eligible for graduation from the work adjustment program or trainee program. In the event that the trainee entered the program with more than 3 or 4 problem behaviors, he/she should be graduated into some kind of advanced status upon reaching and maintaining the success criteria for 3 or 4 of these target behaviors. High praise and discussion of improvements should occur as the trainee reaches the intermediate targets.

In addition to that type of behavioral incentive, clients should be given frequent verbal approval for their improvement as well as for their attainment of the success criteria. These clients are not used to success in those work behaviors and will readily return to the old levels if they do not see value (behavioral incentives and frequent reinforcement) in the new levels of success. Once the increase in work productivity or decrease in work breaks has become habitual, verbal reinforcement can be slowly decreased in frequency until it matches that in the natural environment, i.e., that frequency of reward characteristic of a typical shop whether it be office or factory.

Figure 2



Graph of Effect of Client Monitoring Own Tardiness (Based on a similar graph of reduction of aggressive behaviors in work adjustment training at Hot Springs Rehabilitation Center).

Dependency Behaviors

General Definition

This class of behavioral problems consists of attempts by clients to utilize the intellectual, emotional, or physical resources of others to guide them when they are believed to be capable of directing their own behavior and making their own decisions. Often the person being utilized responds negatively to the client's dependent behaviors.

Dependency problems are common in rehabilitation and are described in many ways. Some of the descriptions given by rehabilitation professionals which suggest a dependency problem are as follows:

> Can't make decisions, relies on instructors, needs excessive supervision, needs constant support, bothers others with trivia, constantly asking stupid questions, continually seeking reassurance, etc.

Here is an example that is not uncommon with these clients.

Situation: The client has been instructed to sweep a training area. It is shop standard operating procedure (SOP) to put up the broom after sweeping. The shop is in good order and it's quitting time. The client has just finished sweeping.

Client: I'm through sweeping, what should I do now?
Instructor: Put up the broom. (Client puts up the broom.)
Client: I put up the broom. (All other students begin to leave.)
Instructor: Good.
Client: May **I** go?
Instructor: Everyone else is. (Client hesitates.)
Instructor: Out!

Rationale for Treatment:

Dependency is not all bad. There are occasions when the mature, independent person **needs** to depend on the resources of others. It is possible to be too independent, (i.e., never depend on anyone else). It is when the person deviates from the happy medium that we notice them and become concerned. Just as we become irritated with the overly-dependent spouse, roommate, coworker, or child, people become irritated with the overly-dependent rehabilitation client. His or her failure to make decisions or to act can interfere with vocational goals or social relationships. The client might be able to complete a vocational course but may lack the skills and knowledge necessary to live independently, to seek a job, to present his or her capabilities in a job interview, or to make the independent decisions necessary in even the simplest job if hired. Each rehabilitation client needs sufficient training in independent living and working to operate effectively in the complex society of today.

If **you** are preparing to develop a treatment program for a client with maladaptive behavior problems in the area of dependency, the procedures listed below should be helpful.

Step I - Observe the Client

Observe the client and figure out what he or she is doing too much (a behavior surplus) or too little (a behavior deficit). Examine work and education records, and interview the client to see if he or she has problems in making decisions, meeting people, and taking actions.

Step II • Behaviorally Define the Problem(s)

Spell out what the client does or does not do, where he or she does it and with whom. Write it out in such a manner that anyone reading the description could tell you whether or not the client was behaving in that way at any particular time. See Table 2 for examples of redefined dependency problems. Until the problems are redefined as shown, it is very difficult to measure or treat them.

Step III - Select the Problem(s) You Will Work On

You will most often identify more than one problem behavior. Pick the one(s) that is/are most important.

Step IV - Establish the Baseline

Select an appropriate target period (e.g., recreational period from 5:00 - 7:00 PM). Select the number of target periods you will use to establish the baseline (e.g., the next 5 days the client is present at the 5:00 - 7:00 PM recreation period). Take your frequency count of the problem behavior for each period for the next 5 days. This is your baseline. For other methods of measurement, see pp. 3-7.

Step V • Graphing

Make a graph similar to those shown in Figure 1 and plot the dependency count for each day. If you have counted more than one kind of dependency behavior, you can plot it on the same graph or put each on a separate graph. The graph lines of these surplus behaviors will get lower on the graph if treatment is successful. If you have counted or measured one or more deficit dependency behaviors, plot those on a separate graph. If treatment is successful, the graph line will rise.

Table 2

Example of Redefinition of Dependency Surpluses and Deficits

Behavioral Surpluses	Measurement and Behavior Specification
1. Asks stupid questions frequently.	1. Number of times the client asks recreational staff about recreation hall rules that he or she has been told many times.
2. Hangs around counselor.	2. Number of times the client visits the counselor's office per day.
3. Needs excessive supervision.	3. Number of times the client asks instructor to examine his or her performance on training tasks.
Behavior Deficits	
1. Lacks initiative.	1. Number of times the client goes to the next task after finishing one training task.
2. Poor grooming.	2. Number of times the client bathes weekly without being requested to do so.
3. Waits for instruction.	3. Number of times the client puts up tools after finishing a job.

Step VI - Select the Treatment

Review the "Cafeteria of Treatments" Section below and select your treatment procedure.

Step VII - Treatment, Review and Revision

Carry through on your treatment program and review the "Precautions" Section periodically. If the treatment selected is not showing an effect on the graph, it is either due to the treatment not being carried out appropriately or the treatment is not effective with that client in that situation. Review your treatment procedure, and if you believe that it was carried out correctly, change to one of the other treatments. If you change treatments, draw a vertical line on the graph that shows when the change took place so that you can hold the next treatment accountable.

I. Positive Reinforcement

In respect to dependent clients, rehabilitation workers are like middle class parents. Parents often only notice their children when they are doing something which they shouldn't be doing or when they neglect or forget to do something they are supposed to do. Too often parents don't notice, pay attention to or reward the children when they are playing quietly, being polite, doing their chores or homework.

And so it is in rehabilitation settings, we don't notice or pay attention to the client when he is making decisions. In order to increase independent activities, we must reinforce the person for those few decisions made. We must start rewarding him by a smile, a nod of the head, a word of approval, when he/she takes independent action even when it is insignificant. When we frequently reward the client for small steps toward independence they increase in frequency. This type of program will allow the individual to learn that independent actions are a means of getting attention without seeking attention; that independent actions are more rewarding than dependent actions.

To start, we have to watch the client function during his/her daily or weekly activities. We need to note or record what activities are initiated without help. Does the client do any of the activities shown in Table 2? Each of the behaviors offers an opportunity to reinforce independence.

If the client finds that he/she is noticed for these or other independent actions and finds that the supervisor or counselor gives him/her attention or says a word or two of approval, the client will start becoming more and more independent. We start changing the client by rewarding for those few times he/she is independent.

Some words of caution—Positive reinforcement is not like a pill for instant success. Those of us who are independent have had a long history of practice in and reward for being independent. Our client has not. The client will slowly learn to be independent if we build a world around him/her in which rewards are frequent for independent action. Later as the client discovers the benefits of independence, verbal reward and supervisor approval can be given less frequently. **Secondly,** be prepared for inappropriate independent action. When the two year old child first begins to show independence from his/her parents, the child is as liable to explore the street as to explore the yard.

Example

The nurses at a VA Hospital began to reward any sound of a 50 year old veteran who hadn't talked for five years. Imagine their surprise when the first words they could understand were 'You old bitches."

Our rehabilitation client will make mistakes while becoming more independent. Eventually, less mistakes will be made as he or she finds that some independent actions are more rewarding than others. It is important that we reward independence and tolerate, at first, the client's imperfect actions and words. Individuals need to practice in a permissive, rewarding atmosphere where mistakes will be tolerated and corrected in an accepting manner.

Table 3

Opportunities to Reinforce Independent Behaviors

A. Get up in the morning without being told.
B. Wash, shave, fix hair, etc. without being told.
C. Select clothes to wear.
D. Make bed.
E. Put dirty clothes away or arrange clothes.
F. Go to meals on his or her own.
G. Go to work or class on his or her own.
H. Show up for an appointment.
I. In class, without being told ...
   (1) sharpens pencil
   (2) takes seat.
   (3) starts an assignment.
   (4) turns in an assignment.
J. In work without being told ...
   (1) get the proper tools.
   (2) start work.
   (3) request help when it really is needed.
   (4) help somebody else when his or her work is completed.
   (5) start a new task when previous task is completed.
   (6) ask for another job when previous task is completed.
   (7) return from a break on time.
   (8) put tools away.
K. Goes to the recreation room without being told.
L. Initiates a ping pong, pool, or shuffleboard game in recreation.
M. Turns on the TV or changes to a specific station without being prompted.
N. Reads a book or writes a letter on his or her own.
O. Turns the radio, or lights off without being told.
P. Invites somebody to go to a movie.
Q. Invites somebody to go get a coke or cup of coffee.

II. Extinction or Removal of Reinforcement for Dependent Behaviors

This procedure can be very useful for the client who seeks help unnecessarily, requests assistance in a task which he/she could do alone, visits the counselor's office on trivial matters, or just stands there doing nothing as if waiting to be told what to do. This client has frequently had a very long history of being rewarded for these actions. It may have started upon finding that the only way to get attention from parents was to seek help when it was not needed or to ask advice unnecessarily, and typically he/she got their attention and was reinforced. This behavior continued in school; the client got attention from the teachers and classmates whenever he/she acted dependent or helpless. If a child just sits in a seat doing nothing long enough, a helpful teacher will walk up and give a suggestion, smile, pat the child on the back, and, thus, reinforce this helpless behavior so that it continues as a means of getting attention.

Part of the solution for this type of client is to avoid reinforcing them for dependent behavior. This is often very difficult because these clients have learned so many types of dependent behavior that will be reinforced. Furthermore, they often are on a partial reinforcement schedule for dependency—they only receive attention every second or third time that they seek it. Behavior that persists with infrequent reward (partial reinforcement schedule) is very hard to decrease. It is very helpful if all rehabilitation workers who come in regular daily contact with the client follow the same or a similar procedure:

Do not reward dependent words or actions

Do reward independent actions
(see Positive Reinforcement procedure above)

Suggested Approaches to
Extinguish Dependent Behavior

A. Work Supervisor or Classroom Instructor

Keep a chair empty at the front of the classroom or near (but not next to) the instructor's desk. If the dependent client comes to the desk, tell him or her in a neutral manner to sit in the chair until the instructor is free. Wait 3-5 minutes, then ask what he or she wants. Tell the client to decide what to do and then do it. During regular activities it is very important that the instructor keep an eye on this client for opportunities to reinforce him or her with attention and approval for decision-making behavior as explained in the positive reinforcement section.

B. **Office Visits with a Secretary**

In those cases where a client comes to the counselor's or instructor's office many times a day over trivial decisions, you might instruct the secretary to ask the client why he or she is there and persist until a reason is given. Then the secretary should show the client a card that says, "You decide what to do and do it. Then come back and tell me." The card has the instructor's or counselor's name and signature on it. If and when the client returns, the secretary again asks for a reason for an interview. If the client says that he or she did the activity and wants to report it, the secretary immediately smiles (reinforces) and notifies the counselor, etc. who would immediately hear the client and give reinforcement for the decision making activity. The secretary should continue this procedure for all future visits by the client until it is certain that only appropriate visits or requests for assistance are being made. All conversation by the secretary should be conducted in a neutral manner.

C. **Office Visit, No Secretary**

If there is no secretary available for this behavior management procedure, you should adopt a slightly modified procedure. When the client arrives, do not give him immediate attention. Make him wait 5-7 minutes in an uninteresting place. (Some clients find it reinforcing just to be in an office where they can watch and hear what is going on.) Then, in a neutral tone, ask why the client is here. Then say, "Go decide what to do, do it, then come back and tell me about it." The client is then escorted out. Give your instructions in a neutral manner.

Notice that both of the above procedures include no reinforcement (attention, approval) for coming to you for unimportant matters, a prompting procedure for getting the client to decide and act, and a means to give the client attention and approval when he or she has made a decision.

Note:

It is also important that those clients who are missing class or work time in their office visits be made to make up that time in work or class, or they be allowed to visit the office only during a designated time of the day.

D. **Dormitory, Supervisors, or Recreation Personnel**

Use a procedure similar to that of the counselor or classroom instructor. Speak in a neutral manner so as to neither punish nor reward dependency. Give the client 5-7 minutes time-out prior to inquiring why he or she is there. Prompt him/her to decide and act. Look for opportunities to reinforce independent actions.

III. Fading Procedure To Encourage and Shape Independent Activity

Fading consists of providing a cue or signal to the client that tells him orher what to do next and then, step by step, removing parts of the signal, until the client is able to initiate the activity or sequence of behaviors without the signal being present.

Example

When the automobile mechanic reads a manual to learn the steps to follow in replacing the brake lining of a car, he is **dependent** on the manual. But he typically reads only parts of it the second or third time he changes brake linings and then is able to do the job on almost any car without such instructions after he has had sufficient experience.

In the dormitory we may have to give clients detailed instructions in making beds, cleaning areas, or caring for personal hygiene at first. Once is enough for many clients if we occasionally reinforce them for doing it, but the dependent client seems to need such attention over and over again. A fading procedure can be used in such cases as shown in Table 3. **(Caution:** This procedure is used only when the problem is one of not doing a complex act without constant instructions. For a retarded client or one who has difficulty in carrying out the steps in the correct order a **backward chaining** procedure would be advisable. That is one where the client observes the complete exercise except for the last step which she then completes. Next he/she learns the step before that, etc. See Martin and *Pear,* 1978, pp. 146-148.)

Notice in this table that the supervisor instructs, reinforces, serves as a prompt, fades her or himself as a prompt out of the situation, and decreases the reinforcement slowly. Also a card with instructions is faded out by first substituting a card with fewer instructions.

Table 4

Example of Fading

Objective: Client makes bed before breakfast without instruction—to encourage decision making with client who didn't make his bed in the morning. (Supervisor's presence and prompt card are faded)

Behavior: Client did not make his bed before going to breakfast at 7:30 AM. Client said, "I forgot. I don't know how."

Behavioral Goal: Client initiates bedmaking without direction and makes bed correctly before breakfast at 7:30 on weekdays and before 9:30 AM on weekends.

	Supervisor (S)	Client (C)
Monday:	S arrives at client's sleeping area at 7:15. Says it is time to make your bed. Hands card to C. "What is the first thing on the card?"	"Make bed before breakfast"
	"What is the next thing on the card?"	"Take blanket, pillow, and top sheet off the bed."
	"Do that"; waits, 'Good." "Now what?"	"Pull bottom sheet tight until wrinkles are removed; tuck in bottom, head, corners and sides."
	"Watch me do the head and then you do the bottom."	C does bottom.
	"Good, now I'll do this corner like this and you do the others."	Client does others.
	"Good, now what?"	"Tuck in sides." Does it.
	"What is next on the card?"	"Put top sheet on bed." Does it.
	"Now you pull it down like this, then what's on the card?"	"Pull wrinkles out of the pillow and put it at head of bed." Does it.
	"Fine." Looks at card.	"Put blanket on bed and even with top sheet." Does it.
	"Always line up the top of blanket with top of sheet & remove wrinkles." S shows how. Looks at card.	"Fold six inches of top sheet and blanket over."
	"Like this, you do your side."	Does it & reads from card "Tuck bottom of blanket & sheet in together and then tuck corners & sides."
	"Show me."	Client does it, but makes mistake on corners.
	S shows client & then undoes it and asks C to do it.	C does it correctly.
	"Great, the bed is made and now we can tape the card on your dresser so you can look at it if you don't remember." Does so & leaves.	
Tuesday:	S arrives at 7:15 and stands looking at bed if client has not begun making it. Waits until client begins, reinforces him/her and leaves. Returns to reinforce the successful parts & refers C to card if there are errors. Watches, reinforces & leaves.	

Wednesday:	S arrives at 7:15 and looks at bed.	Client has not started. Starts when S looks at bed.
	S leaves to return to reinforce C for finishing.	
Thursday:	S walks by C's sleeping area at 7:15. Nods & smiles if C is making bed. If C is not making bed, asks "What is the last thing you do when you get dressed?"	"I put on my shoes."
	"Take off your shoes so that we can practice a reminder."	C takes off shoes reluctantly.
	"Now put them on."	C does do.
	"Now what will you do?"	"Make the bed."
	"Good."	C starts on bed.
	Tomorrow if putting on your shoes doesn't remind you to start the bed, we will practice by having you put them on again and starting on the bed." S leaves and returns to re-inforce later.	
Friday:	S arrives at 7:25 and reinforces bed-making behavior or repeats training of Thursday by having C repeat practice twice.	
Monday:	S checks from distance between 7:15-7:25.	C making bed.
	No verbal reinforcement.	
Tuesday:	S arrives to reinforce.	C making bed.
	Removes card & replaces it with one that says "Make bed before break-fast."	
Wednesday:	No reinforcement.	
Thursday:	S arrives to reinforce at 7:25.	Bed made.
Friday:	S arrives at 7:15 - 7:25 & says "You are doing so well that you don't need the card or me." Card is removed.	Bed made.
Next Weeks:	Reinforcement is thinned to once a week.	Bed made,

Fading might also be used for a client who is in a work adjustment center or classroom situation or for a client who is showing any initiative or who may be dependent on the instructor for continuous guidance. Three procedures for helping this client are suggested:

Type I • Fading

Use a fading procedure similar to that shown for bed-making, above, for complex tasks such as repairing a washing machine, radio, or watch, setting or cutting hair in a hair-styling course.

Type II • Fading

Give the client a card that shows the detailed steps to follow in a particular course. For example, in a work adjustment center the client might be given a card that says:

When you report to work, go immediately to your assigned task area. This is the same area in which you worked yesterday morning, unless your instructor has told you to change areas. Get your tools and equipment, start working. When you finish one project, start another project. Keep working until the instructor tells you to stop. If you run out of material, go get some more or ask the instructor where you can find some more material. Before leaving your area for breaks, lunch, or at the end of the day, put your tools, equipment, and materials away and then clean and sweep your area.

This type of prompt card tells or signals to the client what his options are. For the highly dependent client, a very detailed instruction card is given at first. He is verbally rewarded periodically for following the directions. When he/she is showing successful work behavior with the detailed card, that card is replaced with a less detailed card. Again, the client should be reinforced for following instructions and for making decisions. Then a card is substituted that has even less direction. Again he/she is rewarded for any initiative or decision making behaviors.

Finally, the card is removed entirely and the client is complimented on his/her ability to initiate certain tasks, get materials, continue working, change tasks, put equipment away, etc., without an instruction card or without directions from the instructor.

Type III • Fading

A third type of fading procedure is possible with dependent clients who simply sit at a desk at their work area or just stand around. This procedure is also useful in shaping improved work habits in clients who are often labeled as lazy because of their frequent prolonged pauses at their assigned work station. A simple hand signal is shown to the client, such as index finger extended toward client and hand moved in a circular direction (any visual signal which is acceptable to both client and supervisor can be used) which means that the client is to continue working, to get more materials, or take on a new task. When the instructor has informed the client what the hand signal means, the client is then sent to the work area and instructed to go to work. At anytime the instructor observes the client just sitting or standing he or she looks at the client and then gives the hand signal.

If the client did not start work following the hand signal, it is very important that the instructor immediately tell the client, in a neutral tone of voice, to (first), get busy, (second) get some more material or start a new task. If the client did start following the hand signal, wait about a minute and then verbally reward him or her for working. The next time the client follows the hand signal, wait two minutes before rewarding. Next wait four minutes before rewarding, etc. Then start fading out the hand signal. Each time look at the client for five seconds when he or she sits or stands doing nothing, then give the signal. Soon, merely looking at the client will become a signal for becoming active. In the same fashion, if we look at the client every time he or she pauses for a long time, if we give a hand signal every time we look at him/her, and if we go to the client and tell him/her to initiate work everytime he/she continues to pause following a hand signal, then the client's own pause will become a signal to get back to work. Reinforcement must continue until the client is carrying out his or her assigned job without prolonged pauses. Of course, other students and workers should also be occasionally reinforced by attention and approval for maintaining appropriate work habits.

The dependent client must be reinforced for progress made. The client must learn that decision-making, initiative, and work are rewarding (receives approval). He or she must learn that his or her decisions will not be punished. Again, it must be emphasized that errors in judgement of the dependent client should be tolerated and definitely not punished. This type of client may be highly dependent because of a long history of disapproval or punishment for any independent action at home.

IV. Programmed Instruction for Teaching Independence

Role-playing in groups - The counselor gathers together in scheduled group meetings 3-6 clients who have similar dependency behaviors. They are encouraged by shaping and reinforcement to discuss their typical reactions to a number of situations presented by the counselor. These situations are preselected as occasions where dependent and independent behaviors are possible e.g., a young woman is sewing two pieces of material together in a dress-making class when the machine runs out of thread. In each situation the clients are encouraged to discuss what they would do. Then one or more, depending upon the situation, is chosen to role play the situation and the group's independent action solution. The group leader may have to model one or more of the situations and independent solutions to get things started. The preselected situations should include scenes that are familiar to the students in work, dormitory, and social areas of their lives.

Since particpation in discussion and role-playing includes independent action, especially volunteering to role-play, much reinforcement should be given. Clients should be encouragea at the beginning of the group meetings to tell about situations in which they acted independently. They might also be encouraged to choose somebody else in the group to act out the situation. Dependent verbalizations by individual members of the groups should not be rewarded by attention from the counselor.

V. Individualized Treatment

Some clients will respond favorably to a program in which they first discuss their dependency problems with the counselor, leam to identify and specify dependent and independent behaviors, and then plan with their counselor their daily activities. Opportunities for independent action are identified and one or two of these situations are selected as target situations in which to practice independent actions or decreased dependency. They are then encouraged to report as soon as possible or at the next scheduled session their success. Care must be taken here that the client doesn't begin to report successes when there actually was no attempt to change. The counselor may have to visit some of the target situations in order to act as a prompt for independent action and then fade him- or herself out following success and reinforcement. Or the counselor may alert the client's supervisor to prompt and reward success.

Other clients who are dependent because of fear of consequences of independent action may need relaxation therapy to counter tension, desensitization therapy or assertiveness training. These treatments should be carried out by a psychologist specializing in behavior therapy. Assertiveness training is described in the section for Treatment of Withdrawn Behaviors (pp. 53-63).

Aggressive-Hostile Behaviors

Aggressive-Hostile Behaviors

General Definition

There are many words and phrases that are used by both the lay public and professionals to refer to aggression and hostility. Some of these words are more descriptive of the behavior that is observed than are others. Here is a list of some descriptions that are often used when a person is referring to aggression or hostility, but which do not clearly describe the actual behavior.

> Acting-out, acts annoyed, angry, blows-up, can't stand stress, doesn't get along with others, "bad-mouths" others, evil-eye, low frustration tolerance, pissed-off, resents authority, temper tantrums, trouble maker.

Better descriptions of hostile-aggressive behavior are those terms that indicate what a person actually does when he or she demonstrates aggressive or hostile behavior. These are categorized into verbal behaviors and physical behaviors.

Examples of verbal behaviors:

> Swearing, cussing, shouting, yelling, screaming, criticizing others, threatening others, calls names, arguing, teasing (defined as verbal comments to another who has asked that the comment not be made), insulting (defined as critical comments about another).

Examples of physical behaviors:

> Physical fighting, wrestling, hitting, pushing, biting, butting, stomping, shoving, kicking, pinching, squeezing, choking, throwing objects at another, clothes grabbing, throwing objects, breaking objects, damaging environment (scratching paint, furniture, etc.), threatening others with fists or facial expressions.

Rationale for Treatment

Aggressive behaviors and words cause problems in work and non-work settings. Persons who fight, scream, and throw things when they are angry will lose their jobs if the behaviors occur at work. Fighting in non-work situations can result in their not being able to show up for work because of physical damage they receive or because they were arrested. Furthermore, others do not like to work with, live with, or even be with persons who are frequently insulting, arguing, hitting, etc. Thus, frequent aggressive behaviors are targets for rehabilitation programs.

But some persons who are never aggressive may be withdrawn or unassertive. Although withdrawn behaviors and methods of increasing assertiveness are discussed in a separate chapter, we must be aware that some persons who exhibit aggression by shouting and fighting do not know any other ways to be assertive. Thus, it is important with some clients that we teach them other ways to vent and state their frustrations and anger without alienating people by insulting and attacking them.

Action Steps

To develop a program for reduction of aggressive behaviors, the steps below should be followed.

Step I - Observe the Client

Watching the client at work, in social situations and in recreation can be very helpful in deciding whether or not aggressive or hostile behavior would interfere with rehabilitation. In addition, an interview with the client may reveal difficulties he or she has experienced because of an uncontrolled temper, fights, or not getting along with others. Usually the client will blame these difficulties on others but observation of his or her interactions with others can be used to determine whether or not this aggression is unprovoked and whether the client also demonstrates appropriate behaviors in interacting with others. Records from other agencies and the referral source may also indicate problems in relating to others. Usually, it is best to assume that the client's aggressive-hostile behaviors are within the limits tolerated by society until you actually see or hear aggressive acts that interfere with his/her or other client's rehabilitation program.

Step II - Behaviorally Define the Problem(s)

Write the description of what the client does so clearly that staff who are going to measure or treat the problem can agree that the aggressive behavior has occurred. It should be stated so that the client can understand what it is that he or she is doing too much of, although some levels of retardation could prevent this. See the list of terms used to describe verbal and physical behaviors in the definition of aggression above. Do not use the vague expressions such as acting-out and low frustration tolerance.

Step III - Select the Problem(s) You Will Work On

After consultation with the staff who interact with the client in the place where the behaviors occur, decide on which problems you will treat and which are not practical to treat. For example, throwing ping pong paddles in recreation can be treated if there is supervision of the room where the ping pong tables are located, but insulting others in the hallways cannot be treated easily without the development of a self-management program.

It is also necessary to decide which aggressive behaviors interfere with the client's rehabilitation program. Review the discussion in Rationale for Treatment. Certainly, physical attacks on others and on the environment are more serious than name-calling. Both might be treated but the former should receive first priority.

Step IV - Establish the Baseline

Although each physical aggressive action can be measured separately, most workers in rehabilitation and education find it more convenient to group them under the label of aggression and measure them as a group. The general rule to follow is that if the behaviors will receive different treatments, they should be measured separately. Usually, verbal acts are measured separately from physical acts.

Behaviors that are grouped and measured as one category of aggression must be described so they can be observed. For example: Mary's aggression acts include throwing objects at others, hitting or slapping others, and kicking at others. We could do a frequency count of aggressive acts from that description, or we could do an interval measurement of aggressive acts. For the latter, we could break the work day from 8 AM until 3:30 PM into 15 half hour intervals. At 8:30 we note by an X or a 0 whether or not she threw objects, hit or kicked somebody. See Table 5.

After measuring the behavior for that day as shown in Table 5, we would use the same method of measurement for the same time period the next day, and the next until we had a baseline measurement of the level of Mary's aggressive behavior. As described in Chapter 1, we would continue the baseline until we had a fair estimate of the severity of the problem before treatment.

Step V - Graphing

The daily measure is then plotted on a graph (see pp. 3-7). If different measures of aggressive behaviors were taken, different graphs should be made unless they can easily be seen on the same graph. The graph should also show when the treatment begins and when treatments are changed.

Step VI - Select the Treatment

Read the Cafeteria of Treatments of Agressive-Hostile Behaviors and choose one that best fits the situation. Make sure that all staff who interact with the client are familiar with the definition of the behaviors to be treated and are trained to carry out the treatment. Active role-playing the different aggressive acts and immediate staff response is very helpful in producing the necessary consistency in treatment.

Step VII - Treatment, Review and Revision

The client who is aggressive has usually had many years of practice in many situations with many people. His or her aggression will probably be quite resistant to change; thus, a consistent, patient approach is required. Seldom is there an overnight change. The treatment plan must be carried out in a consistent manner by all staff. If the measurement is continued and graphed, the program should begin to show an effect in about two weeks. If there is no decrease, review the procedure to see if it is being accurately and consistently carried out. If not, modify it, retrain the staff, and continue graphing. If the modification does not produce a change in the behavior, change treatment and continue to measure its effect.

Table 5

Different Measures of Mary's Aggressive Acts
Aggressive Act: Hits, Kicks, or Throws Object

		What Supervisor Wrote Down When He Measured By:	
Time	**What Mary Did**	**1/2-Hour Interval Method**	**Frequency Method**
SAM	Arrives at Workshop		
8:30			
8:42	Hits Bill		
8:45	Hits Bill		
9:00			
9:02	Swears at Bill		
9:10	Swears at Tom		
9:11	Swears at supervisor		
9:30		**0**	
9:53	Kicks Tom		
10:00		**X**	
10:12	Kicks Tom		**1**
10:14	Hits Mike		**1**
10:17	Hits Sue, Tom & Bill		111
10:30		**X**	
11:00		**0**	
11:28	Hits Tom		
11:30			
11:35	Hits Tom		
11:42	Throws paper at Sue		
11:49	Kicks Bill		
11:52	Curses everybody		
12:00			
	Morning Totals	**5**	**12**

Behavior Treatment Cafeteria for Aggressive-Hostile Behaviors

I. Response Substitution Through Positive Reinforcement

This method can be used in individual counseling sessions, the dormitory, or in the classroom and workshop. A group of responses that are incompatible with aggression are selected for reinforcement. When these acceptable responses are reinforced, they come to occur more and more frequently and thus replace the aggressive behaviors. Some examples of behaviors that are incompatible with aggression are shown in Table 6.

Table 6
Examples of Behaviors that are Reinforced Because they Interfere with Aggressive Behaviors

Aggressive Behaviors	Incompatible Social Behaviors
Hitting, shoving, kicking, throwing objects at another	Cooperating with another, helping another
Threatening facial expression	Smiling at another
Swearing, criticizing, or arguing	Complimenting others, talking about non-controversial subjects
Threatening others	Offering to help others
Shouting, screaming	Speaking in quiet voice

When the appropriate interpersonal behavior is observed, it must be reinforced quickly and frequently if this method is to be successful. It also helps to occasionally reward the client with a reinforcing activity such as a recommendation for a pass, a choice of seats or work stations in the class or shop, a trip, etc., when he or she has shown a significant improvement. That is, when the client has not had a fight for a complete day, an extra work break or a recommendation for a pass might be given as a reward. For the client whose aggression is primarily verbal (swearing, threatening, name calling, teasing, etc.), the staff member also might give verbal reinforcement frequently for the nonoccurrence of these behaviors during the counseling session or during the observation period. If the verbal aggressive acts have been frequent, the counselor might reinforce the client for just ten or fifteen minutes of no swearing, criticizing others, or name calling. Notice that the client might be complimented for ten minutes of non-swearing even though he did criticize others or call them names. In class or workshop, the instructor-supervisor might compliment the client for not swearing, fighting, or shoving during the previous hour. As improvement begins to take place, reinforcement can occur less frequently. However, if reinforcement is withdrawn too quickly, the aggressive behavior may begin to increase.

II. Time-Out

This procedure has been successfully used to decrease physical behaviors that are potentially damaging to people or objects, as well as verbal aggressive acts such as screaming, shouting, teasing, etc. It can be used in the classroom, workshop, or in any place where there is a nearby room or chair where the person cannot see, hear, or do interesting activities.

As soon as the client exhibits the inappropriate act such as hitting, or yelling at somebody, he is immediately sent to or taken to the time-out place. He then must remain there for about five or ten minutes. If the individual continues to yell, swear, hit or struggle, the time-out period continues for five or ten minutes past the time he stopped yelling, swearing, hitting or struggling.

Caution: Time-out is effective only if the client likes doing the activity from which he or she must take time-out. Thus, it would not be an effective treatment for a client who dislikes physical exercise and is made to take 5 minutes time-out from the physical education class because he pushed somebody. Nor should it be used to treat "name-calling" during math class if the client dislikes math.

When time-out is used:

1. It must be applied immediately after the aggressive act.
2. Tell the client exactly what he or she did wrong.
3. Be neutral in voice and manner. Don't let the client see any emotion that you feel. If you must tell the client that his or her act upsets you, do it without showing anger.
4. Tell the client exactly where he or she must go for time-out and how long (a limit of 7 minutes is the usual).

Caution: All time-out places must be comfortable, lighted, and observable by the staff member.

5. If the client continues to scream, etc., in the time-out place, tell him or her the time-out begins when he or she has quieted.
6. When the time-out is ended, be positive but tell the client that he or she will have to take time-out again if he/she hits, insults, etc., again.
7. Watch the client and reinforce quickly for appropriate responses (See Table 6).

For a more complete description of time-out see Marr & Krauft (1980).

The recreation director is using time-out when he or she removes the ping pong ball for five minutes because two of the clients are arguing, name-calling or shouting over the game. The dormitory counselor or supervisor might remove a deck of cards for five minutes when similar aggressive acts occur during a game. The counselor might remove a pass for one evening or delay a pass for one hour because of an aggressive act, but this would only be successful if he does it in a neutral manner and makes sure that this time-out from pass is communicated to the client immediately after the aggressive-hostile behavior occurs.

III. Negative Practice (see Marr & Krauft (1980) for more complete instructions)

This procedure can be used in almost any setting in a rehabilitation facility, although it is best practiced in a room that is near the place where the act occurred and that is somewhat isolated from other clients. When the person is verbally aggressive by shouting, swearing, name calling, etc., he is immediately taken to the place selected and asked in a neutral fashion to practice the inappropriate behavior some more. Thus the individual who has been swearing is asked to say all the swear words he/she knows or to repeat the particular swear word he/she used over and over again. When the client stops, he or she is asked to continue for another two minutes.

The rehabilitation counselor might interrupt the client who is calling other people names or swearing while in the counselor's office and ask him to repeat those names a few times, then a few more, etc., until the client refuses. The counselor then indicates to the client that they will practice again the next time the client commits the verbal aggression and then continues the previous conversation. If this is done every time the client demonstrates the aggressive verbalization, the behavior will decrease in frequency.

Caution: It is not unusual for your graph to show an increase in this behavior when the treatment begins. This is because the act is receiving attention from you every time. Keep it up and the behavior will decrease.

A variation of this procedure is the negative practice of the aggressive act. As soon as the client hits somebody or throws something, he or she is taken to the place for practice and requested to hit a pillow or some similar object, or to throw some non-breakable item over and over again. If the client refuses to practice, he or she is told that the act must be practiced a few more times so that he or she can better understand it before returning to the shop, classroom, etc. If the client doesn't practice, then the negative practice procedure is converted to a five to ten minute time-out or "cooling-off" period.

In all cases, the negative practice session is terminated with the supervisor informing the client in a neutral manner that the client will get to practice again the next time he or she does the aggressive act. To be effective the practice must be consistent and administered whenever the supervisor observes the aggression. If a particular occurrence of the aggressive act is not judged to warrant the negative practice treatment, it should be completely ignored.

Positive reinforcement of responses that are incompatible with aggression should be administered as described in Treatment One above, in addition to the negative practice for the inappropriate interpersonal behaviors while decreasing the aggression.

IV. Response Cost

If the client is in a setting where a token economy is being practiced, a response cost in tokens or points can be used to decrease aggressive behaviors. A complete description of procedures to set up and administer a token economy are in the accompanying manual by Marr& Krauft (1980).

The aggressive behaviors selected for treatment are added to the Reinforcement Menu and the cost of each is listed on the menu. This procedure shows the client that he or she is choosing to save tokens so that he or she can purchase one of the other items on the Reinforcement Menu, such as a swimming pass, a recreation hall pass, or "chance" to win a movie ticket.

The response cost in tokens can be very effective in decreasing aggressive behaviors or hostile comments if the supervisor charges the client fairly and in a neutral manner every time the client chooses the listed inappropriate behavior. It is essential that the supervisor give frequent reinforcement with tokens and words to the client for appropriate behaviors (especially those listed in Table 6) and not decrease this positive reinforcement following an incident of aggression or else the frustration generated by the response cost procedure could result in additional hostility and aggression. A sure sign of a weak reinforcement system is when the response cost puts the client in the hole, i.e., the last aggressive act costs more than the number of tokens the client has earned.

When there is no token economy being used in the rehabilitation setting, then an individualized program can be developed to decrease aggressive comments and behaviors. In practice the client is given 10 or more tokens or points at the start of the class or work period. The client is told that if he/she still has those points by the end of the class or by the end of the morning session, everybody in the class or group will get 10 minutes off from class work, but if he/she has only 7 points left, they only get 7 minutes off, etc. The client then has one point deducted each time he/she swears, shoves, yells or whatever the target behavior is.

Another variation of this is to deduct time from the client's evening pass time depending upon the number of incidents of aggression. This variation ties the inappropriate behavior to the individual's reinforcing activity and excludes the class or working group. Including the group has the advantage of obtaining their cooperation in trying to decrease the client's problem behavior, i.e., they stop provoking the individual's anger.

V. Behavior Contracts

With certain clients who seem to recognize that they have a problem with aggression, the counselor may find a behavioral contract helpful in producing change. Behavioral contracts are also described in more detail in the accompanying manual (Marr& Krauft, 1980). An example of a behavioral contract is presented in Table 7. This procedure requires the counselor and client to discuss the specific instances of aggression, when they occur, where they occur, and what types of events immediately precede them. Then the client is asked to suggest some positive consequences for a measured decrease in the aggressive acts and some negative consequences for daily failure to control aggression and/or hostile acts. The target behaviors, their consequences, and the positive reinforcements for specific levels of improvement are then spelled out by the counselor in contract form. The contract is then signed by the client, counselor, and witness. Any failure of either party to comply with the contract results in renegotiation of the contract terms. Contracts work best if they are brief and if the first one describes behavioral goals that are very easy for the client to accomplish.

Table 7
Behavioral Contract for Aggression*

I (name)_____ make this contract with my instructor,

_____, (or counselor, houseparent, etc.) on

(date)_____ If I tell one other worker in this shop what I like about him or her and do not

_ call anybody a name today, tomorrow,(date)_____, I get to work at my favorite job all day.

Client Signature

Instructor Signature

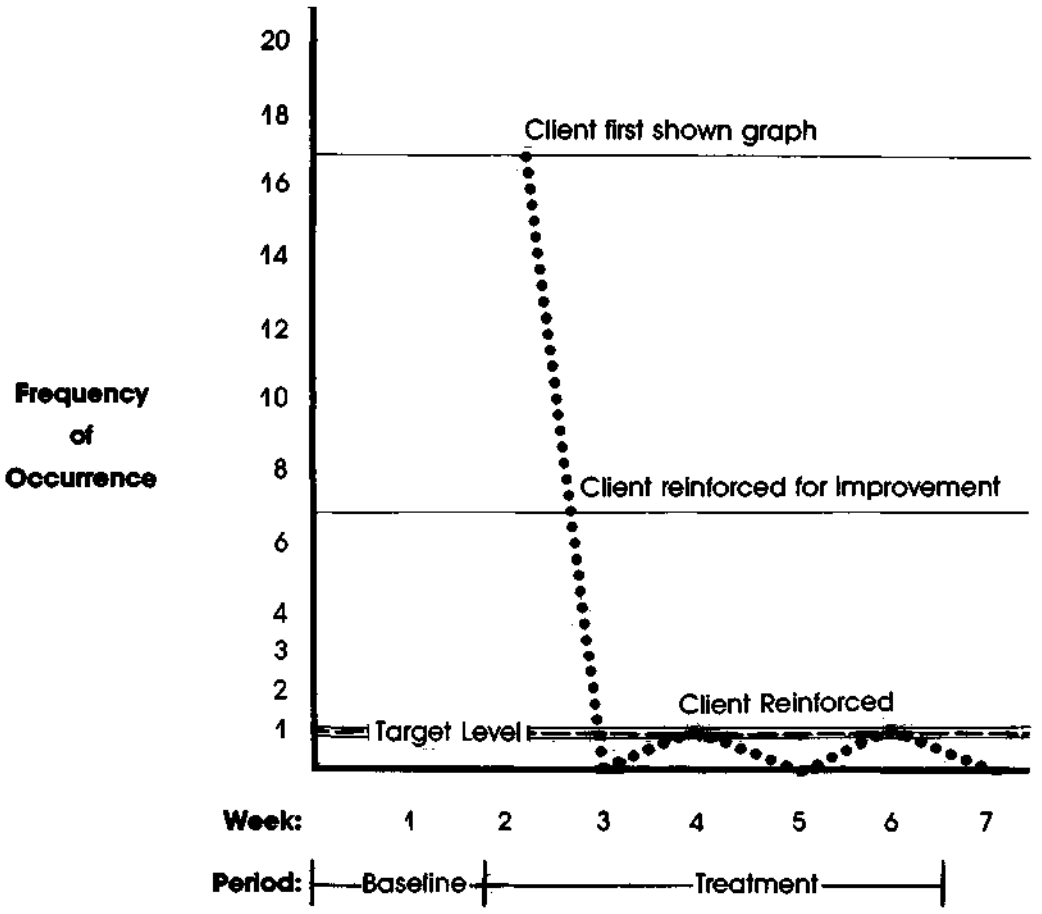
'This is the first contract, the next one may be for two or three days, then a week, etc. Each new contract may have a change in the reinforcement activity (working at favorite job becomes working at new skill, or earning new tool, name and title tag on work bench or work coat, etc.). Some contracts have a place for witness to sign. A copy of contract is given to client or placed where he can examine it.

VI. Measurement and Feedback as Treatment

Although self observation of problem behavior has been found to be somewhat inaccurate and unreliable, accurate self-observation has been found to affect problem behaviors, at least temporarily. In this procedure, accurate measurement of occurrences of the behavior is plotted on a graph and shown to the client daily. This can be done by posting it on a bulletin board (only if the client permits) or by placing the graph in a folder in some place where the client can examine it daily in privacy. The graph should have a dotted line drawn across it at the desired target level of occurrence (see Figure 3). To maintain improvement, the client is given some positive reinforcement event whenever his behavior level reaches the target level. Thus, a client who decreases his or her hostile comments from fourteen a day (baseline) to one a day would receive a recommendation for a pass, a choice of work or even a free movie ticket. A further inducement to maintain the target level is produced when the client is told that he or she must maintain the target level for some specified length of time such as ten days in order to graduate from the work adjustment center, to receive a week-end pass, or to be promoted.

Figure 3

Effect of giving feedback to client on number of occurrences of fighting, arguing, etc., and showing him/her Target Level.



Behavior Problem: Doesn't get along with others

Behavior Specification: Wisecracks, scuffles, arguments

Measure: Count number of each

:

Withdrawn Behaviors

Withdrawn Behavior

General Definition

Withdrawn behaviors are called by many different names and phrases. Some of these do not describe what the client does very clearly or refer to the causes or inner emotional states of the individual. Here is a list of some of the non-specific descriptions:

> inhibited, isolated, timid, shy, quiet, unassertive, apathetic, uncommunicative, doesn't interact, doesn't like to be around others, shallowness of affect, keeps to self, does not cause trouble, clams up, afraid to get involved, prefers solitary activities, indifferent attitude toward others, reluctant to interact, reluctant to ask questions, afraid of others.

A behavioral definition requires that the behavior be so clearly specified that two different observers would agree that an occurrence of withdrawal had taken place.

The major behavioral characteristics of withdrawal are **deficits** in certain behaviors and **surpluses** in others which limit the client's vocational, academic, or social development. The deficits are a lack of behaviors that would bring him or her into contact with or maintain contact with others when such contact would be helpful. A complete list would have to include most of those social activities that have been beneficial for the civilization of humanity. Some of these that are considered to help in rehabilitation are:

> greeting others, verbally rewarding others, talking about past, present, or future events that are interesting to others, asking questions, giving information, helping others, accepting help from others, listening (includes looking at others who are talking while standing near and facing them), playing with others, laughing at another's actions or words, expressing sympathy, fear or anger in response to another.

The possible list of surplus behaviors that can be considered as occurrences of withdrawal is also extensive. This list could include aggressive or hostile comments or actions which function to keep others away. However, aggressive or hostile behaviors are discussed in a separate chapter in this manual. Among the surpluses that define withdrawal in rehabilitation settings are:

> walking or moving away from others who talk to or who approach the client, nonaggressive gestures or words that function to keep others away or to stop others from talking to the client, turning away from or closing eyes when others approach or talk to the client, hiding in a non-play situation, moving to an isolated area of a room when others are present.

Many of the above surplus behaviors are considered to be common or ordinary forms of behavior when an individual is in an unfamiliar place or with unfamiliar people. But they are considered inappropriate and non-adaptive when the person continues to demonstrate them after a place or the people have become familiar.

Note that a treatment plan that serves to increase deficit behaviors such as talking to others will probably help to decrease many of the surplus behaviors such as walking or working away from others.

Rationale for Treatment

As the song says, "People who like people are the luckiest people ..." Wanting to be with others usually results in more contact with others, and this means that we can get more help, give more help, receive stimulation and benefit from the experiences of others. But it is also true that some people enjoy being by themselves, working alone, and playing alone. That is their right. It is only when the isolation is not wanted by the client or when the isolation behaviors interfere with the person's ability to cope with demands of his or her world that withdrawal behaviors become a target for rehabilitation. If a client is so withdrawn that he cannot apply for a job or receive help on the job, he cannot ask for directions, or he cannot taik on the phone, then it is easy to see that he needs help. But when he is able to do enough of these activities to get by, it is difficult to determine whether or not his isolation is by choice or due to a lack of social skills. It takes a skilled professional to determine this in one or more counseling sessions. When in doubt, arrangements should be made for a psychologist, psychiatrist or psychiatric social worker to join the counseling team. To avoid imposing our values about whether or not a particular client should learn new social skills, the rehabilitation professional should consult with others who are familiar with the client before starting treatment.

Action Steps

To develop a program for reducing the surplus behaviors or for increasing the deficit behaviors that define the withdrawn client, it is important to follow these steps.

Step I - Observe the Client

Watch the client at work and in social situations. Notice his or her reactions to staff and other clients. Is the client's isolation by choice or is it the result of a lack of social skills? Sometimes additional data is available from the records, interviews with relatives, previous employers, or reports from other facilities where the individual has been.

Careful questioning of the client in a nonthreatening manner may reveal the difference between a person who has the social skills but chooses independent work and play and one who doesn't know how to make friends, receive help, or hold a conversation. After consultation reveals a problem, the next step helps to pinpoint the behavior.

Step II • Behaviorally Define the Problem(s)

First a list of the deficits and surpluses that define the problem needs to be made. Deficits are easier to identify than are surpluses. For example, the client is liable to never greet others in the hallways, dormitory, classroom, or workshop. He or she never initiates a conversation and only answers questions with brief replies. The list supplied in the definition section (p. 54) should help to identify and specify the problem.

Surpluses are more difficult to assess. The list given in the Definition section should help to specify such problems as moving away from others who sit down near the client, or closing his or her eyes when others look at or talk to him/her (note that the latter problem can be redefined as a deficit, the client does not look at others when they talk to him or her).

Caution: Persons from some sub-cultures or of different ethnic origins display some mannerisms that might be interpreted as withdrawn but which are preferred behaviors for their sub-culture.

Step III - Select the Problem(s) You Will Work On

After consultation with the other staff who are in the position to influence the client's behavior and with the client (and/or counselor), decide which behaviors will be treated and which will first be treated. You will need measures of all to be treated, but may not need to develop an intervention plan for some if the first priority behaviors change the others without your assistance. For example, teaching a person to talk about what he/she has read in the newspaper may result in his or her developing friends who teach that client other social skills. Similarly, shaping a person to ask questions may result in the client accepting help from co-workers.

Step IV - Establish the Baseline

Measure the behaviors for a week to ten days to determine the severity of the problem prior to treatment. Even if the staff believe that the client never greets anybody, asks questions, or answers questions, it is necessary to verify this by systematic measurement. It has frequently happened that when teachers report that a child never follows instructions, careful measurement has shown that the child does what he or she is told 75% of the time. We can sympathize with the teacher because that 25% of the time causes havoc in the instruction but without the baseline we could not have known that our "successful" treatment that produced 3 out of 4 instances of following instructions was no improvement.

The measure selected should be sensitive to change in behavior. If we used a frequency count of how many times the_cljent stands in the corner, the measure would not be sensitive to a treatment that decreased the amount of time the client stays in the corner. (The client still stands in the corner 4 times a day but he or she used to stand there 6 hours and now is there only 10 minutes.) Time sampling (as described in Measurement, p. 5) would be more sensitive to the severity of that type of behavior than would a frequency count.

The measure used during the baseline will also help the staff to set a target level. If the client was standing in the corner for 6 hours, the staff may agree that an acceptable target level would be any duration less than 10 minutes. If the client tells others to leave him or her alone eight times a day, a target level of one or zero might be selected.

For more severe cases of withdrawal, the counselor is referred to the method of measuring the degree of apathy by recording the variety of behaviors observed in the client's day, described in the book by Schaeffer and Martin (1969).

Step V - Graphing

The daily measure of each behavior to be treated is then plotted on a graph as shown in Figure 1 (see p. 8) . Sometimes two or three behaviors can be plotted on the same graph. When treatment begins, show it on the graph by drawing a vertical line on the day that intervention began.

Step VI - Select the Treatment

Read the Cafeteria of Treatments for Withdrawn Behaviors and select one or more that most closely fit your situation and resources. Severe cases of withdrawal and depression should be seen by a psychologist or psychiatrist, and treatments can be planned by a team that includes consultation with one of those professionals. Staff should discuss, role-play, and rehearse the procedures so that all involved in the intervention are consistent in the manner in which they proceed.

Step VII - Treatment, Review, and Revision

No treatment that is presently known will make the withdrawn client into the social leader of the rehabilitation facility. Nor do rehabilitation service agencies have the time, money, or manpower to continue rehabilitation programs indefinitely. If the treatment plans described below are carefully followed, they can be expected to produce significant improvements in the problem behaviors. Each procedure can be held accountable if measurement and graphing are continued during treatment. If the graph shows no change after a month of consistent treatment, the plan should be revised or a different plan should be selected from the Behavior Cafeteria of Treatments.

Behavior Treatment Cafeteria for Withdrawn Behaviors

I.- Extinction of Withdrawing Behaviors and Shaping of Social Skills

Clients who demonstrate a lot of withdrawn behavior have probably received much of their social reinforcement in the past as a result of their withdrawal. Since these clients were not "trouble-makers" in school, they were probably better liked by their teachers than the aggressive children. They were the quiet children. Well-meaning adults will often approach these quiet children and give them extra attention because they seem so shy. Thus, they have been receiving rewards in the form of attention for isolated behavior. The rule to follow in this treatment, then, is to not give attention or verbal reinforcement to the person for any withdrawal behaviors except in a very subtle form that rewards any movement towards others. This might be done in various ways depending upon the client's form of withdrawal, the situation, and the type of reinforcement to which he or she might respond.

•. Make sure that staff do not reward withdrawal behaviors such as hiding, going to a secluded part of the room or standing in a corner. As previously mentioned, many of these behaviors may be maintained by well-meaning professionals who give the client extra attention because he or she is shy or "lonely."

b. Give immediate attention and approval to any behavior of the client that moves him or her in the direction of approaching or verbalizing with others. This attention must be presented in a manner that does not scare or embarrass the client.

c. Make certain that client observes other clients being reinforced fo rsocial interactions. It is especially helpful to reinforce those behaviors in others that are deficits for this client **and** that are within his or her capabilities. That is, it would not be effective to reinforce the social leader of a group since those well developed social skills are likely to be seen as much too difficult or frightening to the social isolate.

d. Reinforce personal hygiene behaviors such as brushing teeth, combing hair.wearing attractive clothes or jewelry since these behaviors make the individual more attractive to others, Shaeffer & Martin, 1969). His improved appearance may result in others showing him more attention and approval.

e. Reinforce appropriate work behaviors such as starting an assignment as soon as the client is told, completing an assignment quickly, doing good quality work, etc., since these behaviors may indicate that the client is trying to "please" or gain approval from the supervisor (Schaeffer & Martin, 1969).

f. Try assigning the client to a classroom, dormitory, or work station activity that requires interaction with others and reinforce the client with the others for their activity. This procedure could include assigning the client to another worker or student who is noted for his or her ability to work well with others.

Reinforcement of gradual increases of behaviorthat are incompatible with withdrawal can be a very slow process but has been found to be very effective in a number of different settings, (hospitals, schools, and homes). Its success depends in part upon the staff's readiness to quickly reinforce slight improvements in approaching and interacting with others. Once the individual does begin to answer greetings, answer and ask questions, to discuss, and to compliment others, more and more social reinforcers become available to him or her and will maintain the client's gains.

II. - Token Economy

Clients who are members of classes, workshops or dormitories that include token economies can be readily treated for problems of withdrawal. Tokens are very useful in an intervention program for withdrawal because,

a. tokens can purchase activities that are valued by the clients. This means that a token can act as reinforcement when supervisor approval does not seem to be valued by the apathetic client.

b. tokens can be presented quickly and quietly when the client demonstrates small gains.

c. the number of tokens presented can be varied depending upon the amount of progress a client shows as he goes about his daily activity.

Table 8 shows an example of the steps that might be followed in shaping the deficit behaviors of a withdrawn client. Note that the number of tokens are varied depending upon the size of the step taken by the person. Each step might be reinforced a few times to maintain it and increase the likelihood of the client making the next step. We have to keep the client from stepping down a rung of this ladder of successive approximations in order to make a step up possible. When he or she moves up, we no longer need to reinforce the earlier steps. In addition, if the counselor or instructor verbally shows approval each time tokens are administered, the counselor's approval takes on more value.

Another advantage of the token economy in developing an intervention program for this type of behavioral problem is the potential use of a response cost system. Since some clients actively extinguish the social responses of others by surplus behaviors such as hiding, moving their desks away from others, choosing isolated working areas, etc., the individual in selected cases can be charged a response cost of a small number of tokens for each such behavior. Thus, the response costs for itemized withdrawal behaviors are listed on the person's reinforcement menu and he or she decides whether to spend tokens on an isolated work bench (5 tokens per day) or on a recommendation for a weekend pass (25 tokens), for example. As with any token economy, response costs are effective only if there are other very attractive alternative activities listed on the menu for purchase. When this client has increased his or her deficit behaviors and decreased withdrawn behaviors to the target levels, he or she is undoubtedly beginning to experience the natural reinforcements present in social interactions and the token economy can be phased out for him or her as described in the manual on behavior management procedures (See Token Economy chapter in Marr & Krauff, 1980).

Table 8

Shaping Social Behaviors in a Withdrawn Client with Tokens*

Step	Behaviors	Tokens
1	Watching others talk, play, or work	1
2	Standing, sitting, or working within 10 feet of others	1
3	Standing, sitting, or working within 5 feet of others	1
4	Step 3 and looking at others talking	3
5	Smiling at remarks of others	1
6	Working with another or a group	3
7	Responding with more than one word to another's questions	3
8	Asking a question	3
9	Initiating a conversation	3
10	Participating in a discussion	5
11a	Helping others	5
11b	Reinforcing others	5
11c	Volunteering for jobs	5

"Although tokens are used here to shape behaviors, the same series of steps could be followed without tokens if approval and other verbal reinforcement are valued by the client and are given as each behavior step occurs.

III. - Behavioral Counseling

Although one of the procedures described above maybe used for treatment of withdrawal problems, it is possible and sometimes advisable to also give individual behavior counseling or group behavioral counseling to certain clients. In some rehabilitation facilities, it is impractical to use either token economies or shaping procedures in classroom, dormitory, or work settings. Then the individual treatments listed below are the only intervention plans that are possible.

A. Individual Counseling Behavioral Procedures for Withdrawn Behaviors

These may include confrontation, assertiveness training, desensitization, and behavioral rehearsal.

Confrontation of the client with his or her deficit and surplus behaviors may take many forms depending upon the particular set of behaviors of the client. They may include almost any combination of the behavioral deficits and surpluses listed on p. 96, in the **Definition** at the beginning of this section. The client may be able to describe and explore these problems with help from the counselor or may need prompts, suggestions, or a simple description of these behaviors from the counselor. Discussion should include reasons why the deficits and surpluses would impede his or her progress in the particular rehabilitation program and would handicap his or her work and social worlds in the future. Certainly these explorations of the problem should include plenty of verbal reinforcement for talking out, initiating descriptions, suggestions, reasons, and agreements. The counselor may have to shape increases in verbal behavior in the first few sessions.

In some extreme cases, point economies might be employed during these individual sessions. The client receives points for closer and closer approximations of the type of verbal interactions that are deemed desirable by the counselor. When he or she has attained some specified number of points, he or she can purchase a pass, a recommendation for a pass, a movie ticket, a swimming pool permit, or whatever the counselor finds is reinforcing—maybe a telephone call home.

Assertiveness training consists of teaching the client to assert him- or herself as a person in a number of social situations. At first this might include teaching the individual to show emotions with his/her face, body, or voice. The counselor may have to model these, encourage and reinforce the client for imitation and initiation of expression of emotion, or discuss places and situations where they might be practiced. Assertive speeches may have to be composed jointly by the counslor and client (See O'Leary and Wilson, 1975, pp. 295-296, for an excellent example). The speech for a particular place and/or type of person may have to be rehearsed, taped, listened to, practiced, and reinforced. For example, a client may say he or she does not know how to get to know fellow workers. In that case, the client-counselor team might work out a number of verbal statements that the client can comfortably say and then practice these under heavy counselor reinforcement procedures.

Actually when the counselor is helping the client practice asserting him- or herself in selected social situations, he or she is also using a form of behavioral rehearsal. This counseling procedure includes role playing on the part of the counselor who acts the part of some significant-other person in the client's world, verbal instruction and sometimes modeling of appropriate behavior to be imitated by the client, and presentation of reinforcement, both those which might occur in the natural situation being rehearsed and those given for appropriate imitation or role playing by the clients (Karen, pp. 399-400).

Some of the characteristics of a behavioral approach to counseling that have been formulated by Karen (1974) are the following.

1. The client's problem is specified in terms of behaviors that can be observed, as in the Definition section of this chapter.
2. Continuous records are kept so both client and counselor can observe progress.
3. Only one problem is worked on at a time.
4. Behavior change is attempted in small steps.
5. The client's problems are dealt with in a manner that will facilitate generalization to the client's everyday life. In some cases, the behavioral counselor may be working with the client in work settings, dormitory, and recreational hall—he or she is not limited to treatments conducted in the office.

B. Group Counseling using Behavioral Procedures for Withdrawn Behaviors

In addition to or instead of individual sessions, group counseling can be very helpful to clients. The group session can be used successfully to teach assertive behaviors and other behaviors that help individuals to interact with others. The group members might be guided into discussing behaviors that help a person meet and get along with others, topics of conversation that interest and topics that bore others, and advantages in developing social skills. The counselor should be liberal with his reinforcement during these discussions as he or she may need to prompt and shape some members of the group.

Other sessions might include role playing specific situations such as meeting a stranger, asking for a date, applying for a job, offering to help another, or holding a conversation. Different members of the group should be praised, and members observing the role playing should be prompted to reinforce and support the actors and then be reinforced for their words.

Group assignments, such as making a new friend, can be given. Members discuss with whom and how to do this and even rehearse behaviors that they feel are necessary. Each person is asked with whom or how he or she intends to carry out the assignment, is reinforced for even weak suggestions, and helped in planning by the counselor and other members. In the next session, members are asked to report on their assignments. Group reaction to successful reports is liable to be more rewarding to some than reinforcement from the counselor in individual treatment. Individuals who were less successful might be helped in further planning and maybe even assisted in their efforts the next week either by the counselor or by other group members.

The group counseling sessions, thus, use modeling, assertiveness training, behavioral rehearsal, and group reinforcement to modify behavioral deficits and surpluses. In some cases, the counselor can include a token economy which is limited to group sessions. Tokens or points could be given for specific social skills shown in treatment sessions such as talking, suggesting, volunteering, reporting, reinforcing, role-playing, and group progress (where everybody receives tokens). Individuals might be asked to estimate how many tokens should be given for each success and reinforced for partial progress. Tokens earned could be used to buy material or activity reinforcement such as movie tickets, passes, or even group field trips.

Whether the counselor chooses to use individual treatment procedures or group sessions should depend upon the individual clients and the particular rehabilitation setting and circumstances. Some clients are too withdrawn to be started with a group and some clients progress so fast in groups that they might be moved back into individual planning sessions with the counselor. Some might even be promoted to assistant group leaders for helping others in a new group which would further enhance their development. In any case, where it is possible, the procedures discussed earlier, extinction of surplus behaviors, shaping of deficits and token economy methods, might be used in addition to the individual and group counseling procedures.

Immaturity: Inappropriate Social and Verbal Behaviors it

Immaturity
Inappropriate Social and Verbal Behaviors

General Definition

There are many types of behavior that are labeled as immature, but they all are more characteristic of adolescence or early adulthood. In all cases, the exhibited behavior is inappropriate for the situation in which the individual is located. People who exhibit these behaviors often are called impulsive, inconsistent, irresponsible, or indecisive, and sometimes are said to have short attention spans or to need immediate gratification. Typically, mature persons did show these behaviors when they were children but dropped them as they grew older.

Some of the ways that immaturity has been described by rehabilitation professionals that seem to refer to things that the client does are:

> Horseplay, goofs around, plays around all the time, acts in a childlike manner, touching and putting hands on others, listens in on others' conversations, irresponsible, impulsive, wants immediate gratification, short attention span, inconsistent.

Other problems described by rehabilitation staff when referring to immature clients seem to include things that clients say or the way they say them:

> can't make up his or her mind, boasts, sarcastic, giggles, talks too loud, talks out at inappropriate occasions, comments on everything, interrupts, inappropriate topics of conversation, inappropriate comments, whines, bad mouths others.

Whether the problem consists of what the client does or what he or she says, the specific behaviors must be identified. The behavioral description should be so clear that two different rehabilitation staff members can agree that an immature action or comment has occurred. Some examples of specific behavioral descriptions of immature behaviors are shown in Table 9. When the immature actions or words are described in terms of specific behaviors, different observers can agree on their occurrence and the client can better understand what is meant when asked to act more mature.

Rationale for Treatment

When children or adolescents exhibit behaviors that irritate others or that prevent them from coping with everyday demands of their lives, we usually are not very concerned. We believe that as they grow older they will become more mature. But we forget that maturity results from a person interacting with his or her environment and learning to accept responsibility for his or her actions. When a person's behaviors result in unpleasant consequences, parents, teachers, and other agents of our society protect the individual from severe consequences and slowly teach the child behaviors that are acceptable to others and behaviors that have better consequences. Most children and young adolescents in America learn from experience in protected middle-class environments.

Table 9

Some Examples of Specific Behavioral Descriptions of Inappropriate Social and Verbal Behaviors

Inappropriate Social Behaviors	Example Behavioral Descriptions
Horseplay	Tickling others, grabbing others, throwing paper airplanes
Acting childish	Making faces, standing on chair, goosing others, mimicking others, making sounds of cars or airplanes
Impulsive	Turns in paper before completion, doesn't check answers, interrupts others
Inappropriate Verbal Behaviors	
Talks loud	Can be heard 20 feet away when talking to somebody 3 feet away
Bad mouths others	Says something critical of another person
Sarcastic	Says something that makes another sound foolish—repeats what others say while using very low or high voice

Some rehabilitation clients were not fortunate enough to learn social skills and other behaviors necessary to function in society. They were overprotected (sometimes because of their physical disability) and seldom required to accept consequences for misbehavior. Or they received little training in skills that are necessary to learn or work. Or they may have had poor models or systematic reinforcement for behaviors that are obnoxious to others. Thus, the task of the rehabilitation professional is to habilitate rather than rehabilitate these clients.

If the behaviors of a client interfere with his or her ability to live and work as independent as his/her mental and physical ability would allow, then the "immature" behaviors are potential targets for treatment. But if the behaviors only reflect different values than ours or in our professional judgement will not interfere with his or her ability to function, or are only temporary products of being in a rehabilitation facility, then the staff responsible for designing and carrying out the individual rehabilitation plan should ignore those behaviors.

Action Steps

To develop a program for changing behaviors that have been labeled immature, the steps below should be followed.

Step I - Observe the Client

Information that reflects immaturity can come from the client, evaluators, relatives, instructors, field-counselors, or records. Regardless of source, the information should be verified by direct behavioral observation. Observations of the client can take place in the counselor's office, cafeteria, evaluation center, work adjustment training area, work stations, or dormitory. These observations should continue until the persons making the observations can agree that the deficits or surpluses are customary and will interfere with successful rehabilitation. Finally, the counselor should discuss the problems with the client to determine his or her feelings and beliefs about the problem. It may be that the client never was told that the behaviors were a problem before. In that case, counseling the client to recognize the problem and accept the need for change is very important.

Step II - Behaviorally Define the Problem(s)

Write the description of what the client does or says, or needs to do or say, so clearly that all staff who are going to measure or treat the problem can recognize and agree on every occurrence of the behavior. If the client has the intellectual ability to understand, the description of the problem should be clear to him or her also. Table 10 in the Definition section of this chapter gives examples of some immature behaviors that have been clearly specified in the right-hand column. Note that the list in the left hand column is not specific and would cause disagreement among staff as to their meaning.

Step III - Select the Problems That You Will Treat

After consultation with the client and staff who interact with the client in those places where the problems occur, decide which problems will be treated and which will be treated first. Those that would cause the client the greatest difficulty in independent living and working may not be the problems that should receive the first attention. For example, goosing and grabbing others in combination with frequent jokes may be more serious in terms of living with others or retaining a job, but the client's frequent talking in a loud voice may need to be treated first. Since the client's loud, incessant talking interferes with his or her and other's instruction in vocational training, it may receive first priority in order to keep him or her from being suspended from classes.

Step IV - Establish the Baseline

Each behavior to be treated must be measured to determine the severity prior to treatment. Use the Measurement section (see pp. 3-7) to help choose a method of measurement that is easy to obtain but is also sensitive to changes in the level of behavior. The baseline measurement should continue until the variation from one day to another is represented.

Frequency, fixed interval, or time sample counts have been used to accurately measure immature behaviors. The frequency count is taken by choosing a time interval and place to observe the client, such as from 7 PM -10 PM in the dormitory or from 8:30 AM -11:30 PM and 12:30 PM to 4 PM in the Work Adjustment Center. Then the immature behaviors such as making faces, goosing others, or making airplane sounds are counted. This count is recorded on a graph for that day and a similar procedure is followed every day for a week or two. This time interval is the baseline period, and the graph record can be used to compare the recordings of the same behaviors after treatment has been started.

If it is impractical to take a frequency count of the behaviors or if the behavior doesn't have a definite beginning or end (he or she babbles all the time), then a fixed interval count or time sample measure can be used. For either, a time interval is selected as described above, e.g., 7:30 PM-10:30 PM in the dormitory, and this time interval is marked off into separate time units such as half hours: 7:30-7:59,8:00-8:29,8:30-8:59, etc. Then for fixed interval counts, the observer records an X at the end of the time unit if the immature act took place or 0 if the act did not take place. At the end of the measurement period for that day, the observer simply counts the number of X's recorded and records that number on the graph for that day. For time sample counts, we simply note whether or not the behavior is occurring at the end of the interval (7:59, 8:29, 8:59, etc.)

Step V - Graphing

Refer to the Measurement and Recording sections (see pp. 3-9) for ideas on graphing immature behaviors. The measure of behavior taken in Step IV should be plotted on a graph daily or twice a week to show the severity of the behavior prior to intervention. Two or three behaviors could be shown on the same graph if they were counted in the same way, i.e., all measured by frequency daily or all counted by time sample. You may want to plot the same behavior on two different graphs if it is being measured in two different places, i.e., the dormitory and the workshop.

Step VI • Select the Treatment

The behavioral treatment for decreasing immature behaviors and increasing mature behaviors is partially revealed by an examination of the typical history of individuals who exhibit deficits in mature behavior and surpluses of immature behavior. The socialization process in our society usually results in increasing frequencies of rewards for acting more

maturely, fewer rewards for acting immaturely, and punishments if we continue to act immature as we get older. In addition, the individual usually imitates the behavior of significant others around him or her, especially if they appear to be successful in obtaining rewards and avoiding punishment and if they appear to be interested in him or her.

By contrast, individuals who continue to act in an immature fashion have been living in a world where one or more of the above have failed to happen. That is, although they have grown up physically, someone (parents, teachers, supervisors, or peers) has been rewarding them (giving attention and approval) for their immature behaviors, have not been rewarding them in a consistent manner for acting more maturely, or have not consistently punished them (by showing immediate disapproval) for the immature behaviors. To treat these types of problem behaviors in a rehabilitation program, it is required that we intensify the teaching of the correct manner of behaving in a much shorter period of time than it normally takes for a person to mature.

The treatments in this section are presented in two sections, Inappropriate Social Actions and Inappropriate Verbal Behaviors. Turn to the section that represents the problem of your client when you have started the baseline graphing and select a treatment that best fits your staff and situation. It is advisable to read through all treatments before selecting one. All staff should be trained to be consistent in treatment.

Step VII - Treatment, Review, and Revision

Once the staff who will be part of the intervention have been trained, treatment should begin and measurement continued. If daily measurement is not possible during intervention, use the same counting method as in baseline but only count twice a week. If after three weeks, the graph shows no improvement in the behaviors, review the treatment by actually watching the staff who are doing it. If they are consistent in the manner in which it is being carried out, then revise the program or select a different treatment plan from the Behavior Cafeteria.

Behavior Treatment Cafeteria for Immature Behaviors

In this section, treatment plans for inappropriate social behaviors characteristic of immature clients will be presented first, followed by treatment procedures for immature verbal behaviors.

A. Treatments for Inappropriate Social Behaviors

Behaviors described as horseplay, "goofing off," and playing around all the time usually occur in classroom or work situations, but occasionally also happen in hallways, cafeterias, dormitories, or even in the waiting rooms of the counselor, physician, etc. Five behavioral techniques that can be effective in decreasing the frequencies of these surplus behaviors are (1) time-out and positive reinforcement, (2) fading and positive reinforcement, (3) extinction and group positive reinforcement, (4) extinction-correction and individual positive reinforcement, and (5) response cost in token economies. More complete descriptions of these procedures are given in the manual by Marr and Krauft (1980). In all cases, the focus of the treatment is on helping the individual discover alternative ways of getting attention and reinforcements other than by "goofing off."

I. - Time-Out and Positive Reinforcement

If an individual is prodding others with a pool cue in the recreation hall, "goosing" people in shop, or shooting paper wads in class, 5-10 minutes of time-out from an activity that he or she wants to participate in can be very effective. For this technique to be successful in decreasing these types of behavior, the supervisor must apply the time-out procedure every time the behaviors occur. Care must be taken, however, not to reward the individual with attention. All time-out should be given in a neutral manner by the supervisor. Since some individuals are more likely to "horse around" when they are bored, removal from a class room or workshop for 5-10 minutes probably will not be very effective. On the other hand, a five-minute delay in leaving the shop at the end of the day for each infraction can be very effective, provided the individual is told immediately after the infraction that the delay will take place because of the incident. Five or ten minutes delay in obtaining

freedom in the evening, or a few minutes time-out from the pool table or ping-pong table, can also be effective. Swim life guards have found how effective it can be to decrease horseplay in or around the pool by making an individual take five minutes time-out at a bench or else be banned from pool premises. The latter produces hostility and resentment while the former produces behavior change.

Teachers have found that they could get much more work from their students in a fifty minute class period if they gave the class permission to talk, play cards, write letters, etc., during the last ten minutes of the class. Those individuals who "goofed off' in any fashion during the first forty minutes are delayed from the free time two minutes for each disruptive incident. This is only effective as a suppressor of inappropriate social actions if the student is told immediately (in a neutral manner) that he or she has just lost two minutes from free time because of the immature act.

It is very important that the instructor or supervisor compliment and give attention to the client when he or she has shown improvement in behavior even though improvement is slight. The most reliable law which exists in the practice of behavior modification is that behavior which is reinforced will increase in frequency. Even though the improvement appears to be an accident, it should be rewarded. "I really appreciate it that you have not been fooling around this morning, John." "You have made this class a lot more pleasant this morning, Tom. I like the way that you have been working (studying, etc.)."

II. - **Fading and Positive Reinforcement**

This procedure uses the common observation, "When the cat's away, the mice will play," by putting the cat so close to the mouse that it doesn't dare play. Reward the client for not playing, and then gradually fade (remove) the cat. But continue to reward the mouse for not playing. Some clients who "horse around" usually do this only when the supervisor is busy, out of sight, or not likely to see them do it. Once the instructor has obtained baseline data, he or she starts the first treatment period by moving to a position where the client won't perform the inappropriate behavior, waits a short period of time and then rewards the client with a compliment for the way he or she went to the desk or work area and started working without any horseplay or whatever. Next, the instructor moves to a place slightly farther away, waits, and then reinforces again. He/she continutes fading himself or herself out of the picture but continues reinforcement.

A similar procedure might be used in the dormitory or recreation hall. After rewarding appropriate behavior, the supervisor returns to his control position and then moves (turns) to a **slightly** less imposing or controlling location, waits a while longer, returns to the client and again compliments him or her. This procedure is continued until the instructor can return to the usual shop, class or recreation hall activities. However, the rewards should continue, although much less frequently than when the first treatment period was initiated. **Caution:** Rewarding statements must be made in a sincere fashion or they will betaken as sarcasm, i.e., punishment.

III. - **Extinction and Group Positive Reinforcement**

Inappropriate social behaviors occur because the client has had a history in which those behaviors have worked for him or her some of the time. Those behaviors were rewarded by peers some of the time. To extinguish the behavior, we would have to arrange the situation so that the client never receives attention or reward for misbehavior. Although it would be difficult if not impossible to follow the client around everywhere and ask people to ignore his or her goofing around, it is possible to control this problem behavior in a particular work room, classroom, or dormitory by giving the client's fellow students or workers an incentive for ignoring him or her when performing the inappropriate behavior.

This is done by explaining to the class that his or her behavior is a problem, why it is a problem, and what the correct manner of behaving would be. The instructor then asks the class to help by not laughing, looking at, or giving attention to the client when he or she "horses around." They are then told that if they all will ignore the client every time he or she acts inappropriately, the behavior will change, and they will receive a group reward of their choice (within reason). The instructor might then ask for suggestions for group rewards and might suggest some, such as a field trip, movie, longer breaks for a week, etc.

Similarly, the plan is explained to the client and he or she is told that a decrease in the offensive behaviors will result in his or her earning the rewards for the group. This procedure makes both class and client participants in treatment and can result in the individual discovering that his new mature behaviors result in some peer prestige (reinforcement).

IV. - Extinction—Positive Practice and Individual Reinforcement

When the client clowns, grabs objects, and fools around in other ways in the counselor's office, reception room, etc., he or she should be given no attention at all until the inappropriate behavior has ceased for at least 5-10 seconds, and then told in a neutral manner that his or her behavior was inappropriate and that you would like him or her to not act in that manner in the future. If it is possible and practical, ask the client to reenter the office or room and———(tell the client exactly what he or she should do). When the client reenters the room and behaves appropriately, compliment him/her and tell him/her how much you appreciate the behavior being repeated in the correct manner. Have the client repeat it again and again reinforce. If this procedure of not reinforcing the inappropriate behavior through attention, giving practice in acting appropriately, and then rewarding the mature behavior is continued every time the client "acts childish," the inappropriate behavior will decrease in frequency in that situation and the more mature behavior will increase.

Of course, a client who uses the misbehavior to irritate persons in authority positions (usually because they react) will not respond well to this technique if the counselor is not a very important source of reward. The counselor's approval must be important and genuine in order for this technique to be successful.

A slight modification of this procedure can be used for the individual who comes up to the counselor, instructor, or supervisor and puts his or her hand on the supervisor's arm, tugs at the sleeve, or otherwise signals with an inappropriate activity. The client is ignored until the behavior ceases, or if the behavior cannot be ignored, the counselor stops whatever he or she was doing and stares at the offending hand or signal until it is withdrawn or stops, continues what he or she was doing before the interruption for a short period of time (at least 10 seconds but not over 30) and then thanks the client for waiting. The counselor then explains to the client that the handling, tugging, or whatever was inappropriate and that he or she should do———in the future. Then the counselor asks the client what he or she wants.

If this inappropriate behavior does not change, consider using Response Cost (below) or Negative Practice (See Section B, Treatment III).

V. - Response Cost

Inappropriate social behaviors can be quickly extinguished if a token or point economy is operating in the classroom, work setting, or dormitory (See Token Economy, Manual by Marr and Krauft, 1980). The client is receiving tokens or points for appropriate behaviors and spending them for activities that he or she wants. Response costs are behaviors that are listed at the bottom of the Reinforcement Menu (below the desired activities) and are inappropriate or nonadaptive from a rehabilitation point of view. Such immature behaviors as shoving or hitting, throwing objects, yelling, or failure to wear safety goggles when using the machinery in shop, would have a cost in tokens assigned to them. The cost should be determined by the severity of the behavior. Thus, being five minutes late would have a smaller cost than cutting class. However, the cost should never be so high that it would be almost impossible to purchase the activity. We want to put the individual into a choice situation. Does he or she want to hit somebody which will cost 50 of the 75 points saved or purchase a pass that night for 50 points?

It must be their choice.

In a home token economy, the parents had listed a response cost of eating cookies between 5 and 6 PM; the family usually ate dinner at 6 PM. One cookie cost 1 point. One day the ten year old boy was observed reaching into the cookie jar and getting 5 cookies at about 5:15 PM. He was reminded to mark the cost down in his point book. (Often in homes where there is not point economy, a parent would say "Put those cookies back, its almost dinner time." The child would say, "But, I'm hungry, I'm

starving," and the verbal battle would be on.) The boy then looked at the cookies and said, "I think I'll put one back. No, I'll put two back." He hesitated over the cookie jar some more and then said, "I guess I'll wait until after dinner," and put the remaining cookies back in the jar.

The Response Cost procedure puts the individual into a situation where he or she must choose to perform behavior that will cost tokens which he or she would rather use to purchase something else that is more valuable to the individual. If the cost is too large, he or she won't purchase the inappropriate behavior because there are never enough tokens or points to purchase it. But if it is kept within his or her price range, then the individual can choose to not do the immature action (a habit we want to encourage) because there are other activities he or she wants to earn.

Another procedure that encourages the practice of not choosing the response-cost behavior is to give a bonus in tokens or points, once a week or month, for not choosing the response-cost behavior for that week or month.

B. Treatment of Inappropriate Verbal Behavior

Immaturity has often been described by the way an individual talks or interacts verbally with others and by the effect of this verbal behavior on others, e.g., can't get along with others, not liked by others. Verbal interaction with others can be rewarding, boring, or even punishing. Boasting, bad-mouthing others, making sarcastic comments, and talking too loud are ways of talking to others, but they all punish the listener. The person who uses these forms of communication is using them to get attention. Unfortunately, they do get attention sometimes, and he or she is thus reinforced part of the time. Since behaviors that are learned on a partial schedule of reinforcement (occasional attention) are extremely difficult to extinguish, we find that these behaviors are very hard to decrease. In addition, some clients who use these behaviors seem to be insensitive to the negative feedback they get from some listeners. It appears that any attention, even negative attention, is better than no attention at all.

The treatment for immature behaviors such as the above must consist or memo as TO increase verbal behaviors that are more acceptable in our society as a means of interacting with others. In this section treatments to decrease the inappropriate verbalizations are presented first. These are extinction, verbal punishment and extinction, negative practice, and response cost. With each of these, positive reinforcement practices and methods of removing negative reinforcement are described which increase appropriate verbal behavior and teach the individual to discriminate between comments that others like to hear and those that others dislike. Finally, methods of instructing the individual in more appropriate ways of dealing with others are discussed.

I. • Extinction of Inappropriate Verbal Behaviors

Extinction of boasting, loud talk, sarcastic comments, etc., is very difficult because the individual is probably getting some attention and approval for these behaviors from his or her peers. It is impractical to try to get all the people whom he or she normally meets in a day to ignore the client when he/she demonstrates one of these behaviors. However, it is possible to teach the client to discriminate between those occasions where sarcasm or loud talk will be reinforced and those where they will not. Thus, the client can and will learn to extinguish sarcasm, boasting, loud talk, etc., in conversations with a particular person (e.g., counselor, work supervisor) if that person immediately turns away or walks away from him or her whenever he/she boasts or talks loudly. This technique has been found to be effective even in social situations, such as a conversation between two persons at a table in a cafeteria. When A starts to boast, B immediately looks away and continues to look around the room, never responding or looking at A until the boasting has stopped.

II. • Verbal Punishment and Extinction

Schaeffer and Martin (1969) reported a slight modification in the above procedure which improved the extinction of nonsense talk or psychotic talk in a hospital ward. Whenever a patient started to talk "nonsense" during a conversation between the nurse and patient, the nurse would say, "That's crazy talk, and I'm not listening to crazy talk," and then he or she would leave.

This procedure could be applied in a number of rehabilitation settings. For example, all the rehabilitation workers who interact with a client who talks loudly much of the time could follow the procedure of saying to the client whenever he or she talks loud, "That's loud talk, and I don't want to listen to loud talk," and then leave. The advantages that Schaeffer and Martin (1969) report for this treatment are that it (1) gives the instructor or counselor something specific to do instead of listening to the client, and (2) it more clearly identifies the inappropriate behavior for the client.

The treatment for giggling is similar. Simply turn to the client when he or she giggles and say, "You're giggling; I don't like giggling," every time he or she giggles. This statement terminates any conversation that was going on and acts like a short time-out before the conversation resumes. This treatment is very similar to behavioral procedures that have been very successful with nervous tics. Every time a tic occurs, music that the patient has been listening to terminates. The tics tend to decrease in frequency. In the case of giggling, clients should be verbally reinforced forgoing longer and longer periods without giggling.

Note that children are taught to not interrupt in a similar fashion. Whenever the child interrupts, the parent says immediately, "You are interrupting me," or "You have just interrupted Mrs. Smith. Wait until I have (Mrs. Smith has) finished talking." The the parent continues talking or listening to the other person for another 30 seconds and then turns to the child, reinforces him or her for waiting, and asks what he or she wants. If the client acts in the immature fashion of interrupting others, he or she would be treated in the same fashion that the child was.

Caution: These procedures of extinction or verbal punishment will be effective in decreasing inappropriate verbal behaviors only if the counselor, supervisor, or instructor is a person with whom the client would want to continue conversations. They must be valued as sources of interest or gratification in order for their loss of attention or approval to be effective. On the other hand, if the instructor is constantly criticizing the client or giving him or her orders, then the client's sarcasm is reinforced when the instructor turns away.

III. • Negative Practice

If a person who "bad mouths" or criticizes others frequently is taken into a separate room or office from where the error occurred and told to criticize some more, some more, and more, and more, until he or she says "I can't or won't," then we are using the procedure of negative practice to produce a decrease in a surplus behavior. If this is done every time the individual criticizes somebody, the criticism will decrease. The procedure dramatically calls the behavior to his or her attention, and the encouragement to practice it, in private with no comment from the instructor except to urge him or her on, gets to be punishing until the client learns to inhibit the criticism almost as soon as he or she begins to criticize. Eventually, the behavior will cease entirely in those situations where negative practice is contingent upon criticism. However, the "bad mouthing" is liable to continue around others who give attention for his or her comments. Positive reinforcement should be given to the client for decreases in criticism and increases in favorable comments about others. Some clients never learned to say nice things about others and need instruction, practice, and reinforcement (See V., below).

This practice can also be used for those who giggle, or boast if the graph shows that the extinction procedures, above, do not appear to be affecting the behaviors.

IV. • Response Cost

A token or point cost can also be assessed for inappropriate verbal behaviors where token economies are being used. (See response cost to decrease inappropriate social behaviors, Section A, Treatment V.) Response costs have been used very successfully to decrease "crazy talk," delusions, and even hallucinatory talk in mental patients.

V. - Instruction in Appropriate Verbal **Behavior**

So many of the individuals who are described as immature not only have surplus behaviors of loud talk, boasting, or sarcasm, but they also have deficits of appropriate ways of dealing with others. Many have never had mature persons around who modeled behaviors of listening attentively to others, commenting with approval on what others said, selecting topics of conversation that are interesting to the listener, and answering questions in a polite, non-sarcastic manner. Or, if the client was exposed to that type of person, he or she may not have attended to the relevant behavior. Meanwhile, the client was probably being rewarded for immature behaviors by peers, parents, and teachers.

One way to bring about increases in appropriate verbal interactions with others is through formal instruction. This can be done individually or in groups by the counselor or psychologist. The goal of the instruction is to produce a greater frequency of mature interactions with others, but the procedure requires that the individual clients (1) be confronted with their inappropriate behavior, (2) be confronted with the short term and long term impact of their present behaviors on their relationships with others, (3) be instructed or sensitized to alternative ways of talking or dealing with others, (4) be given the opportunity to practice these alternative behaviors in a permissive, rewarding atmosphere, (5) be encouraged and guided in planning specific opportunities outside the instruction setting to practice what they have learned, and (6) be encouraged to report back their successes and failures in practicing the new ways of dealing with others.

Confrontation of the client with his or her behavioral surpluses and their effects on others (Steps 1 and 2, above) usually should be done in an individual session with each client. In the first meeting, reasons can be given for assignment to further sessions dealing with the problem or for assigning him or her to group instruction, questions can be answered, and the importance of this instruction for the client's rehabilitation plan can be discussed. The counselor should reveal his or her greatest degree of accurate empathy, warmth, and genuineness. The remainder of this section dealing with instruction will describe group procedures, although they can be readily adapted to individual counseling sessions.

Step 3, sensitizing the clients to alternative behaviors, can be initiated by assigning readings in books or pamphlets dealing with how to win friends in social and employment settings. These reading assignments can then be topics for discussion in the group. The instructor has to be very careful here to reinforce frequently any verbalization which indicates even slight interest in alternative ways to dealing with others. Group techniques that have been used successfully are role-playing encounters with others (prepared ahead of time by the instructor), listing and discussing topics of conversation which the clients find interesting, and listing topics that peers, children, men, women, employers, nurses, retired persons, etc., might be interested in. The discussions should include reasons why those topics are interesting to particular groups. Thus, the group meetings progress from sensitization, to alternative ways of talking and interacting with others, to actual practice in a group situation where the counselor or instructor is supportive of their initial attempts to try out some of these methods of interacting with others.

King, Armitage, and Tilton (1960) reported their use of a technique to promote better interpersonal skills in chronic schizophrenics that could be adopted fairly easily to group instruction in rehabilitation settings. In this procedure, called "operant interpersonal method," a token economy is initiated with a list of target behaviors, points or tokens, and a backup menu (See Token Economy, in Man and Krauft Manual, 1980). The target behaviors can be selected by the group and consist of social behaviors that result in cooperation and improvement in interpersonal relationships. Some examples would be greetings, courteous responses to questions and requests, initiation of conversations that are interesting to others, listening in an attentive manner, contributing to a conversation about a topic that the client is not highly interested in (he is likely to call it boring), etc. In this type of group interaction, clients earn tokens or points which they can use to purchase group or individual activities, i.e., a trip to a swimming pool, a "chance" for a drawing for a theater ticket, or a pass.

When individual members of the group are showing sufficient skills in appropriate ways of interacting with others, they should be encouraged to relate any attempts at extending these behaviors to situations outside the group meetings and be given praise and encouragement for their attempts as well as their successes.

For those members of the group who show some reluctance to try out their new behaviors, group or individual planning is initiated (Step 5). Here there is a great need to encourage the individual to start with a small step in which he or she tries greeting somebody in a nonsarcastic manner in the dormitory, work setting, or classroom; initiates a conversation about something that is interesting to another person. Step 6 takes place when the individual begins to report successes to the group and shows some interest and enthusiasm for continuing practice of these more mature or cooperative forms of behavior outside of the group meetings.

Complaining About Somatic Conditions, Sickness and Incapacities

Complaining About Somatic Conditions, Sickness and Incapacities

General Definition

Rehabilitation facilities have many clients who seem to be preoccupied with somatic complaints. Some have physical disabilities that have become the center of their attention or have become the focus of attention of their doctors, nurses, families, and friends. Since social reinforcement has so often been associated with their disabilities, it is understandable why their favorite topic of conversation is their disability. Other clients who have no apparent physical disability will often complain about physical problems because they have been raised in a world where the family or friends give them a great deal of attention whenever they seem to have a complaint. They have frequently been excused from tasks, school, and work whenever they verbalized a complaint about their stomach or head pains. To them, the complaints may be as real as the complaints of the clients who have observable disabilities. Still a third group of clients have become aware of the use of physical illnesses to get out of new situations that demand effort or stimulation which they believe they can not handle.

Psychiatric classification schemes have typically categorized these clients as hypochondriacs or as malingerers. Since the behaviors of all these clients are so similar, the behavioral treatments suggested are much alike. Clients suffering from hypochondriasis are said to believe they actually have some kind or many kinds of physical disorders. The person who scores high on the Hs scale of the MMPI has many vague and nonspecific complaints about bodily function and malfunction:

> "high scorers are sour on life, whiny, complaining, and generally handle their hostile feelings by making those around them miserable. Frequently they use somatic complaints to control others. They tend to be cynical and defeatist, especially as regards others' efforts to help them. They are highly skilled in frustrating and infuriating physicians, of whom they often engage a great number in succession."
> (Carson, 1969, p. 284)

These clients in rehabilitation may complain about headaches, nausea, feelings that they are going to vomit, chest or heart pains, fatigue, weakness, tremors, ulcers, weight loss, loss of sleep, etc. Rehabilitation staffs have described these clients in various ways:

> always bellyaching about a problem, always has a pain, contantly talks about ailments, feels bad all the time, talks about illness, seeks attention with illness, something always hurts, psychoneurotic illness.

The person who is said to be a malingerer is often using many of the same complaints, but the professional believes that he or she is pretending to be ill or otherwise incapacitated in order to avoid work or duty. This client also tends to focus concern on his or her limitations rather than assets, often saying, "I can't do it." The description of these clients often emphasize the pretense of the complaints:

> fakes aches and pains, looking for a free ride, exaggerates pain, uses disability as a crutch, seems to want to be disabled, dawdling, enjoys his misery, dallies, goldbricking.

Both categories of clients are often complaining about physical illnesses, their disabilities, or their inability to do something. It is easier to suspect the complaints of the malingerer because his or her illnesses often appear during class or work and seemingly disappear when it is time to quit work or have fun. The hypochondriac client may have more complaints even though they are vague, more anxiety about his abilities, and be more consistent in the concern over his or her inabilities across work and non-work situations.

In all cases, the rehabilitation intervention plan should include a complete diagnosis of the extent of disability or physical condition from a physician which includes a description of any physical limitations.

Rationale for Treatment

Physical disability often limits an individual's activities in daily living and restricts an individual's vocational opportunities. Complaints about illness, physical discomfort, pain, and disability can further restrict attainment of one's maximum potential in work and social activities. Research and treatment programs at the Department of Physical Medicine and Rehabilitation at the University of Minnesota (The Pain Clinic, 1977) and at the University of Washington School of Medicine (Fordyce, 1976) have shown that a person complaining of chronic pain can be taught through behavioral methods to function normally for a person of his or her age and sex without pain. The Minnesota Pain Clinic, referred to above, lists a number of objectives for their patients that are relevant here (The Pain Clinic, 1977, pp. 15-16),

1. to increase his or her physical activities to levels consistent with the patient's age, sex or physical limitations,
2. to eliminate all nonessential medications, including pain medications and psychoactive medications,
3. to return to a life situation which is satisfying to the patient and the family and consistent with any physical limitations that the patient might have,
4. to no longer use pain as a means of controlling relationships with family and others,
5. to no longer be dependent on physicians, hospitals, and other health care providers, except as needed for new medical problems or old medical problems not related to pain,
6. to cease exhibiting verbal and behavioral pain complaints, and
7. to feel more comfortable with oneself and others.

The interventions presented in the remainder of this section are primarily targeted at objectives 4 and 6 above. Effective treatment of those should help to influence some of the others. Complete treatment of chronic pain would require referral of the client to one of the pain clinics such as in Minnesota or Washington.

Action Steps

If you are preparing to develop a treatment program for a client who frequently complains about real or imaginary physical problems at inappropriate places and times or to inappropriate persons, follow the steps below.

Step I • Observe the Client

Familiarize yourself with the client's disabilities and behaviors. It is essential that no treatment be started until the client has had a complete physical exam and the physician advises the treatment staff as to the physical conditions and limitations of the client, the physical activities appropriate to the client, and any existing medical conditions. This information forms the basis for what the client is encouraged to do in a rehabilitation program, so that the rehabilitation staff are not completely dependent upon what the clients says he or she cannot do.

The previous medical records and referral records also can provide information about excess discomfort or complaining behaviors. The client has probably had a long history of receiving attention for verbalizing discomfort so that his or her works, facial expressions, and mannerisms have become ways to manipulate either knowingly or unknowingly those around him or her. Referral records or medical histories may indicate that the client's level of complaining about his or her disability does not correspond with his or her physical condition.

Staff in evaluation or admissions can quickly note whether a client complains frequently or states that he or she is unable to do many of the evaluation tasks. That information must be combined with the information from the physician to determine what the individual actually can or cannot do.

Finally, the counselor's first interview with the client will usually reveal the problem of surplus complaints of physical problems. The behavior of complaining is usually such a high priority topic of conversation for this client that he or she cannot refrain from the topic when confronted with a warm, empathetic person such as the counselor.

Step II - Behaviorally Define the Problem(s)

After consultation with the relevant staff who have observed and evaluated the client and after interviewing the client, behaviorally define the problem. Write down what the patient says and does to indicate that he or she is unable to do something. Check to make sure that what the client says he or she can't do is within his/her physical capabilities.

In some cases a behavioral assessment outline might be helpful.

Antecedents: When does the client say or do it?
Where?
Who else is present?

Behaviors: What does the client say or do?

Consequences: What happens when he or she says or does it?

Example 1

Antecedents: When staff ask him or his group to do something.

Behavior: He says he can't because he has a headache,
He says he is not feeling well,
He says he is sick, or
He groans and holds his head or stomach.

Consequences: Staff let him just sit or sympathize or send him to medical.

Step III - Select the Problem(s) You Will Work On

If there is only one behavioral problem that you wish to treat and it occurs only in one situation, proceed to Step IV. If there is only one problem but it occurs in many locations, such as dormitory, vocational class, and counseling office, consider measuring the behavior in one, two, or three places but start treatment in only one. This would allow you to determine the effect of the intervention and to adjust it before implementing it in the other locations.

When there are two or more problems, choose one to start and then later treat the other or start measurement and then treatment of both in one location. Later introduce the treatment to other locations.

Step IV - Establish the Baseline

Select a method of measurement (see pp. 3-7). Frequency counts or interval counts are probably the best methods to determine the severity of the problem. In counseling sessions the counselor could count the number of physical complaints the client makes. In the vocational class or evaluation, staff could count the number of times the client comes to the supervisor to complain during a two or three hour period.

Another method to measure the problem is to divide the work or classroom period into time intervals such as half hours. At the start of every time interval, approach the client and wait for a comment or ask how he or she is doing. If he/she complains, make a record of "X" or "Yes," if he/she doesn't, record a "0" or "No."At the end of the measurement period, count the number of time intervals that have "Xs" and record this number on the graph. One week of such recording will serve as a baseline.

If the number of complaints that were made in two or three counseling sessions are counted and if those numbers are graphed, they will serve as a baseline with which to compare the record taken during counseling sessions after an attempt to decrease complaints has been started.

Step V - Graphing

Make a graph as described in that section (see pp. 7-9). A group of behaviors that all deal with physical suffering could be on the same graph. Similarly all behaviors that concern the individual not being able to do something could be counted together and placed on the same graph. For example,"! can't," "That's too hard for me," "My back won't let me," might all be grouped under inability statements and graphed. Behaviors that are receiving different treatments should have different graphs so that each treatment can be held accountable.

Step VI - Select the Treatment

Review the behavior treatments presented in the Cafeteria for Complaining Behaviors.

The intervention procedures presented there are described separately but should be combined whenever possible, since the clients complaints are likely to occur in all areas of the rehabilitation facility. The particular combination of the intervention procedures for a specific client should be selected after evaluation for the presence of anxiety over his or her inadequacy or incompetency, the presence of a physical disability, and complaints about somatic problems. Thus,

Client	Disability or Somatic Complaints	Physical Disability	Anxiety About Abilities
A	Present	Present	Present
B	Present	Present	Absent
C	Present	Absent	Present
D	Present	Absent	Absent

Every staff member involved in the intervention must be informed about each of the categories above. Staff must be trained and rehearsed in the proper procedure before treatment is begun. Training staff is always important but special care must be taken for intervention procedures dealing with complaints about physical illnesses, bodily conditions, and incapacities. All questions about the client's physical limitations and the disability must be discussed. Staff in rehabilitation facilities were reared in a society where concern and sympathy is the approved behavior when somebody complains about their illness or show facial expressions that indicate they hurt. Rehabilitation staff whether they are nurses, physicians, counselors, or instructors have been trained to "comfort" people who have disabilities and who complain. Careful education and discussion are necessary to let staff know that they are actively treating a serious rehabilitation problem when they systematically ignore complaints.

Step VII - Treatment, Review, and Program Revision

Thorough training of staff, careful measurement during baseline and after treatment is initiated, and consistent treatment will allow an assessment of the effect of the intervention program. The client has probably had many hundreds of reinforcements through attention and concern for physical complaints. Those behaviors are strong habits, and they will not disappear immediately no matter what the treatment.

An intervention program must be given a chance; three weeks are probably a minimum period to allow the potentially successful treatment to **begin** showing an effect. If the program does not show an effect after a month of consistent application, review the procedures, modify them, or select a different treatment. Measurement and graphing are the means by which the professional can hold an intervention program accountable.

Caution: In some cases, the habits are so pervasive in the life of the client that they are untreatable with the limited staff, resources, or time of the rehabilitation facility. Referral to one of the pain clinics might then be considered (See The Pain Clinic, 1977).

Behavior Treatment Cafeteria for Complaining Behavior

When there are physical disabilities present, the intervention procedures selected for treatment of complaints must include complete medical evaluation, consultation, and cooperation.

I. - Extinction and Positive Reinforcement

All intervention plans should include these treatments when complaints about fatigue, headaches, soreness, sickness, etc., are frequent topics of conversation for the client. These persons have been receiving occasional reinforcement in the form of attention, concern, and empathy for complaining about their illness or disability. If we withdraw reinforcement completely, the client will typically seek out others who will show concern, which is why so many hypochondriac patients change doctors so frequently. Thus, the procedure is one of maintaining or increasing his or her present level of reinforcement but switching the reinforcement to other behaviors or characteristics (clothes, work) of the client.

The steps to be followed are:

a. Notify all staff who will be involved directly with the rehabilitation of this client as to the extent of his or her disability or illness and of any physical limitations.

b. Notify all staff that any somatic or disability complaints are to be ignored. This does not mean that the client should be ignored. Reinforcement for any appropriate behaviors or conversational topics should be continued or preferably increased.

c. If the client does occasionally comment on the work place, tools, the job, relatives, interests, friends, activities, plans, or clothes in a noncomplaining manner, give him or her immediate positive attention. Let the client know in a sincere fashion and a comfortable manner that what he or she is saying or has said is interesting. When he/she has gone a whole half hour, half day, or day without complaining, tell him or her that day that he/she has been a very pleasant person to deal with, talk with, work with, or whatever, that morning or day.

d. If the client does not talk about anything else except his or her illnesses, wait for an opportunity when he/she is not talking and then ask about something that he/she is likely to be interested in, such as some piece of clothing, or jewelry that he/she is wearing. When he/she answers, show a lot of positive attention. If the client starts to complain, tell him/her that you don't want to hear about that and walk away in a neutral manner. Return soon and try again.

e. If he or she comes to you with complaints, ignore them and switch the topic of conversation. If he/she persists with complaints, tell him or her that you don't want to hear about that and walk away if he/she persists.

f. If the client says that he/she needs medical attention, tell where and when he or she can get that attention but don't allow him/her to leave work, assignment, etc., unless his/her physician has said that this is necessary.

g. It is essential that he or she receive a lot of attention and praise for all other appropriate behaviors, dress, conversation, etc. Do not ever show anger at his/her complaints. Ignore them or respond in a neutral manner that you don't want to hear about them.

h. Continue to measure the frequency of complaints as is suggested in the section on measurement in this chapter. This measurement will show a slow, steady decrease in complaints if a consistent program of reinforcement and extinction is used.

II. • Token Economy

When there is a token economy operating in the program to which the client is assigned, tokens can be used to increase appropriate behaviors and decrease complaining. The procedure that is followed here is very similar to that described in the preceding section when we reinforced the client every time he or she spoke positively about himself, or about something he or she was doing. Now, however, we can use tokens in addition to verbal approval to reinforce him/her.

Although the whole group or class including this client may be receiving tokens for appropriate dormitory or work behaviors, each client may have some behaviors listed on his or her treatment plan which are specific to his/her problem and for which he or she can earn tokens. The clients who complain a great deal about their disability, fatigue, or other real or imaginary illnesses would receive tokens for talking about other topics. In addition, they can be given a bonus in extra tokens at the end of the morning or afternoon for not complaining all morning or afternoon. Later this time period can be extended to all day and then all week.

For those clients who are quite anxious about their feelings of inadequacy or incompetency, it is essential that the supervisor find ways of reinforcing these clients frequently. However, the token reinforcement must only be given for specific behaviors—dress, actions, or words. Similarly, reinforcement should be frequently administered to the non-anxious complainer, or complaining about not getting as many tokens as everybody else might increase.

In some cases, a response cost might be used. The client is informed that complaints about his or her fatigue, illness, or disability should only be made to the physician. Complaints in the shop, class, or dormitory do not help; so they will cost one token each. The client is allowed to make as many complaints as he or she wants, but each complaint will cost. This method emphasizes to the client that it is his or her choice as to whether he/she wants to spend tokens on complaints or on one of the other items on the reinforcement menu. The cost for complaints should be small so that the client cannot say that the high cost of a complaint is keeping him or her from purchasing them. In a sense, we are putting the person in a conflict where he/she must choose.

Caution: Response costs might be used for the malingerer who uses complaints to avoid work but should not be used for clients who exhibit a great deal of anxiety or uncertainty about their ability.

A variation of the token economy system could be used in some cases when there is no token economy already existing in the classroom or work center. The complaining client is given ten or twenty tokens or points at the beginning of the work or class day. At the end of the day, he or she will be able to exchange points for either a group reinforcer or individual reinforcing activities. One point is deducted during the class or work sessions for each complaint. Thus, the more complaints, the fewer remaining points he or she has to purchase reinforcing activities such as recommendations for a pass or recreational activities. If this type of token economy is used, it is important that the client still receive frequent verbal reinforcement as outlined in Section I above. For more details on implementation of a token economy, see Marr and Krauft (1979).

III. - Negative Practice

In certain selected cases where the client is believed to be malingering since he or she only complains about disability, health, or fatigue when on the job or asked to perform a task, a negative practice strategy might be used to decrease the complaints. After baseline measurement, the treatment consists of asking the client to complain some more whenever he complains once. Thus, when the client says that he or she has such a severe headache that he/she can't work, he/she is asked to, "Tell what else is wrong," "How else does he/she feel," "Describe in detail the headache," and so on for about three minutes until he or she cannot or will not tell any more about his or her somatic condition. No reinforcement should be given nor should relief from work be allowed. All interaction between the supervisor, instructor, or counselor and the client should be conducted in a neutral manner. The procedure should be continued until the client no longer makes complaints about illnesses to avoid work. However, reinforcement should be maintained for occasions when he/she does not complain.

This procedure should not be used with clients who show considerable anxiety about their abilities or disabilities.

IV. - Individual Treatment Programs

A. Retraining

This intervention program can be done in a class especially formed for instruction in facilitation of personal behaviors, in a group of clients who all lack successful interpersonal behaviors, or in individual counseling sessions. It can be initiated for a particular client either with or without confronting him or her with his/her frequent complaints.

If confrontation is believed to be important, then the interview and discussion is conducted in a positive, non-argumentative manner. Discussion should include a description of the disability (if any), physical limitations related to his or her academic, work, and social activities, and a presentation of the counselor's understanding of the client's feelings about the disability in a warm, empathic, and genuine manner. Then, the counselor must explain to the client that complaints to anybody else but the physicians, nurses, or physical therapists who are treating the disability are not only useless (nobody else can make the illness go away), but are interfering with his or her interpersonal and, maybe, vocational adjustment. The individual is then assigned to the class, group training, or individual counseling sessions for learning interpersonal actions and words that will substitute for complaints.

The training sessions include a number of different procedures, but they all must maintain a pleasant, reinforcing atmosphere so that all the clients will want to continue sessions. Reading assigments in books or pamphlets that discuss ways of making and keeping friends in social and work settings can be helpful. Or if the group contains clients who cannot or do not read, selected topics from such books can be introduced by the counselor for discussion. Williams and Long (1975) have an excellent chapter, "Enhancing Interpersonal Relationships," which discusses ways in which behavior can become reinforcing to others. They include examples of passive and active listening to others; giving approval that is appropriate, consistent, and frequent; and self-management exercises.

The training sessions should include role-playing between counselor and client, client and client, and, where appropriate, role-reversal, which can be very enjoyable and instructive. When the group leader or counselor believes the client or group is ready, practice sessions outside the group meetings are planned in the training sessions. These practice sessions are aimed at getting the client to consider generalization of the behaviors he or she has learned in class, work, and social situations in daily life. Behavioral rehearsal should be encouraged. Behavioral rehearsal methodology is outlined in treatment 3A, **Withdrawn Behavior.**

Clients are then encouraged to carry out their plans and reinforced heavily for reports of slight progress that they make in later meetings or counseling sessions. It is helpful to include discussion of the positive effects on others as well as themselves that result from these early attempts to modify their own interpersonal skills. The counselor should be prepared for negative comments that may be made about failure or perceived failure since these clients are so thoroughly experienced at complaining about themselves and others. These new complaints are further attempts to continue behaviors that have brought attention and should receive no attention. Instead the client should be ignored until he or she has ceased complaining and then be prompted to give examples of what positive effects may have occurred or might occur in the future if he or she continues trying. Slight improvement here should be followed by immediate reinforcement.

B. Self-Monitoring as Treatment

In some cases, clients respond well to self-management of their verbal behavior. This is more likely to occur when they are willing to admit that they exhibit a lot of complaining behavior. To initiate this procedure, it is suggested that a confrontation session be held as discussion in the **Retraining Treatment** section above. Then the client is asked to measure the frequency of his or her complaints by either keeping a diary or by defining the type of complaints, recording, and graphing.

In the diary method, he or she is encouraged to use a **critical incident technique** in which he/she attempts to identify what, where, and when he/she complains. What was he/she doing immediately before the complaint, where was he/she, who else was present, when or what time of day did it occur, and what complaint was made. After the client has kept such a diary for a few days, he or she goes over it with the counselor. Discussion can then occur about how many times a day he/she complains about his/her disability, illnesses, or fatigue; whether or not there are certain times, places, or persons present when these complaints are made; and what the complaints accomplished. The recording and discussion is often very attractive to these clients because it concerns a subject that is very interesting to them, and the effect is likely to give them a better understanding of their relationships with others and what they would rather do and say to others than complain.

The measurement by recording frequency of complaints can be a very effective means of treating surplus complaining by itself. Thoresen and Mahoney (1974) reported a number of studies showing that accurate self-observation has been successful in decreasing surplus behaviors. However, accurate self-observation can only occur if the client and counselor discuss in detail the definition of a complaint. Such discussion should focus on the kinds of verbal statements about one's health that would be considered a complaint, and different types of examples might be presented until the counselor is convinced that the client is including all the varieties of complaints that are viewed by the rehabilitation staff as being surplus (unnecessary).

Once complaining has been accurately defined, the client is instructed to record every complaint he or she makes during the next 24 hours. He or she then brings that tally back to the counselor, who reinforces him/her for recording and gives any further instruction that is necessary. The client is then asked to keep the record for two more days, three, or a week before returning to the counselor. The number of days before he/she is asked to return should depend on how capable he/she is to delay reinforcement for the record keeping and how independent or reliable he/she is. When he/she returns, the counselor should reinforce him/her for those records turned in, even if they are incomplete, and put them on a graph so that the client and counselor can see any change. For some clients, it may be necessary for the counselor to either check his/her recording during the day by observing him or her in class, in the dormitory, or at work, or have somebody else check his/her recording. Walking up to him/her at one of these locations and asking, "How are you," or "How are you doing," allows an opportunity to reinforce him/her for not complaining or to reinforce him/her for recording any complaint that is made.

In some cases, the counselor may want to include one of the self-control procedures.

C. Self-Control Through Self-Instruction

Although the label of self-control suggests that the individual is treating himself, this is not entirely true. He or she is taught self-control intervention strategies by the counselor, given practice in the presence of the counselor, reinforced by the counselor for his/her practice, aided in planning, and supported by the counselor.

Stenger (1972) relates a very simple strategy that he has used successfully with a boy who was being kicked out of school every day for attacking other children who accidentally bumped him. The child's attack was almost an automatic act, just as the hypochondriac client seems to automatically complain whenever he/she starts to talk to somebody. Dr. Stenger taught the boy in one session to say, "I don't have to get mad," whenever somebody hit, pushed, shoved or bumped him. Basically, the procedure consists of teaching the client to say something to himself that is contrary to the things he/she usually does or says.

Once the client agrees that he or she may be complaining too much, the client together with the counselor select some other belief about himself that he/she can say to himself in those situations where he/she usually complains. The statement could be, "I don't need to complain," or it could be based on some positive characteristic, activity, or interest in his or her job, or about his/her activities that day, or something of interest about his/her immediate future. He/she is then asked to practice saying this out loud to the counselor. Then the counselor asks the client to visualize or imagine himself in a number of everyday activities in which he/she typically complains. As he/she imagines each one, he/she is asked to describe it and the counselor asks him/her to say out loud the new response. The client is then taught to say the response himself as he/she imagines the situation. When the counselor is assured that the client is well-rehearsed, the client is instructed to go practice the new behavior in some real situations. At the next counseling session, the client is encouraged to relate his or her experiences, focusing on what happened, what was the other person's reaction to him/her now that he/she didn't complain, etc. Much reinforcement should be offered by the counselor in a warm and genuine manner.

The self-instructional technique is more completely described by Merchenbaum (1973) and also by Karen (1974) under the topic of coverant control therapy. Many variations are possible, but the rehabilitation professional is likely to find that self-instruction can be successfully combined with both the **Self-Monitoring** treatment and the **Retaining** procedures described earlier in this section (p. 84).

Epilogue

We hope the reader finds these procedures helpful. It was the intent of the authors to present a humanistic approach to behavior change in rehabilitation. By decreasing those surplus behaviors that interfere with an individual's ability to work and socialize with others and by increasing those deficit behaviors that allow an individual to learn, work, socialize, and live an independent life, we are helping the person to obtain the most benefits from rehabilitation.

The basis of our humanism forms from consistency, measurement, and positive reinforcement. Consistent treatment across professional staff and across rehabilitation settings and service areas is important. Without consistency, change will be slow or will not take place. Consistency is more likely to occur with training of staff, communication across service sections, and encouragement by supervisors. Specific descriptions of problem behaviors are necessary for measurement and successful treatment. Measurement is the mark of the professional. It allows us to hold our treatments accountable, to see our success and to face our failures quickly. Finally, we hope the reader has noticed that positive reinforcement is present in every treatment program suggested because it is the basic ingredient of humanistic behavior change. Frequent and sincere positive reinforcement to clients and co-workers creates the atmosphere in which successful behavior change takes place.

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