Constructional Behaviour Therapy as leading paradigm in psychosocial rehabilitation [1]

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Psychosocial rehabilitation.

Psychosocial rehabilitation covers the needs of people dependant on long-term care. Psychosocial rehabilitation has been developed in different fields in health care: psychiatric hospitals, custodial clinics, institutes for people with pervasive developmental disorders, institutes for people with sensory or motor handicaps, nursing-homes etc. Although each field has specific features in their rehabilitation programs, in every field you will find two main options: reducing the impact of chronic disorders, impairments and handicaps (so called sickness reduction) and inducing a way of life 'as normal as possible': health induction.

Developments

Traditionally health care professionals are trained to focus on problems and disorders. So when psychosocial rehabilitation started to develop, the first focus was on sickness reduction followed by training procedures in order to get the client more skilled to live as normal as possible. So early psychosocial rehabilitation programs were problem-oriented and development-oriented. Evaluations of these programs reveal that even when problems are diminished and skills well trained, this does not automatically mean that the clients under concern *feel* themselves better and worthwhile as a person. Besides that, quite a few clients were not motivated for skill training or failed admission-tests for the training-program. In this context psychosocial rehabilitation did not longer focus exclusively on problems and

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development, but also on appropriate, supportive environments in which clients can develop a way of life, which fits their interests and capacities. As you have heard in the previous presentations well-being is a personal matter: only the person himself feels if an action or event contributes to his emotional well being. Safeguarding one's own well-being is the result of a permanent learning process that develops automatically in the interaction of the subject and his environment. By reacting and acting on social and material circumstances in his environment the person experiences if his responding contributes to improve his emotional state or maintain his actual good emotional state. By this, each person develops an individual repertoire of successful behaviour. Functioning-oriented rehabilitation starts with the reanimation of the client's alertness to his environment so that he is able to discover or rediscover, which of his doings contributes to his well-being.

Functioning-oriented rehabilitation

Functioning-oriented rehabilitation is based on the theoretical framework of Constructional Behaviour Therapy. Its main focus is on expanding the range of a person's repertoire of successful behaviour in order to improve or maintain his emotional well-being and to reduce the occurrence of disorder and disordered behaviour. A basic assumption is that every individual has some potential of being in control of and influencing his well-being, even individuals with a very vulnerable emotional and mental state, with severe congenital or acquired disorders, impairments and handicaps. Functioning-oriented rehabilitation does not make problem-oriented and development-oriented rehabilitation redundant, but it should be fundamental in each psychosocial rehabilitation program due to its focus on emotional well-being and the fact that successful behaviour is by definition incompatible with *un*successful behaviour: so you don't have to wait until all symptoms are minimised or all desired skills are mastered. A substantial number of people in need of long-term care has problems in safeguarding their emotional well-being, even when their handicaps and impairments are of a mainly physical nature: apparently they are moved away from their successful behaviour repertoire and seem to be involved by their uncomfortable emotional state. How to regain their natural alertness to their environment in order to maintain or improve

their emotional state of well-being by acting upon that environment instead of being dependent on accidental events of benefit coming from that environment?

Reanimation of the alertness to the environment

In residential settings we are able to reanimate the alertness of our residents by creating a "rich" environment, that is to say an environment with a variety of potential leads for successful behaviour and then guide the resident in his search for possibilities that fit him at that moment.

We do that by giving the resident the opportunity and possibilities to pick things up and let them fall again, so he can discover by himself, can experience what he needs to feel well at that time. By bringing everyday life into their living quarters residents are invited to come alive again. Carers start easy accessible activities on self-care, housekeeping or leisure activities. They can cook and try to get residents involved by asking them to stir the soup or which recipe they like most. They can fold up the laundry together with a resident, if he likes that. They can visit the library, maybe a resident appears to be interested in a certain subject, and so on.

The carers are fully free to do things they consider appropriate at the time and which links up with their own interests. There are no specific goals to attain during these activities. These professional actions are guided by a regular test to the general goal: does this resident behaves successfully, is he feeling well? In contrast with skill-training, the resident isn't supposed to learn to do things by him self or to become more independent. He just has to learn which of his doings contribute to his well-being. And this goes automatically; he doesn't have to think about it. Not only 'at home', but also at workshops, activity centres, during holidays or visits to events, residents can experience which aspects in these environments are leads for their individual successful behaviour.

Let us turn now to a concrete example of how an orientation on successful behaviour can reanimate the potency of safeguarding someone's own well-being. Mr. M is 40 years old, moderate mentally handicapped and nearly totally deaf blind. In the past his deaf blindness was negatively influenced by severe self-injurious behaviour: hitting himself against ears and eyes. M lives in an institute

for mentally handicapped persons. He was referred for a second opinion on the general line of treatment, which had proven to be effective, but at the same time hard to continue for professional carers of M. In the last three years professionals have succeeded in reducing the self-injurious behaviour to 'a satisfactory level', as they stated themselves. M hits himself now and then, but that does not interfere with his following the daily program.

Mayor interventions have made this change happen: physical restraints (in bed and in his chair), improving his system for communication and…. a script of ten pages in which every daily detail is described. His professional carers have a tough job to follow this script to which they stick rather rigidly. The reason for this is that they are afraid that M will fall back to his previous harmful level of disfunctioning. During assessment we interviewed his carers and noticed that they reported several different moments during when M was in 'a better emotional state': he laughs, is exited, and is active in following non-scheduled changes in his environment. They reported that M is sometimes seeking more physical contact with his carers during showering and dressing, he is interested in the other residents at the dinner table (and their food!), he is fascinated by electric devices and likes to smell at felt pens and is finding his way to the offices where he can find them.

For inducing successful behaviour, descriptions of these kind contain the most important information: staff is seeing M behaving successfully reacting on non-scheduled circumstances in his environment. We also assessed during which program-parts M was doing well, was 'functioning'. By this we listed which circumstances in his scheduled environment offered leads for successful behaviour to M.

After this we start informing the staff about the basic elements of the functioning-orientated rehabilitation method and taught them how to fit in this theoretical framework in their professional approach, mainly based on problem-orientation and development. We made use of the following statements:

- Problem behaviour develops due to the absence of favourable environmental conditions i.e. opportunities for M to behave successfully, to function.

- As long as M functions, no problem behaviour will occur.
- Structure has proven to imply opportunities for M's successful behaviour, but observation has learned that there are other opportunities for successful behaviour either; so make use of both according to what is appropriate for you as professional in the actual situation (regarding time, interests of M, interest of other residents, need and availability of guiding etc.). We introduced the slogan: 'Grasp flexibility when it is in the air, use the schedule when that feels safer'.
- Make use of behaviour management when appropriate (i.e. according to your professional standard for example when the behaviour under concern is harmful for M or others: residents, staff etc.) Notice that not all misbehaviour is disfunctioning: some behaviour will 'fit' to M, i.e. will contribute to his well-being, but threatens the interests of others or the societal code of what is appropriate. These behaviours should be stopped (in M's case: sexual behaviour in the living-room).
- Do not bother about some differences in approach between you and your colleagues: every professional behaves according to his own capacities and professional judgements; just test your professional interventions to the aim of the functioning-oriented approach: does M improve or maintain his emotional state of well-being.

Besides this we offered a weekly supervision of staff in order to give room for dilemma's, doubts, questions and…. coaching. After three months, staff reported that the strong scheduling had been loosened; the frequency of problem behaviour diminished and M seemed to be less stereotype in his behaviour. In general he seemed to be in a better emotional condition. Carers reported that they felt themselves 'more relaxed' in working with M.

In outreaching programs, professional influence on the potencies of the environment to induce successful behaviour is less evident. Yet functioning-orientated rehabilitation is possible without a direct control over the actual environment of a client.

At first when a client is able to answer questions about every day life during the last few days procedures as described in the previous presentation, like Reversal Question and Response Search, enable the

professional case manager to arrange a renewed confrontation for the client with specific stimuli that have controlled his successful behaviour. Another option concerns support in exploring new environments, for example frequently visiting a Day Activity Centre where the client can experience which opportunities for doing things contribute to his well-being. Sometimes a more structured exploration of the environment is necessary by guiding the client during exploring activities.

Big advantage of the functioning-oriented rehabilitation approach is that due to the assumption that every individual has some potential in safeguarding his well-being there are no terms of exclusion for this approach. The theoretical framework of Constructional Behaviour Therapy is based on research on human behaviour in general that makes it applicable to so many fields in healthcare.

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