NSC Training: Understanding Behaviors

What causes behavior problems?

What maintains them?

What helps address and change behaviors?

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What's underneath/driving the "tip of the iceberg" behaviors?

Aberrant Behaviors

- Sensory Issues
- Medical/mental health issues
- Skill deficits
  - Communication
  - Social
  - Motor
  - Academic/IQ
- Family/community environment

Cox and Schopler 1993; Peeters 1995
Behavior Learning Theory
(Pattern of poor learning events)

Antecedents → Response → Consequences

**Antecedents**
- Intolerable Sensory environment
- Lacks understanding of expectations
- Lacks ability to communicate needs & emotions
- Difficulties understanding & regulating emotions

**Behavior**

**Consequences**
- Pt has experienced:
  - Being able to escape negative experiences with neg. behaviors
  - Lengthy time-outs following event
  - Inconsistent or unrelated consequences
  - Social attention for inappropriate behaviors
Behavior Learning Theory

Example

Antecedents → Response → Consequence

- Biting/ hitting Behavior
- Child taken out of classroom
Tip of the Iceberg

**Antecedents**

**Behaviors**

**Consequences**

**Proactive strategies to address underlying issues:**

- Sensory Issues:
- Medical/ Psychiatric Issues:

**Skill Deficits:**
  - Communication:
  - Social:
  - Motor:
  - Academic/ Cognitive:

**Strategies to address behaviors when they occur:**

Family/ Care-giving Environments:

Gabriels, R. & Barnes, J., 2012
Everyone wants to have control.

We all get control by:

<table>
<thead>
<tr>
<th>Avoiding/ Escaping</th>
<th>Getting</th>
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<tbody>
<tr>
<td>• Social Interaction</td>
<td>• Social Attention</td>
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<tr>
<td>• Difficult/ Boring/ over-stimulating situations</td>
<td>• Desirable item or situation</td>
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<td>• Pain</td>
<td>• Sensory input/ reinforcement</td>
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<td>• Sensory/ Pain relief</td>
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**Intervention Strategies:**

**Antecedents**

**Proactive Strategies**
- Modify environment
- Provide visual cues & predictable routines
- Teach alternative behavior or skill
- Clear Limits/boundaries “First this, then that”
- Teach calming strategies
- Give adult-directed choices
- Positive attention of alternative behaviors

**Response**

**Behavior**

**Consequences**

**Reactive Strategies**
- Natural consequences
- Remove consequences (ignoring)
- Brief Time Outs until calm
- Visual Road Map problem-solving
- Consistent follow through of limits set
Intervention Hierarchy

1. Setting (change environment)
2. Task (change task)
3. Motivation (introduce motivations)
4. Control (medications and physical management)
NSC Positive Behavior Management Strategies

☐ Use “First do this, then get that” directives with the “first” item being something more difficult for the child, and the “then” item being something more enjoyable.
  • EX: “(Child’s name), first set the table, then you can watch T.V.”
  • EX: “First do (independent activity), then we can play a game together.”

☐ Provide visual structure
  • Picture or word schedule (alternating preferred and less preferred activities)
  • Use a timer to indicate how much time an activity lasts and when it is finished.
  • Provide mini-schedule/list of step-by-step expectation for group or chore activities

☐ Lower expectations during difficult times: lower your expectations for the child so they can successfully complete an adult-directed task quickly and successfully then be able to move on to a more enjoyable/preferred activity.

☐ Have child go to quiet area on a regular basis to have fun and be calm. (See Handout)

☐ Use calm, low voice and as few words as possible when addressing an agitated child.

☐ Use positive language, avoid saying “Don’t do that”, rather redirect child and say, “Here do this”, providing an alternative idea/solution.

☐ Use adult-directed choices: Give child a choice between two behaviors or activities to help him/her feel like (s)he has some control in the situation.
  EX: “(Child’s name), you can choose to either color or read a book during this time.”
  EX: “(Child’s name) you can either walk by yourself, or I can help you. Make your choice by the time I count down to one. 3, 2, 1 what is your choice?”

☐ Ignore mild upset behaviors so that they don’t develop into larger tantrums or problem behaviors. Don’t engage in the argument. Ignore the child by not looking or talking to the child until they are calm. Tell them briefly and calmly “When you are calm, I will talk to you/or do (activity) with you.”

☐ Provide child with time to complete requested task. Try counting to _____ in your head before repeating a direction or request.

☐ Provide fidget materials to help child remain focused in less preferred activities like large groups.

☐ Use natural consequences when child’s actions cause a problem
  EX: “You can have computer time starting at 3:00 for 15 minutes. So the faster you finish (activity) of get calm, then you will have all of your computer time.”
  EX: “If the child gets angry and spills milk, the natural consequence is to make him/her clean it up.”

☐ Increase positive time together Teach caregivers how to have fun with their child. The more they can have fun together on a routine basis, the less time the child has to negatively try to get attention. Staff can also use positive time together as a reward following less preferred activity.

☐ Acknowledge positive behaviors Note when the child shows positive behavior and acknowledge it to them. The goal is to provide motivation for the child to engage in positive behaviors.
  EX: “(Child’s name), I like the way you raised your hand when you wanted to speak.”
  EX: “(Child’s name), you did a good job listening.”

☐ Build on strengths: Use child’s strengths to help shape positive behavior.
  EX: Ask child to share their special interest with the group.

Learning styles
What is TEACCH?

TEACCH stands for the Treatment and Education of Autistic and related Communication handicapped Children.

TEACCH is an evidence-based intervention model that utilizes a combination of structured teaching techniques from developmental, behavioral and cognitive philosophies. TEACCH was established in the early 1970s by Dr. Eric Schopler and colleagues and the administrative headquarters of the TEACCH program are in Chapel Hill, North Carolina.

The goal of the TEACCH program is to structure the environment to maximize an individual’s understanding and independent functioning, thereby decreasing their undesirable behaviors. TEACCH offers an approach that meets the needs of individuals with autism spectrum disorders across the lifespan.

TEACCH structure includes four types:

1. **Physical Organization** establish a routine so the individual begins to associate activities with specific areas/places

2. **Schedules & Routines** provide a structure to decrease the individual’s potential anxiety due to lack of predictability and understanding.

3. **Work Systems** provide the individual with a systematic strategy to approach work that needs to be completed. This learned strategy builds independence and enables the individual to generalize skills into other environments. Work Systems answer the following questions with visual cues:
   - “What do I do?”
   - “How much work needs to be done?”
   - “When am I finished?”
   - “What happens next?”

4. **Visual Structure** provides the individual with a strategy for approaching a task and using materials in a flexible manner. Tasks that are visually structured provide the following visual cues:
   - **Visual instructions** - Providing written, pictured, or highlighted instructions or models/examples
   - **Visual organization** - Using space and containers to organize materials and limit the focus of attention to the work at hand.

The Neuropsychiatric Special Care program at The Children’s Hospital was designed to address the specific developmental needs (e.g., cognitive, communication, sensory, and motor coordination) of the patient who is dually-diagnosed with a developmental disability and psychiatric disorder. The NSC program environment reflects the TEACCH (Treatment and Education of Autistic and Related Communication Handicapped Children) philosophy of structuring the environment so as to maximize patients’ understanding and independent functioning and decrease their undesirable behaviors. The goal of this adapted environment is to decrease patients’ behavior problems due to developmental issues so that their needs can be more accurately assessed and addressed. NSC routine activities include daily living, independent work, leisure, music, dance and art therapy, social engagement interventions with peers and family, special education, and hands-on training of caregivers about positive behavior intervention strategies, including TEACCH methods. Studies of individuals with autism spectrum disorders have demonstrated that the introduction of external structure (i.e., TEACCH methods) can help increase on-task behaviors and reduce challenging behaviors (Hume, 2005; Liptak et al., 2006; MacDuff, Krantz, & McClannahan, 1993).
To provide suitable intervention techniques, we need to understand the distinctive ways individuals with an ASD think and learn

"culture of autism" Mesibov (2005)

I. ASD individuals are visual vs. auditory learners
   a. Pictures and other visual cues enhance understanding, help organize and sequence, help initiate activities, help motivate
   b. **Interventions:** Organize environment, provide visual cues/structure, provide predictable routines

II. ASD Individuals tend to think concretely
   a. At risk for responding in inappropriate ways or becoming confused by social situations, conversations, or ambiguous rules or rules that don’t make sense (EX: Rule: “Use deodorant after showering”= Interpretation: “If I don’t shower every day, then I don’t put on deodorant every day”).
   b. Prefer familiarity (repetition, routine, consistency)
   c. **Interventions:**
      i. Provide visual cues for rules & instructions
      ii. Social Stories™ (Gray, 2000)
      iii. Learn by “doing” or role-play
      iv. Use “first do this, then get that” directions and schedules
      v. Error Correction—“Try again” with demonstration
      vi. Highlighting (giving social praise) to appropriate behaviors
      vii. Visual Road Map

III. ASD individuals see the world in a more narrow way, more intensely focused on details and narrow interests
   a. Harder to see the “big picture” which is necessary for awareness of concepts, making connections, generalizing, & seeing things in context
   b. **Interventions:**
      i. Role play-notice what was right/wrong
      ii. Road Map
      iii. Cause-and-effect planned ignoring: “First get calm, then I will talk with you”
      iv. Use narrow interests to engage

IV. ASD individuals have problems with distractibility & self regulation
   a. Sensory stimulation can be very disruptive
   b. **Interventions:**
      i. Modify environment to decrease sensory distractions or increase alertness
      ii. Teach awareness and expression of feeling states

V. ASD individuals have difficulty with executive functioning skills including:
   a. Cognitive flexibility, ability to apply social rules flexibly, controlling impulses, organizing/sequencing, initiating activities (time concepts)
   b. **Interventions:**
      i. Structure, routines, visual cues (see above)
Piaget's Developmental Stage | Age Range | Major Achievements
--- | --- | ---
Sensori-Motor | 0-2 years | Foundations for future cognitions are laid down through a focus on relating to and organizing sensations and motor movements. Child moves from reflexive sensory responsiveness to a beginning understanding of objects and cause-and-effect. Child begins to understand object permanence (objects placed out of sight continue to exist).

**Type of Schedule system needed:** Object to use in each activity location.

**Activities of interest involve touching, feeling, seeing, manipulating, tasting, listening.**

Preoperational/Symbolic Function | 2-6 or 7 years | **Activities:** Child begins to represent absent objects/experiences through imitation, symbolic-pretend play or drawings.

**Language:**
- **2-3 yrs:** Can introduce topics and engages in short dialogues of a few turns. Provides descriptive details and topics do not have to be physically present.
- **3-4 yrs:** Can engage in dialogue beyond a few turns. Acknowledges partner’s turn and can determine how much information the listener needs.
- **4-5 yrs:** Modifies language when talking to younger child. Increased understanding and awareness of listener’s role. Discusses feelings, emotions, and attitudes.
- **5-6 yrs:** Can sustain conversation topic through dozens of turns. Conversation much like adults. Uses a variety of sentences.

**Type of schedule:** Picture-word

Concrete Operations | 6 or 7-11/12 years | Onset of logical thinking. Able to see others’ points of view. Learn best by manipulating concrete objects vs. doing mental operations. Able to classify objects into categories, understands hierarchies, and understands sequencing/ordering objects (e.g. according to size or patterns). Able to focus on several dimensions of a situation simultaneously, Improved sense of equality or justice in which wrong doer must be punished or compensate for damage done.

**Type of schedule:** Picture or word (if reading)

Formal Operations | 11/12 years | Corresponds with beginning of adolescence. Ability to think in the abstract; more flexible thinking - able to consider alternatives in problem-solving; able to synthesize and integrate concepts into larger systems. Begins to think realistically and about the future. Establishes personal rules and values based on a sense of equality.
DSM-IV TR Diagnostic classifications of Mental Retardation

**Mild Mental Retardation (IQs 50-55 to 70)**
Individuals have minimal impairment in sensorimotor functioning, develop social and communication skills during preschool years, and may at times be indistinguishable from other children. With appropriate training, these individuals may achieve academic skills up to a 6th grade level. As adolescents and adults they can acquire the social and vocational abilities needed to support themselves with minimal supervision or guidance.

**Moderate Mental Retardation (IQs 35-40 to 50-55)**
Individuals develop communication skills during childhood. They acquire academic skills up to the 2nd grade level and benefit from training in social and occupational skills. As adults, these individuals may be able to perform unskilled or semi-skilled tasks in supervised settings.

**Severe Mental Retardation (IQs 20-25 to 35-40)**
Individuals may learn to talk during the school years and can acquire elementary self-care skills. They may learn to count and read simple survival words and perform tasks under close supervision.

**Profound Mental Retardation (IQs below 20-25)**
Optimal development for these individuals is achieved by providing them with a highly structured environment. Some people can perform simple tasks under close supervision and may show improvements in self-care and communication with appropriate training. Profound MR is usually due to a neurological condition.
Intervention Strategies
Home Schedule Components
(Evening and weekends)

General considerations:

- Alternate preferred and less preferred activities throughout the schedule.
- Have the child/adolescent participate in making the schedule.
- Develop a system for them to mark off completed activities so it is easy for them to keep on track.
- Use mini schedule to help them sequence what they are to do for activities like chores.
- May use timer to help them understand how long they are to remain in a preferred activity.

Daily schedules should include the following activities to help prepare the individual for daily life:

- Chore (empty dishwasher, set or clear table, trash)
- Self-Care (dressing, bathing, brush teeth)
- Leisure (quiet area/relaxation)
- Social engagement (family time)
- Exercise
SOCIAL STORIES


I. Definition
   a. “A short story that is written in a child-specific format describing a social situation, person, skill, event, or concept in terms of relevant cues and appropriate social responses” (Scattone, et al., 2002).
   b. Stories are designed to teach children with autism how to manage their own behavior during a social situation (Gray 1998).
   c. Social stories describe where the activity takes place, when it occurs, what will happen, who participates, and why the child should behave in a given manner (Gray 1998).
   d. Children with autism tend to rigidly adhere to routines and rules; therefore the social story serves to establish a routine or rule that the child may apply in a social situation (Scattone, et al., 2002).

II. Uses
   a. Why?
      i. Provides non-threatening way of presenting correct social responses.
      ii. Provides steps that the individual can follow to achieve a goal.
   b. How?
      i. Can be used with individuals who cannot read by using audio tapes or role-play.
      ii. Develop a consistent review schedule (read once per day or just prior to each time the situation will occur).
      iii. Keep mastered stories in a notebook so the individual can access them as needed.

III. Writing a Social Story
   a. Use a combination of descriptive, perspective, and directive sentences. General guideline: 1 directive sentence for every 2-5 descriptive and/or perspective sentences.
      i. Descriptive: Describes the event, what people do, why people are doing things.
      ii. Perspective: Describes thoughts and feelings of other individuals, how and why others may react a certain way.
      iii. Directive: Describes how the individual should respond in given situations/strategies.
   b. Partial Sentences: Leave blanks to encourage the individual’s participation in the story-making process & to make guesses about next steps.
   c. Write story from the perspective of the individual (e.g., “If this happens, I will do ……)
   d. May want to have one sentence per page with a drawing done by the child for each sentence, if possible for clarity.
   e. Format: (Includes Where, when, who, what, and why)
      i. Introduction
      ii. Body
      iii. Conclusion
Title: What should I do when I get angry? (Carrie Vlastin)

Sometimes I become angry. All people feel angry sometimes. I feel angry when _______________. When I get angry, I will try to breathe nice and slow. I will try to breathe deeply and carefully. Next, I will find my teacher, mom, dad, or another adult. When I find them, I will try to tell them I feel angry. I will try to tell them what happened that made me feel angry. When I talk to them, I will try to stay calm so that they can understand what I am saying. They will talk to me about what happened and about how I feel. This might help me to feel better. Wherever I am, I can try to find someone to talk to about how I feel.

Title: Lunch at School (Mike Johnson)

It is time for lunch. I walk to the cafeteria and I get in line. I wait for my turn to get my lunch. Next, I take a tray and get a fork, spoon, and knife. I give my tray to the lunch person and tell them what I want for lunch. They put it on my tray. Next, I pick up another item I want to eat. Then I pick up my milk. I give my money to the lunch lady. Sometimes she will give me some change back. Now I find a place to sit and eat. I carry my tray to the table. It is all right to talk to the other kids at the table. After I finish, I bring my tray to the lady that washes the dishes at school.

Title: What to Do When My Mom Talks to other People (Robin Gabriels)

I know that sometimes people want to talk with my mom. Sometimes people call on the telephone to talk to my mom. Sometimes my mom talks to people in other places like _____________. Sometimes when my mom talks to other people I feel _____________. It is important to let my mom have time to talk with other people because _____________. When my mom is talking to other people, I can do other fun activities by myself like: _____________. I know that when I can wait and be calm and quiet by myself when she is talking with other people, she can spend time with me when she is finished talking. Fun things to do with my mom when she is finished talking to other people are: _____________. 
Use of a Quiet Area to increase self-regulation in children with autism and other developmental disabilities

**Quiet Area description:** A place away from potentially distracting environmental sensory stimulation where a child can go during his or her day to “get away” from external demands and relax. This area should have a comfortable place to sit (e.g., bean bag chair, blanket, mat) and a few interesting (cause-and-effect stimulating) toys with which to fiddle (e.g., squishy balls, glitter wands, light spinners/chasers, vibrating toys).

**When to use the Quiet Area:** The Quiet Area should be a place where the child goes on a regular basis as part of their daily schedule, not just when they are upset and need to calm down. The goal is to have the child begin to associate feeling positive with the Quiet Area so they can more quickly calm down when they need to during other times when they are upset and go into this space. A time limit should be set for this area, such as no more than 10 or 15 minutes, so that the child does not begin to use this area to isolate indefinitely.
and THINK

Situation: