AT THE INTERSECTION OF AUTISM AND TRAUMA:

WHERE DO BEHAVIORAL PROVIDERS FIT IN?

A PRESENTATION ON TRAUMA AND ABA FOR TASN-ATBS

Dr. Camille Kolu, Ph.D., BCBA-D

ABSTRACT

Team members providing behavioral services are positioned to make life-changing decisions impacting those with autism: Does trauma matter? How do we ask about it, honor experience and history, and develop ethical and compassionate assessments and plans? This webinar expands boundaries of competence while providing resources, and real-life examples.

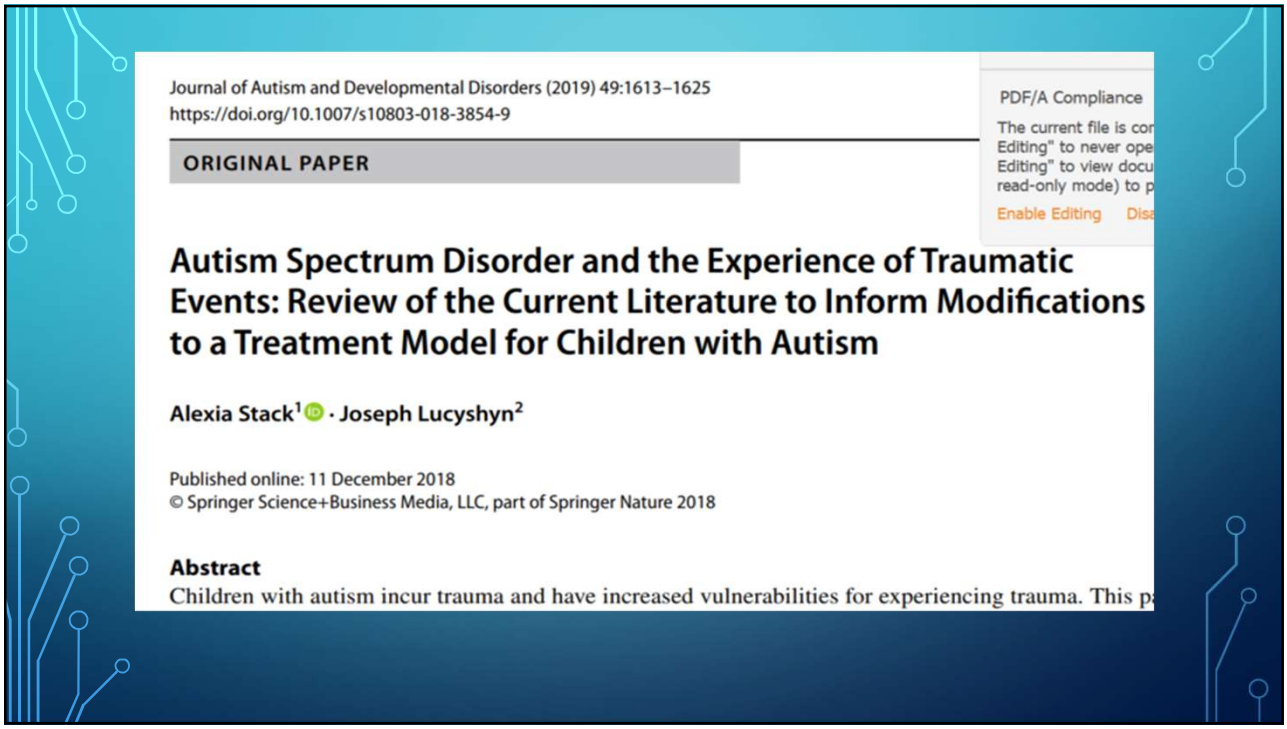
"Trauma-informed behavior analysis is

- the application of behavior analysis to
- supporting a person and treating behavioral concerns
- affected by histories involving trauma,
- including the documentation of
  - those histories,
  - their significance,
  - and related risks,
- in a context of rich team collaboration."

–Dr. Camille Kolu

LEARNING OBJECTIVES

1. Participants will state examples of repertoire components for behavior and related providers critical to trauma-related practice
2. Participants will select ways that trauma related terms can be operationalized in a way conceptually consistent with behavior analysis
3. Participants will state behavioral cusps for teams that can enhance applied behavior analytic practice with people affected by trauma and autism
4. Participants will select procedures that may be contraindicated for some clients with autism and trauma backgrounds



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ORIGINAL PAPER

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Autism Spectrum Disorder and the Experience of Traumatic Events: Review of the Current Literature to Inform Modifications to a Treatment Model for Children with Autism

Alexia Stack[1] · Joseph Lucyshyn[2]

Published online: 11 December 2018

Abstract
Children with autism incur trauma and have increased vulnerabilities for experiencing trauma. This p


… and adults


On the overlap between autism and trauma

On the overlap between autism and trauma

Autism spectrum disorders co-occur with trauma

--Brenner, Pan, and Mazefsky et al (2018); Kerns, Newschaffer and Berkowitz (2015); Hoover (2015); Kerns et al. (2017); King and Desaulnier (2011); Rigles (2017)

About 50% of individuals with autism may have experienced trauma

--Rumball, Happé, and Grey (2020)

Some behaviors are more likely in clients with ASD and trauma experiences; There is an urgent need for practitioners to screen to support this group

--Brenner, Pan, and Mazefsky et al (2018)

On the overlap between autism and trauma

ASD is a *risk factor* for experiencing trauma

--Haruvi-Lamdan, Horesh, & Golan, 2018; Hoover, 2015)

Children with autism are 2.5x more likely to experience foster care (which is another risk factor for trauma)

--Cidav, Xie and Mandell (2018

There are unique risks for the shared population (people with ASD who are adopted or involved in child protection)

-- Green, Leadbitter, Kay and Sharma (2016); Hall-Lande, Hewitt and Mishra et al. (2015)

More on the overlap between autism and trauma

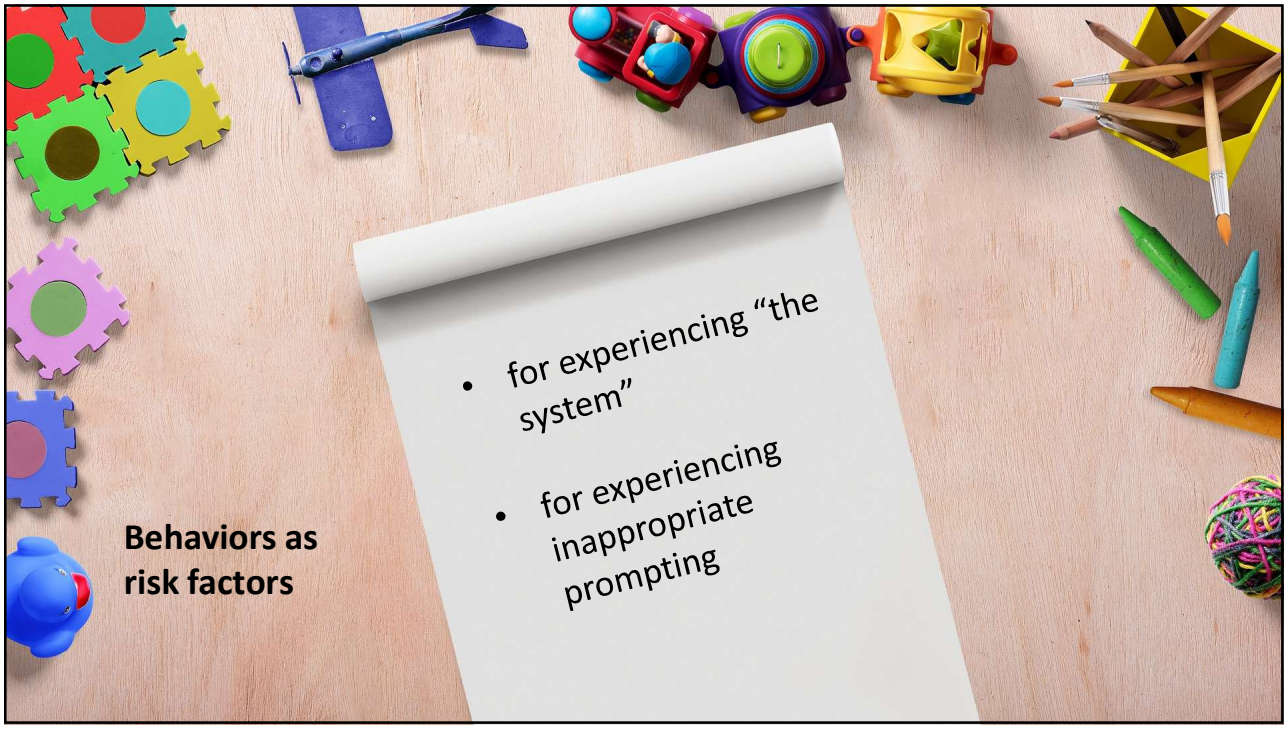
- Your clients with autism may….
  - **face more social isolation** and may be at risk of exclusion and peer ridicule (see Carter 2009 and Rotheram-Fuller et al. 2010)
  - **lack social support networks** that, when present, are protective against peer bullying effects (see Bauminger and Kasari 2000)
  - **have language delays** that can impede reporting abuse or responding to trauma (see Cook et al. 1993)
  - **experience a higher rate of mental health challenges** and psychopathology symptoms (see Konst and Matson, 2014)

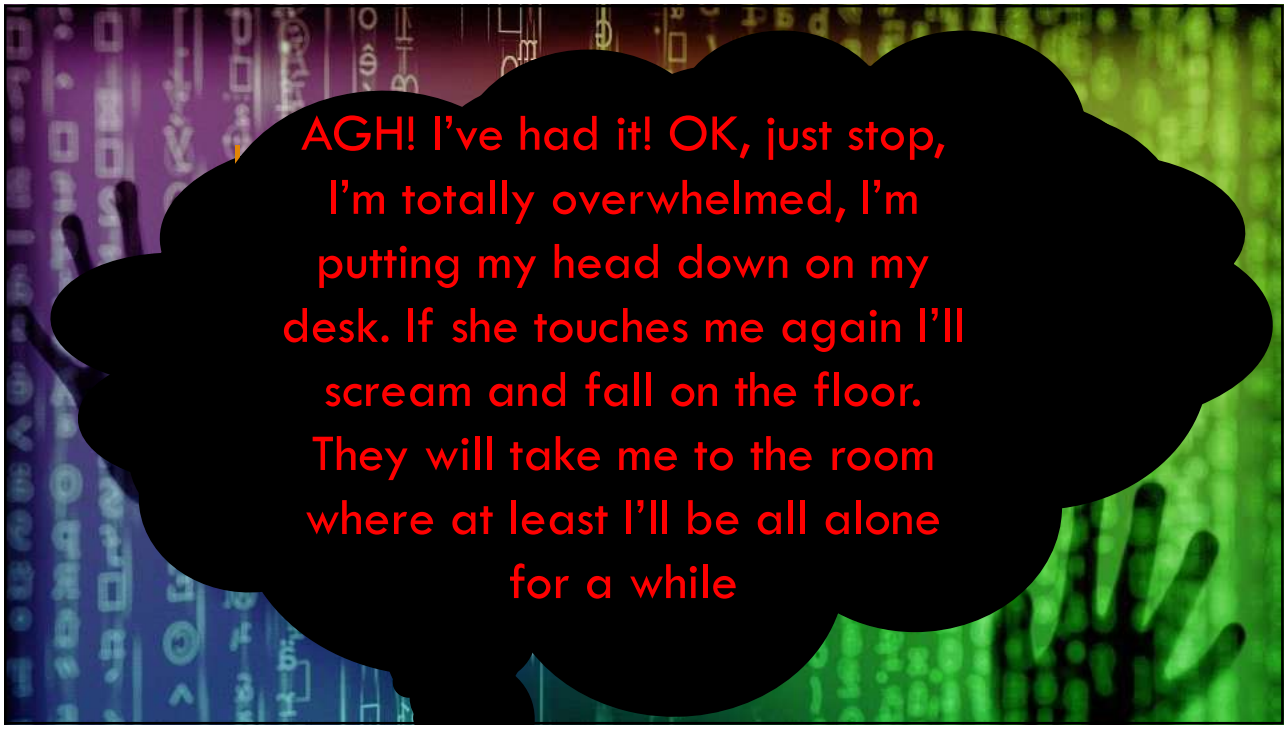
Children with ASD's who attended **full inclusion** classrooms were at **higher risk** than "self contained" class students (Zablotsky, Bradshaw, Anderson and Law, 2014)

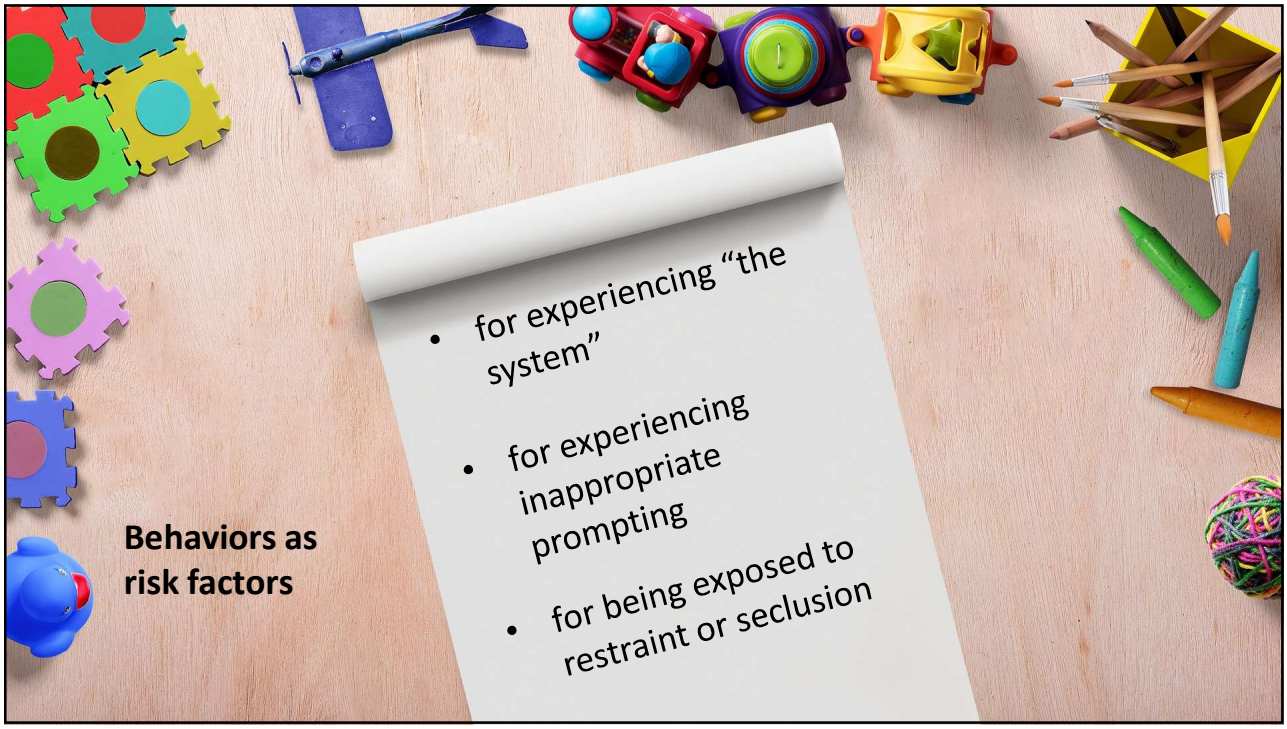
OBJECTIVE 1

Participants will state examples of repertoire components for behavior and related providers critical to trauma-related practice

WHY IS THIS SO CRUCIAL WHEN AUTISM IS INVOLVED?




AGH! I've had it! OK, just stop, I'm totally overwhelmed, I'm putting my head down on my desk. If she touches me again I'll scream and fall on the floor. They will take me to the room where at least I'll be all alone for a while


Behaviors as risk factors
• for experiencing "the system"
• for experiencing inappropriate prompting
• for being exposed to restraint or seclusion

"Should it matter… that Cindra has

just gotten back from being sex trafficked?

Do we still have to start on her following all our instructions?

I mean, she seems like she's pretty upset.

Can't we take a week to just get to know her again?"

-question from a concerned para/BT in an autism school

JOURNAL OF APPLIED BEHAVIOR ANALYSIS 2005, **38,** 51–65 NUMBER 1 (SPRING 2005)

ON THE EFFECTIVENESS OF AND PREFERENCE FOR PUNISHMENT AND EXTINCTION COMPONENTS OF FUNCTION-BASED INTERVENTIONS

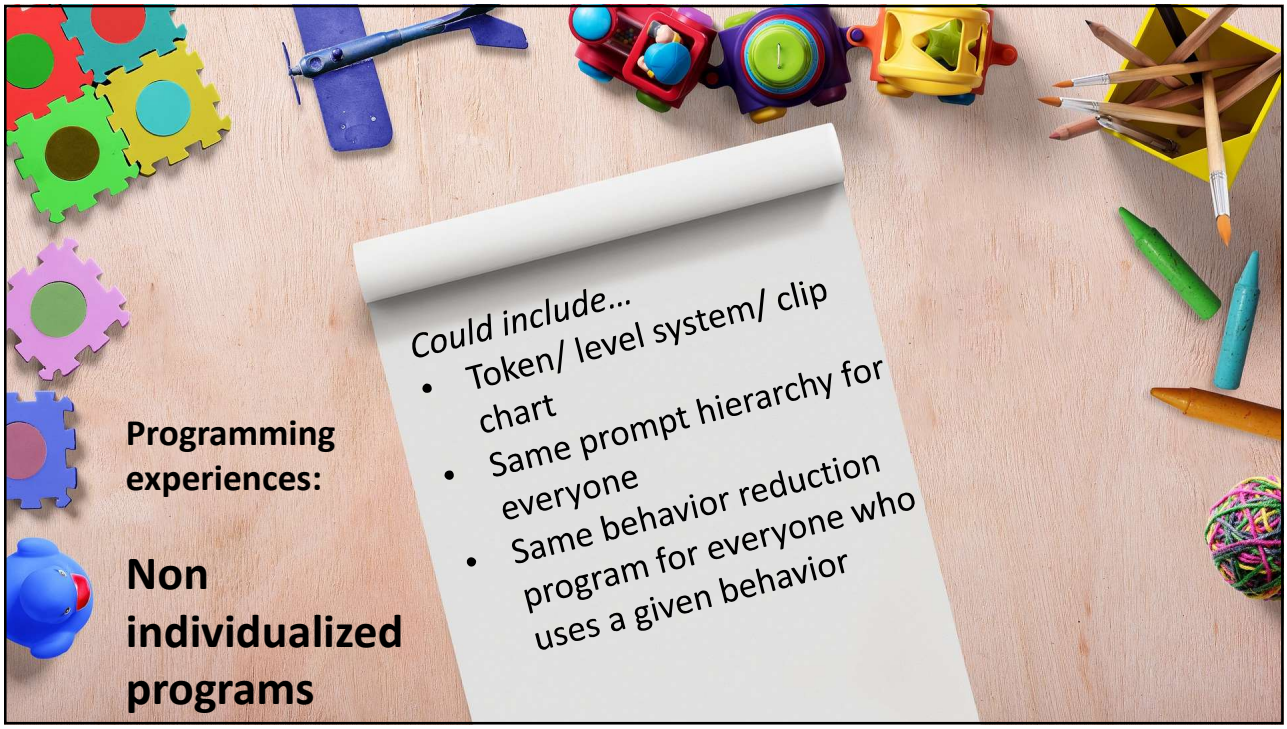
GREGORY P. HANLEY
UNIVERSITY OF KANSAS

CATHLEEN C. PIAZZA AND WAYNE W. FISHER
MARCUS INSTITUTE AND JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE

AND

KRISTEN A. MAGLIERI
UNIVERSITY OF NEVADA, RENO

The current study describes an assessment sequence that may be used to identify individualized, effective, and preferred interventions for severe problem behavior in lieu of relying on a restricted



BEHAVIOR ANALYSTS WHO "GET IT"

DR. GREG HANLEY

See PFA/ SCA approach : Happy, relaxed, engaged learner

DR. PAT FRIMAN

See his circumstances view of behavior

DR. KIM CROSLAND

See her FA of runaway behavior; many articles with trauma population

AND WHO CONTINUE TO TRANSFORM OUR APPROACH…

DR. JEANNIE GOLDEN

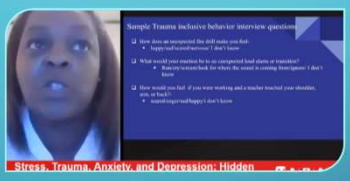
See papers with Walter Prather

DR. T.V. JOE LAYNG

DR. KAREN WEIGLE

OR WHO ARE BRINGING NEW RESEARCH AND IDEAS TO ABA

ELIZABETH HOUCK



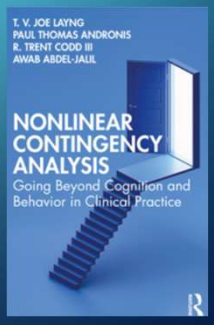
PAULA FLANDERS

ALBEE MENDOZA

BEHAVIORAL REPERTOIRE COMPONENTS

DRS. JOE LAYNG AND PAUL ANDRONIS (AND MENTOR DR. ISRAEL GOLDIAMOND)

- Get familiar with, and practice, nonlinear contingency analysis.
- Analyze alternative sets of contingencies
- See resource:
  - New book- "Nonlinear Contingency Analysis"



Pictures courtesy of researchgate

The Behavior Analyst 2009, 32, 163–184 No. 1 (Spring)

The Search for an Effective Clinical Behavior Analysis: The Nonlinear Thinking of Israel Goldiamond

T. V. Joe Layng
Headsprout

This paper has two purposes; the first is to reintroduce Goldiamond's constructional approach to clinical behavior analysis and to the field of behavior analysis as a whole, which, unfortunately, remains largely unaware of his nonlinear functional analysis and its implications. The approach is not simply a set of clinical techniques; instead it describes how basic, applied, and formal analyses may intersect to provide behavior-analytic solutions where the emphasis is on consequential selection. The paper takes the reader through a cumulative series of explorations, discoveries, and insights that hopefully brings the reader into contact with the power and comprehensiveness of Goldiamond's approach, and leads to an investigation of the original works cited. The second purpose is to provide the context of a life of scientific discovery that attempts to elucidate the variables and events that informed one of the most extraordinary scientific journeys in the history of behavior analysis, and expose the reader (especially young ones) to the exciting process of discovery followed by one of the field's most brilliant thinkers. One may perhaps consider this article a tribute to Goldiamond and his work, but the tribute is really to the process of scientific discovery over a professional lifetime.

Key words: Israel Goldiamond, nonlinear functional analysis, constructional approach

Israel Goldiamond must have become excited as he looked at his data. tained many times before. They had been very careful to follow the

WHY NONLINEAR CONTINGENCY ANALYSIS?

LINEAR ANALYSIS

- Behavior is a function of its consequences
- We look at immediate antecedents and consequences
- Doesn't look too far back into the past
- May identify a "replacement" behavior to reinforce "instead of" the "challenging behavior"

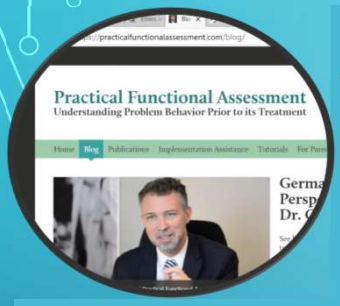
NONLINEAR ANALYSIS

- Behavior is a function of its history …
  - AND the history of its alternatives
  - and is interpreted in the context of contingencies for alternative sets of behavior
- Identifies sets of alternative contingencies

BEHAVIORAL REPERTOIRE COMPONENTS

DR. GREG HANLEY

- Check out his "my way" approach. Learn to do a synthesized contingency analysis.
- Resource:
  - www.practicalfunctionalassessment.com
  - His interview with Matt Cicoria on Matt's Behavioral observations podcast



Dr. Greg Hanley: "Today's ABA is trauma-informed. It is to be assumed that any person in the care of a behavior analyst for problem behavior has experienced multiple adverse events, with many exceeding the criteria for acknowledging that trauma has been experienced. By learning through listening; by enriching therapeutic contexts; by building and maintaining trust; by following one's lead; by relying on personalized contexts in which people are happy, relaxed, and engaged; by listening to communication bids; by not working people through noncompliance or emotional duress; by allowing people to walk away; by making decisions based on performance; and by teaching from joy; today's ABA is trauma-informed.

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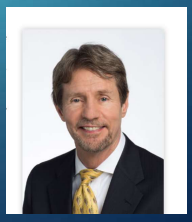
https://practicalfunctionalassessment.com/2020/06/04/a-perspective-on-todays-aba-by-dr-greg-hanley/

BEHAVIORAL REPERTOIRE COMPONENTS

DR. PAT FRIMAN

- Study emotions
- See person's behavior in light of their circumstances, not just its flavor as "good" or "bad" or "disturbing"
- Resource:
  - Dr. Friman's article on the circumstantial view
  - His Ted Talk



Analysis

of Applied Behavior Analysis 2021, **9999,** 1–18 NUMBER 9

There is no such thing as a bad boy: The Circumstances View of problem behavior

Patrick C. Friman

Boys Town and The University of Nebraska School of Medicine

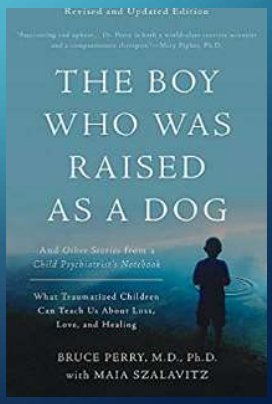
From the beginning of recorded time human beings have assigned blame to persons who misbehave. The first prominent person to make an alternative case was Father Edward J. Flanagan, the founder of Boys Town, who proclaimed there was "no such thing as a bad boy, only bad environment, bad modeling, and bad teaching" (Oursler & Oursler, 1949, p. 7) in other words, bad circumstances. This paper will refer to this perspective as the Circumstances View of problem

BEHAVIORAL REPERTOIRE COMPONENTS

DR. KAREN WEIGLE; DR. BRUCE PERRY

- Learn how to help someone move toward calm, without presenting demands
- Resource: See Perry and Szalavitz book

I think this means,
For behavior analysts,
That we need to learn how to operationalize DEMAND…
INDIVIDUALLY… in someone's behavior plan



BEHAVIORAL REPERTOIRE COMPONENTS

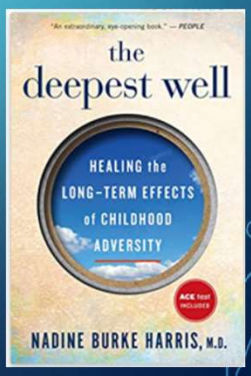
DR. JEANNIE GOLDEN

- Do "microshaping": appreciate TINY amounts of progress
- Learn (be able to operationalize and implement) what it means to be safe for someone, and provide relationship support that builds or rebuilds attachment
- Embody empathy and consistency
- RESOURCES:
  - See her articles (with Walter Prather) for behavioral approaches to reactive attachment and other trauma related challenges

BEHAVIORAL REPERTOIRE COMPONENTS

DR. NADINE BURKE HARRIS (PEDIATRICIAN/ CA SURGEON GENERAL)

- Understand how trauma can function as a medical variable
- Learn how prolonged inescapable stress impacts the body medically
- Resources:
  - Dr. Harris' book The Deepest Well
  - Her Ted Talk
  - Her many papers including those in Pediatrics



The Deepest Well: Healing the Long-Term Effects of Childhood Adversity

Dr. Nadine Burke Harris, California Surgeon General

"Dr. Nadine Burke Harris was already known as a crusading physician delivering targeted care to vulnerable children. But **it was Diego—a boy who had stopped growing after a sexual assault—who galvanized her to dig deeper into the connections between toxic stress and the lifelong illnesses she was tracking** among so many of her patients and their families." (from excerpt on book The Deepest Well (2018) by Dr. Nadine Burke Harris, Surgeon General of California https://www.linkedin.com/in/drburkeharris/

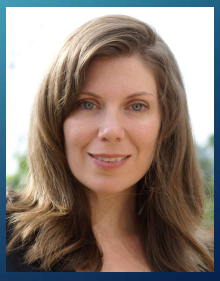
EXAMPLES OF MEDICAL CHALLENGES THAT CAN BE RELATED TO ADVERSE EXPERIENCES

- **Diabetes**
- **Obesity**
- **Infections**
- **Poor dental health**
- **Learning and conduct disorders**
- **Sexual dysfunction**
- **Heart problems**
- **Stress related diseases**
- **Blood pressure issues**

BEHAVIORAL REPERTOIRE COMPONENTS

UNDERSTAND HOW TRAUMA CAN FUNCTION AS A MEDICAL VARIABLE…

- And how to operationalize it,
- Document it,
- Analyze its interaction with other behavioral
- And environmental variables
- In order to document RISKS RELATED TO IT
- And communicate with medical and other providers about this aspect of client's history



SAFE-T Model Components

We may need to do ALL of this before we ever get to …
And in some cases, instead of ever getting to….

SAFE-T Model Components

- ❑ Supervision and support
- ❑ Assessment and documentation of risk
- ❑ FBA on HISTORICAL, not just IMMEDIATE, functions
- ❑ Evaluation (needs, environments, behavior)
- ❑ Training, treatment, and triage

AN IMPORTANT INTERSECTION FOR OUR CLIENTELE

ASD
- Exposed to difficult tasks in education or therapy
- ASD increases risk for trauma
- Difficulties with communication

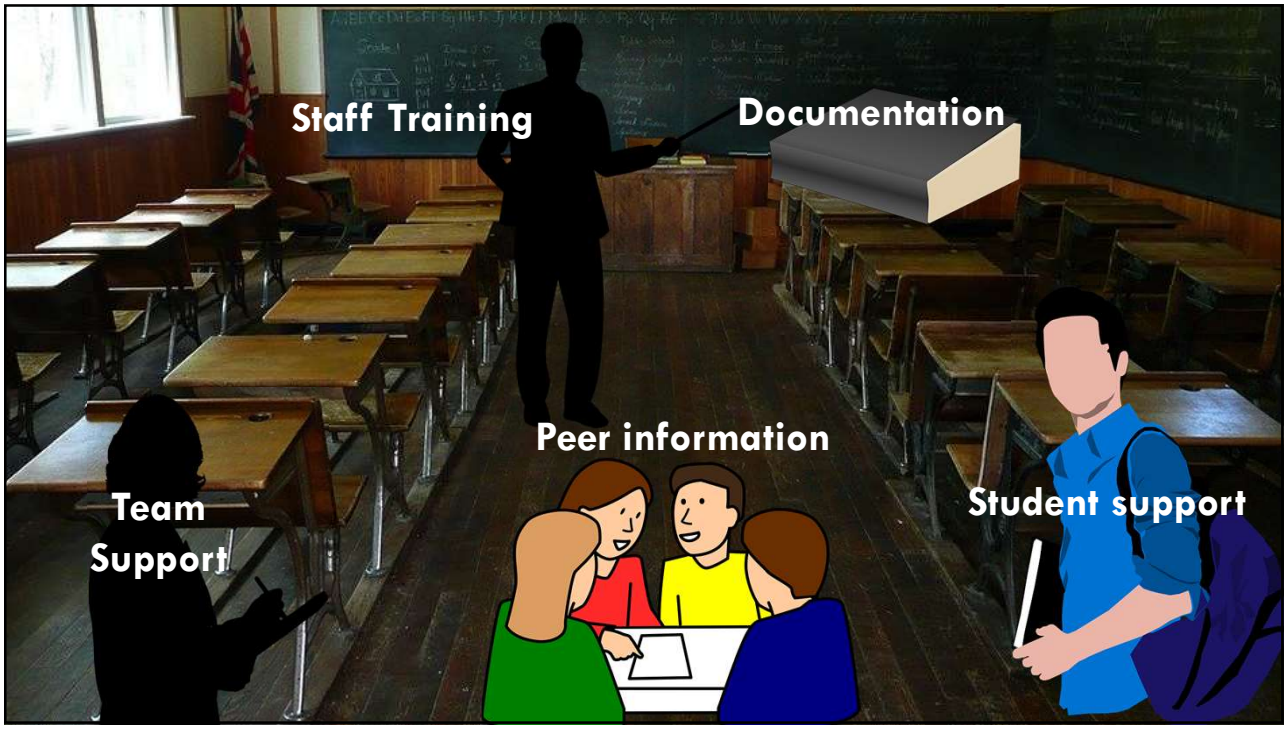
Medical Concerns
- Epilepsy (1/3) or Tuberous Sclerosis (45% of TS also have ASD)
- Co-occurrence of ASD/ genetic disorders (e.g., Angelman's Syndrome, Fragile X, Prader-Willi, and Retts) with seizures
- Behavioral pharmacology (about 40-50% of individuals with ASD also take a drug

Trauma
- Drug side effects increase exposure to punitive or aversive situations…
- And also have behavioral effects that may reduce people's likelihood to escape aversives

SOME BEHAVIORAL EFFECTS OF DRUGS

EXAMPLE: ANTICONVULSANTS

- Act as EO (and increase motivation) for sleep
- Act as AO (and decrease motivation) for effort
- Decrease alertness
- Decrease speech clarity
- Create or enhances memory issues



Documentation

- Seizure history
- Drug history with side effect descriptions
- Interactions between drugs, behavior, environment are all documented
- Examples help observers understand what to look for

Staff training

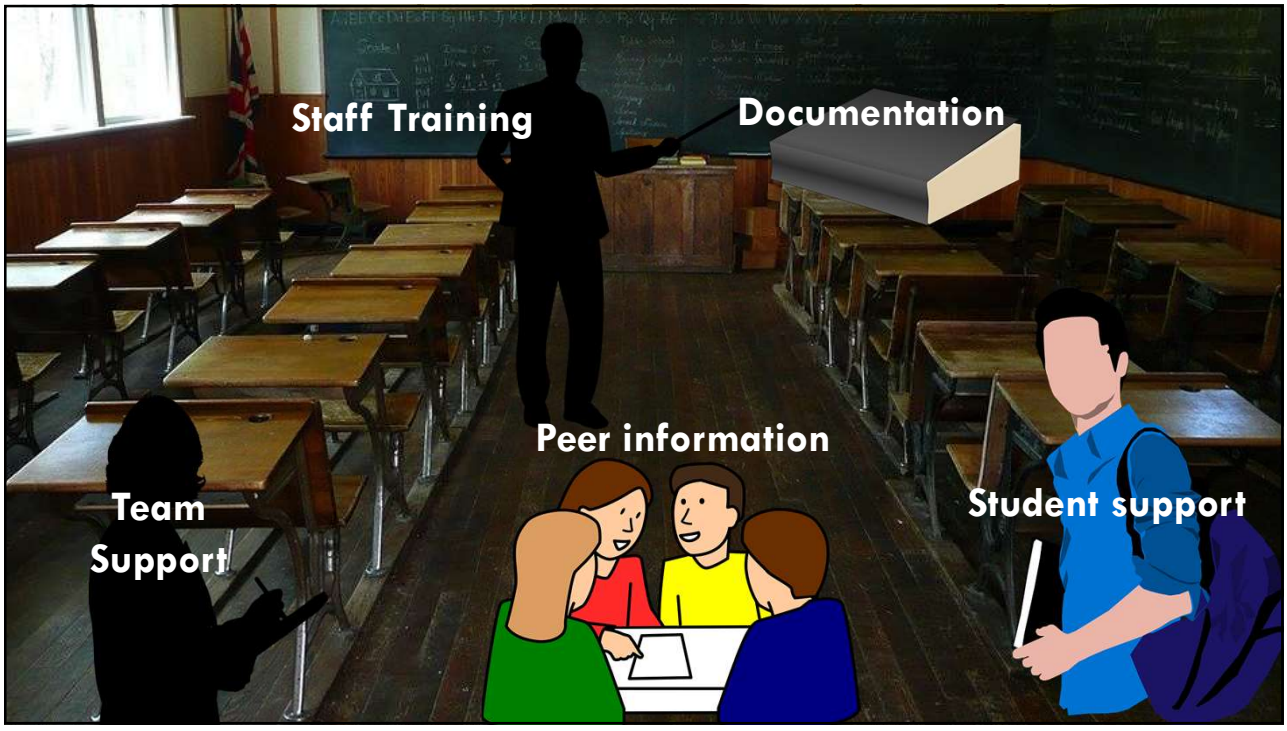
- Staff have information on history and needs
- Staff are trained to keep student safe and respond to seizure
- Staff know what antecedents to avoid

Team support

- Everyone is on same page
- Designated safe person knows what to do and how to document, support, and follow up

Student

- Has the skills to stay safe
- Can tact signs a seizure is coming
- Can request help any time
- Doesn't have to "ask nicely"
- Practices skills when NOT in crisis



WHAT TO DO?

- Use an assessment or list of questions that screen REGULARLY for changes in skin, eating, toileting, sleeping, alertness, behavior, speech, medical changes
- Begin with a nonlinear and historical contingency analysis and repeat when things change

See Task list 5th Edition- F1 review records and available data at outset of the case (and later)

TO DO THIS ANALYSIS, WE NEED TO BE ABLE TO FULFILL OBJECTIVE 2

2. Participants will select ways that trauma related terms can be operationalized in a way conceptually consistent with behavior analysis

LET'S START WITH LEARNING HOW JEANNIE GOLDEN DOES IT:

- **Understand history is not limited to direct experience**
- **Behavior;** direct experience; contingency-shaped behaviors
- **Verbal behavior;** socially transmitted experience; rule following behaviors
- **Observational learning;** modeling by caregivers and community members

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Different situations that might signal danger and evoke avoidance behaviors after abusive or aversive histories

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CONDITIONS THAT COULD DISRUPT "ATTACHMENT" (E.G., SHORTHAND FOR REGULARLY APPROACHING, AND HAVING NEEDS MET BY A FAMILIAR CAREGIVER) AND SOME EFFECTS

- **Early unpredictable interactions** with trusted/familiar adults (e.g., abuse; neglect; abandonment)
- **Discrimination training** takes place: Approaching others in the presence of one's needs is extinguished (or punished), while taking actions that meet one's own needs is reinforced by necessity
  - **Behaviors emerge** that are often not "appropriate" when an adult caregiver is present
  - **Typical development may be interrupted** as behavior stream has to shift to survival related behaviors instead of growth and learning related behaviors
  - **Conditioning of long-lasting harmful CMOs occurs** via contact with reinforcers for unproductive or harmful behaviors (e.g., drugs; alcohol; sexual risk behaviors)

As we talk, engage in private verbal behavior: How are these ideas relevant to …

Person who has been abused by a **parent** figure

Person who has been abused by an **authority** figure

Historically marginalized communities[50]

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CONDITIONS THAT COULD DISRUPT "ATTACHMENT" (E.G., SHORTHAND FOR REGULARLY APPROACHING, AND HAVING NEEDS MET BY ONE FAMILIAR CAREGIVER) AND SOME EFFECTS

Some possible outcomes:

- Adults may become **S-deltas** for approach
- Approach from adults may be **conditioned as aversive;**
- **Onset** of adult's approach may be **established as an SD for** threat-related behaviors; **avoidance**
- Environmental changes correlated with adult's approach may participate in **new conditioned environmental relations**

As we talk, engage in private verbal behavior: How are these ideas relevant to …

Person who has been abused by a **parent** figure

Person who has been abused by an **authority** figure

Marginalized communities

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HOW DO THESE FUNCTIONS LAYER AND COMBINE FOR SOMEONE WITH BOTH AUTISM AND TRAUMA?

IN THIS EXAMPLE, FIRST THINK ABOUT THE "REGULAR" FUNCTIONS OF BEHAVIOR

- Then we'll think about historical context while reading an example. How could context add MEANING for Aniyah's behavior?
- How would it change what you chose, as an educator or therapist, to do about the behavior?

ANIYAH'S EXAMPLE

Aniyah is a girl with autism who is spirited and helpful in the classroom, but often struggles when people other than her team try to help. A BCBA is called to the class and sees Aniyah lying under a desk, banging her head and screaming.

It's a holiday and her regular teacher is gone, so a male substitute teacher has been in the class all week. Things have been getting worse all week and she is now avoiding all demands by screaming.

Today her screaming escalated: He says he tried to place a worksheet on her desk instead of walk away when she screamed. Aniyah began to throw things, destroy property, and hit herself. A security guard is called and restrains her, but eventually the team calls a police escort to a hospital where her medications are stabilized and she skips the rest of the school week.

BEHAVIORS: SCREAMING; PROPERTY DESTRUCTION; SELF-INJURY

FUNCTION:

- "skips the rest of the week"
- Avoiding all demands
- Security guards rush in
- Hospital visit

Avoidance? Attention?

TREATMENT OPTIONS:

- Follow through on demands?
- Go back to FCT; honor "appropriate asking"?
- Bring school demands to hospital and continue them?

RECALL THESE FEATURES AND FUNCTIONS OF TRAUMA-RELATED STIMULI?

- Discrimination training led to adults as S-deltas for approach and SD's for avoidance
- Adult approach **conditioned as aversive**
  - **May be occasion-setter** for inappropriate behavior
  - **SD** for threat-related behaviors
  - Accompanied by conditioned physiological responses
  - Conditioning of long-lasting MO's

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ANIYAH'S EXAMPLE

What if you knew something about me that my school record doesn't show?

ANIYAH'S EXAMPLE

CONDITIONING MOTIVATING OPERATIONS

CMO-T

CMO-R

CMO-S

ANIYAH'S EXAMPLE

CMO-S
(SURROGATE CONDITIONED MOTIVATING OPERATION)

After being paired with a MO in the past, this stimulus now has the same value-altering and behavior-altering effects as that MO.

ANIYAH'S EXAMPLE

What if you knew something about me that my school record doesn't show?

CMO-S
(SURROGATE CONDITIONED MOTIVATING OPERATION)

In the past, Aniyah was abused by a guard who had striking physical features. She got away after injuring herself severely.

Now, when Aniyah sees **Mike**, another guard who looks very similar to that person, Aniyah uses unsafe behavior that occasions a medical emergency and the guard is replaced by medical personnel who handle the emergency.

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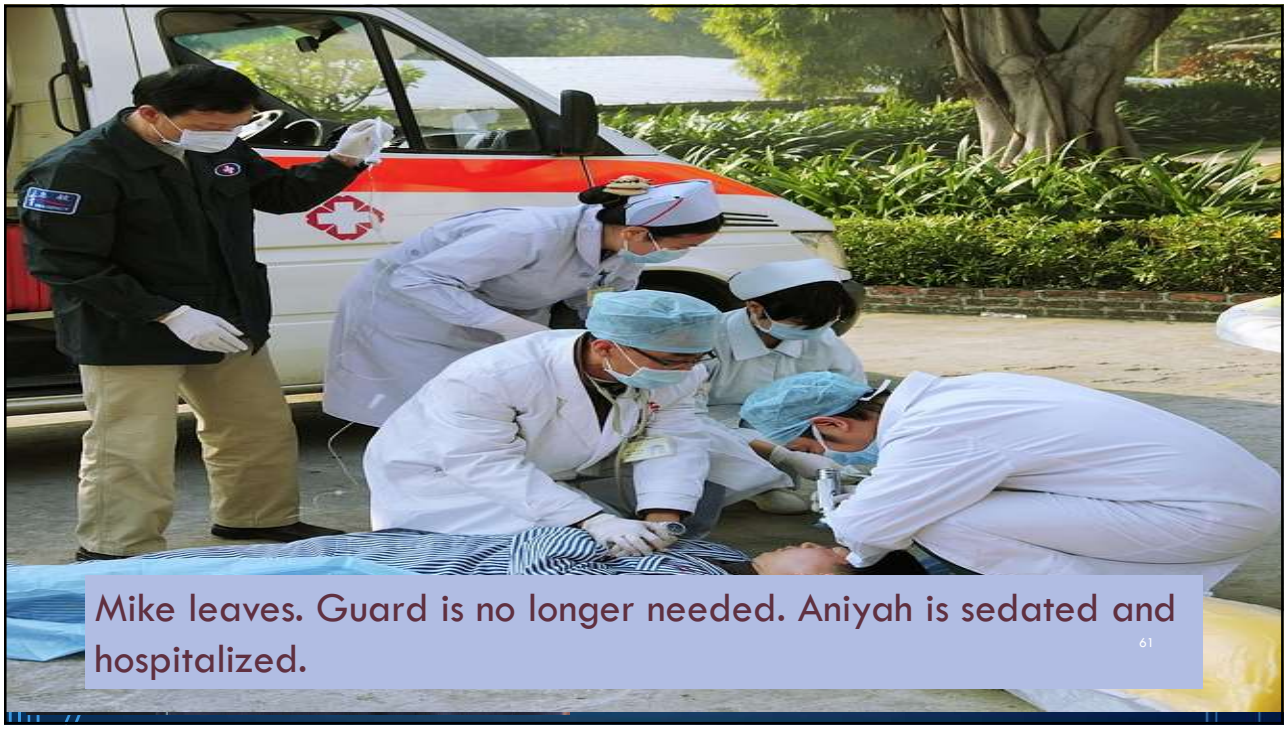

Mike leaves. Guard is no longer needed. Aniyah is sedated and hospitalized.

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Example

CMO-S HAS 2 EFFECTS:

CMO-S
(SURROGATE CONDITIONED MOTIVATING OPERATION)

The environmental condition: Mike walks in

The temporary reinforcing effectiveness of a stimulus is established: Mike leaves/ medical emergency

Temporary increase in behavior that has been reinforced by that stimulus: Unsafe behavior that results in medical emergency

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RECALL THESE FEATURES AND FUNCTIONS OF TRAUMA-RELATED STIMULI?

- Discrimination training led to adults as S-deltas for approach and SD's for avoidance
- Adult approach **conditioned as aversive**
  - **May be occasion-setter** for inappropriate behavior
  - **SD** for threat-related behaviors
  - Accompanied by conditioned physiological responses
  - Conditioning of long-lasting MO's

Plus RFT…

- *Adults, adult approach, and adult related stimuli (instructions! Praise! Demands! Touch!) enter into **relational frames** with new stimuli that weren't related at ALL to the original threat*

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TO PUT THESE TERMS IN TO PRACTICE AND REALLY HELP OUR CLIENTS BE AS FREE FROM COERCION AS POSSIBLE, WE NEED TO BE ABLE TO FULFILL OBJECTIVE 3!

OBJECTIVE 3

Participants will state behavioral cusps for teams that can enhance applied behavior analytic practice with people affected by trauma and autism

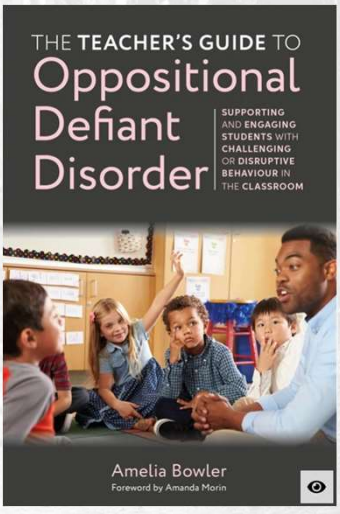
Was Aniyah "free to do the right thing" …

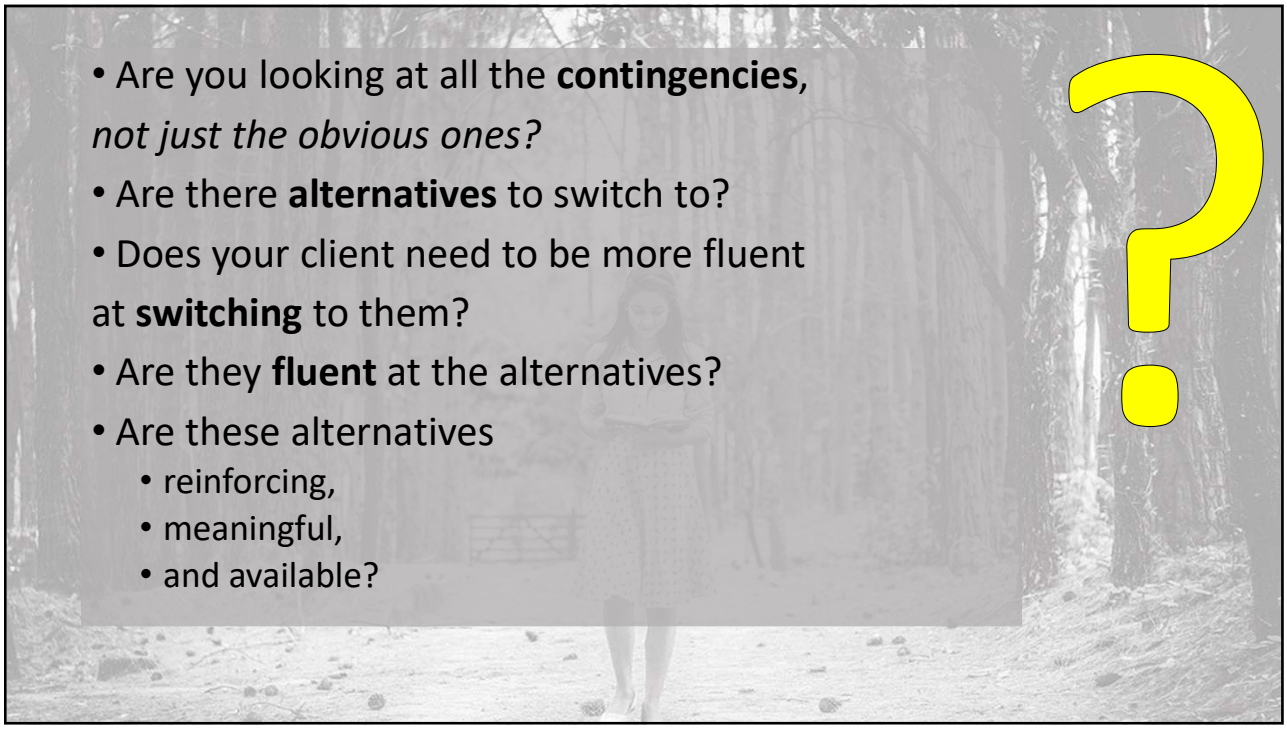
or just doing her best in a coercive system

that was uninformed about her history?

Let's say you are interested in how can you give more *freedom* to your client and yourself.

It may help to ask…




• Are you looking at all the **contingencies**,
not just the obvious ones?
• Are there **alternatives** to switch to?
• Does your client need to be more fluent
at **switching** to them?
• Are they **fluent** at the alternatives?
• Are these alternatives
• reinforcing,
• meaningful,
• and available?


Are you selecting and programming
behavioral cusps ?


Constructional Programs Ask:
Where do you want to go?
The behavior to be established, or constructed
amond (1974)
Dr. Jesús Rosales-Ruiz
Dr. Don Baer


The behavioral cusp

The behavioral cusp

- Sid Bijou (KU developmental psychologist with huge contribution to early behavior analysis) coined the term
- Don Baer and Jesús Rosales-Ruiz clarified the concept and wrote the 1997 paper
- Connects child development to behavior analysis
- A behavior change with an important contribution to future events
  - Can provide access to new reinforcing environments
  - Use in goal selection to target the really important behavior changes
  - Examples:
    - Learning to ask questions
    - Learning to read

Examples of my individualized cusps for clients after trauma

- Describe a person
- Tact body parts
- Successfully request assistance (identifying a person to ask; getting someone's attention; sounding assertive; asking with repetition; waiting until there is a response)
- Using skills that help them remain in the present (noticing; cognitive flexibility)

Examples of cusps for trauma-healing teams

- Detecting and documenting risks/ creating a risk v benefit document
- Screening for trauma in staff, caregivers or clients
- Talking about risks
- Asking for appropriate resources

- *Talking about trauma with other trauma related professionals!*

YOU PROBABLY HAVE THOUGHT OF A MILLION REASONS WHY THIS STUFF MATTERS TO YOU.

- It matters to me too! The whole SAFE-T Model is built to help other professionals with this array of skills
- And to give them resources that enhance their competence in this area.
- Let's pull it all together!

SAFE-T CHECKLIST

Part of the SAFE-T model for safer and ethical treatment of behavior after trauma

TC Kolu 2021

Where does it matter? Why does it matter?

- Medical and behavioral history
- Assessment
- Risk analysis
- Treatment plan
- Person-centered plan
- Medication management
- etc

Medical errors; misdiagnoses; warning signs that someone is ill or at risk

FBA doesn't mention trauma as an important contributor to behavior

Behavior plan never gets around to addressing the problem

But does provide a whole lot of seemingly function-related treatment, perhaps subjecting the person to MORE TRAUMA

Missed mental health needs or overmedication; professionals don't earn trust of client; problems snowball and person is unsupported

Look at this from another perspective

- Medical and behavioral history
- Assessment
- Risk analysis
- Treatment plan
- Person-centered plan
- Medication management
- etc

Spot a trauma-related illness, save a life, steer toward a lifetime of health

Trauma is documented in the assessment and informs the *real* reasons for the challenges

Behavior plan is effective and compassionate

Soon the behavior plan isn't needed and the person carries a plan with them to continue progressing safely

Medications are only used when needed, and the person has a trauma-informed team that acts preventively and supportively

We could screen for trauma.

SAFE-T SCREENING TOOL

Use this page as SCREENING TOOL or to document referral concerns: Write in the date, or check the past and/or current box as appropriate for each item (if there is a possible concern or if the person, to your knowledge, has ever used this behavior or shown this concern).

Challenging behaviors or concerns I have for this person in the past or present

Past	Current	Behavior
		Acts out aggressive or sexual roles with others
		Using alcohol, cigarettes or drugs
		Challenging behavior when almost any transition takes place
		Depicts aggressive events in their writing or drawing
		Challenges with appropriate leisure skills
		Trouble responding to caregiver's instructions
		Challenges with transitioning to rest or bed
		Depicts sexual events with drawing or coloring
		Destroys property
		Eating much less than others the person's age and size
		Eating much more than others the person's age and size
		Eating out of the garbage or eating hygiene products
		Makes false accusations about others
		Several weekly explosive bouts of behavior or crying spells lasting longer

Adverse experiences or difficult caregiving situations that have affected this person in the past or present

Past	Current	Situation
		Everyday caregiving techniques seem to make challenges worse
		Client exposed to drugs in utero
		Client homeless as a child
		Client shows reduced eye contact with caregivers but not other people
		There is documentation of mistreatment, abuse or neglect
		It is likely a client was present during drug use
		Medical diagnosis, or medical concerns
		Mental health diagnosis
		It is likely a client experienced neglect
		It is likely a client experienced sexual abuse
		It is likely a client experienced physical abuse
		It is documented a client witnessed family violence
		Client was abandoned as a child or young adult
		Client stayed in foster care
		Client was adopted
		Client was in multiple foster care placements
		Client was in a failed adoption
		Person's primary care was interrupted by a caregiver's incarceration or poverty

TOOL

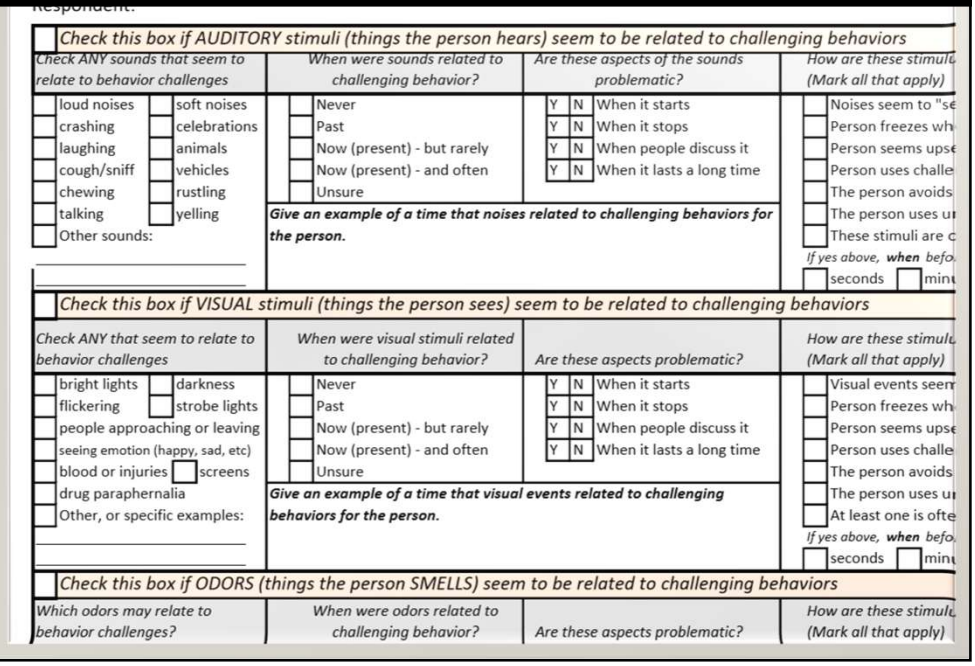
SAFE-T Screening Tool

- 1 page form
- Often used during intake
- **Left:** Behavioral concerns
- **Right:** Situational factors

We could document "hidden triggers".

TOOL

IPASS (Inventory of Potential Aversive Stimuli and Setting Events)



Respondent:

☐ Check this box if AUDITORY stimuli (things the person hears) seem to be related to challenging behaviors

Check ANY sounds that seem to relate to behavior challenges	When were sounds related to challenging behavior?	Are these aspects of the sounds problematic?	How are these stimuli (Mark all that apply)
☐ loud noises ☐ soft noises ☐ crashing ☐ celebrations ☐ laughing ☐ animals ☐ cough/sniff ☐ vehicles ☐ chewing ☐ rustling ☐ talking ☐ yelling ☐ Other sounds:	☐ Never ☐ Past ☐ Now (present) - but rarely ☐ Now (present) - and often ☐ Unsure	Y N When it starts Y N When it stops Y N When people discuss it Y N When it lasts a long time	☐ Noises seem to "se ☐ Person freezes wh ☐ Person seems upse ☐ Person uses challe ☐ The person avoids ☐ The person uses u ☐ These stimuli are c *If yes above, **when** befo* ☐ seconds ☐ minu
	Give an example of a time that noises related to challenging behaviors for the person.		

☐ Check this box if VISUAL stimuli (things the person sees) seem to be related to challenging behaviors

Check ANY that seem to relate to behavior challenges	When were visual stimuli related to challenging behavior?	Are these aspects problematic?	How are these stimuli (Mark all that apply)
☐ bright lights ☐ darkness ☐ flickering ☐ strobe lights ☐ people approaching or leaving ☐ seeing emotion (happy, sad, etc) ☐ blood or injuries ☐ screens ☐ drug paraphernalia ☐ Other, or specific examples:	☐ Never ☐ Past ☐ Now (present) - but rarely ☐ Now (present) - and often ☐ Unsure	Y N When it starts Y N When it stops Y N When people discuss it Y N When it lasts a long time	☐ Visual events seem ☐ Person freezes wh ☐ Person seems upse ☐ Person uses challe ☐ The person avoids ☐ The person uses u ☐ At least one is ofte *If yes above, **when** befo* ☐ seconds ☐ minu
	Give an example of a time that visual events related to challenging behaviors for the person.		

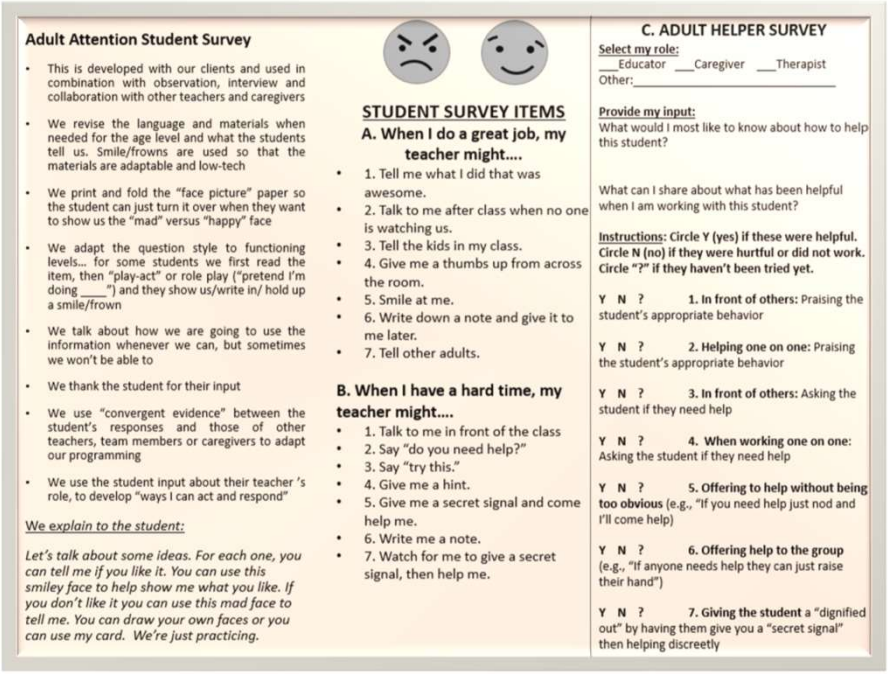
☐ Check this box if ODORS (things the person SMELLS) seem to be related to challenging behaviors

Which odors may relate to behavior challenges?	When were odors related to challenging behavior?	Are these aspects problematic?	How are these stimuli (Mark all that apply)

We could TRULY INDIVIDUALIZE reinforcers
and learn about how stimuli function for individuals,
Instead of making assumptions
(like "praise should just be a reinforcer!")

TOOL

Adult Attention Preference Assessment



Adult Attention Student Survey

- This is developed with our clients and used in combination with observation, interview and collaboration with other teachers and caregivers
- We revise the language and materials when needed for the age level and what the students tell us. Smile/frowns are used so that the materials are adaptable and low-tech
- We print and fold the "face picture" paper so the student can just turn it over when they want to show us the "mad" versus "happy" face
- We adapt the question style to functioning levels… for some students we first read the item, then "play-act" or role play ("pretend I'm doing ____") and they show us/write in/ hold up a smile/frown
- We talk about how we are going to use the information whenever we can, but sometimes we won't be able to
- We thank the student for their input
- We use "convergent evidence" between the student's responses and those of other teachers, team members or caregivers to adapt our programming
- We use the student input about their teacher 's role, to develop "ways I can act and respond"

We *explain to the student:*

Let's talk about some ideas. For each one, you can tell me if you like it. You can use this smiley face to help show me what you like. If you don't like it you can use this mad face to tell me. You can draw your own faces or you can use my card. We're just practicing.

STUDENT SURVEY ITEMS

A. When I do a great job, my teacher might….

- 1. Tell me what I did that was awesome.
- 2. Talk to me after class when no one is watching us.
- 3. Tell the kids in my class.
- 4. Give me a thumbs up from across the room.
- 5. Smile at me.
- 6. Write down a note and give it to me later.
- 7. Tell other adults.

B. When I have a hard time, my teacher might….

- 1. Talk to me in front of the class
- 2. Say "do you need help?"
- 3. Say "try this."
- 4. Give me a hint.
- 5. Give me a secret signal and come help me.
- 6. Write me a note.
- 7. Watch for me to give a secret signal, then help me.

C. ADULT HELPER SURVEY

Select my role:
___Educator ___Caregiver ___Therapist
Other:_____

Provide my input:
What would I most like to know about how to help this student?

What can I share about what has been helpful when I am working with this student?

Instructions: Circle Y (yes) if these were helpful. Circle N (no) if they were hurtful or did not work. Circle "?" if they haven't been tried yet.

Y N ? **1. In front of others:** Praising the student's appropriate behavior

Y N ? **2. Helping one on one:** Praising the student's appropriate behavior

Y N ? **3. In front of others:** Asking the student if they need help

Y N ? **4. When working one on one:** Asking the student if they need help

Y N ? **5. Offering to help without being too obvious** (e.g., "If you need help just nod and I'll come help)

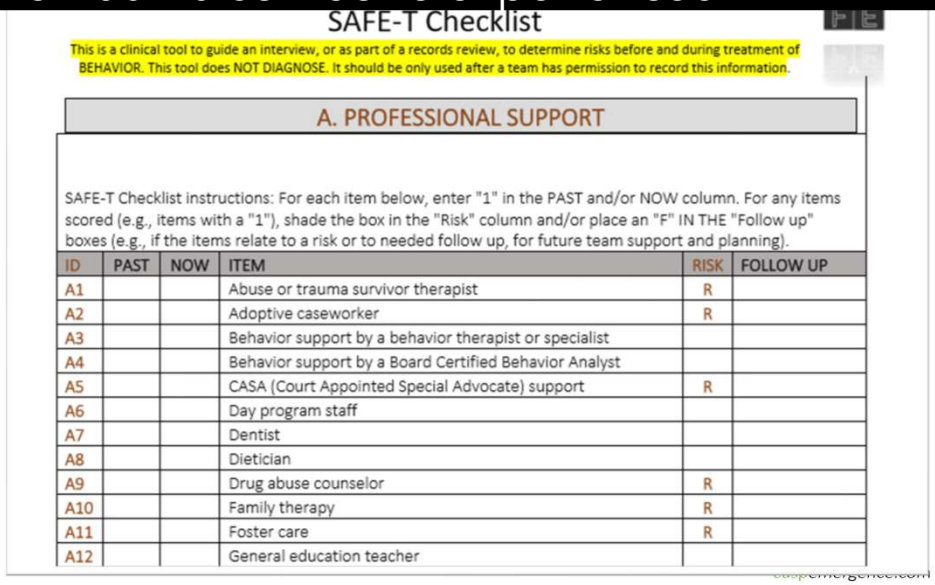
Y N ? **6. Offering help to the group** (e.g., "If anyone needs help they can just raise their hand")

Y N ? **7. Giving the student** a "dignified out" by having them give you a "secret signal" then helping discreetly

And when needed, we could document risks related to the trauma someone experienced.

TOOL

SAFE-T Checklist



SAFE-T Checklist

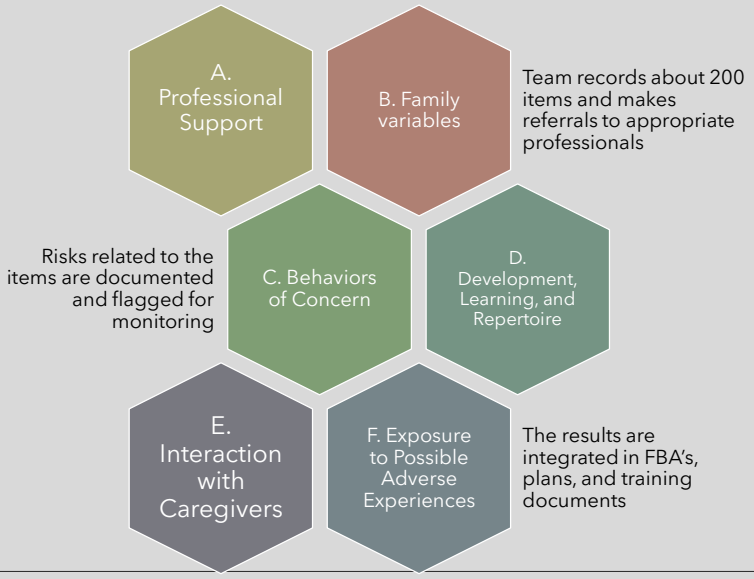
This is a clinical tool to guide an interview, or as part of a records review, to determine risks before and during treatment of BEHAVIOR. This tool does NOT DIAGNOSE. It should be only used after a team has permission to record this information.

A. PROFESSIONAL SUPPORT

SAFE-T Checklist instructions: For each item below, enter "1" in the PAST and/or NOW column. For any items scored (e.g., items with a "1"), shade the box in the "Risk" column and/or place an "F" IN THE "Follow up" boxes (e.g., if the items relate to a risk or to needed follow up, for future team support and planning).

ID	PAST	NOW	ITEM	RISK	FOLLOW UP
A1			Abuse or trauma survivor therapist	R	
A2			Adoptive caseworker	R	
A3			Behavior support by a behavior therapist or specialist		
A4			Behavior support by a Board Certified Behavior Analyst		
A5			CASA (Court Appointed Special Advocate) support	R	
A6			Day program staff		
A7			Dentist		
A8			Dietician		
A9			Drug abuse counselor	R	
A10			Family therapy	R	
A11			Foster care	R	
A12			General education teacher		

Domains of the SAFE-T checklist



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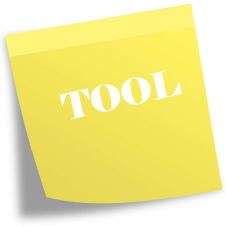

SAFE-T Checklist

D8			Person uses challenging behavior that seems to indicate that they need something		
D9			Person is diagnosed with autism or a developmental disability	R	
D10			Person is diagnosed with a medical disability		
D11			Person is on prescribed medications		
D12			Person is affected by and diagnosed with allergies		
D13			Person is diagnosed with seizures		
D14			Person has been diagnosed as having at least one traumatic brain injury (TBI)	R	
D15			Person has a trauma-related diagnosis	R	
D16			Person is diagnosed with PTSD	R	
D17			Person is diagnosed with cognitive impairment		
D18			Person is talking on track (or if older, developed language on developmental track as a child)		
D19			Person is walking on track (or if older, walked on developmental track as a child)		
D20			Person is eating on track (or if older, developed feeding skills on developmental track as a child)		
D21			Toileting on track (or if older, developed toileting skills on developmental track as a child)		
D22			Toileting accidents occur	R	
D23			Pain threshold seems higher than other peers of same age; does not respond to painful stimuli	R	

We could make risk mitigation plans By planning for risk clusters OUR CLIENT experienced.

- Clues that caregivers need special support

Items in RISK area or CLUSTER	Description of potential caregiver related risk or need
E0, E4, E5, E6, E7, E9, E11, E21, E27, E30, E31, E34, E35, E37, E45	
E4, E5, E6, E7, E9, E11, E27, E30, E31, E32, E37, E45	
E4, E5, E6, E7, E9, E30, E31, E35, E37	
E4, E6, E9, E11, E29, E30, E31	

Section E. Potential risks related to caregiver and/or family needs

Risk Clusters

- Educational needs
- Helping teams to be preventive

Items in RISK area or CLUSTER	Description of potential caregiver related risk or need
E2, E20, E23, E24, E38, E40, E42	Examine unaddressed educational needs if risks cluster in this area: Client's behavioral difficulties may be related to educational needs that are unaddressed, or repertoire gaps
E38, E39, E40, E41, E42, E43	Support for communities and teams, especially during transitions, working with NEW caregivers and new environments/ communities: If suspension from previous environments has taken place due to behavior concerns, new teams need preventative training to avoid setting up a pattern* that is harmful from the beginning

We could use all this information to move toward using fewer counter-indicated procedures…

https://cuspemergence.com/2020/09/08/contra indicated-behavioral-procedures-after-trauma/

Take special care with…

previous food insecurity, food related abuse or neglect, and/or severe food deprivation	previous sexual abuse	medical complications from sexual or physical trauma (could include incontinence, fecal smearing)
previous neglect or adverse circumstances (deaths of parents, removal from unsafe conditions, war, immigration or poverty related issues)	physical and/or sexual abuse, circumstances consistent with RAD, inconsistent caregivers in childhood	neglect and involvement with law enforcement, suspensions and challenging behavior

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https://cuspemergence.com/2020/09/08/contraindicated-behavioral-procedures-after-trauma/

Take special care with…

Edible reinforcement	**1:1 without oversight**	**Toilet training procedures**
attention related EXT, differential reinforcement of appropriate versus inappropriate requests, or time out from attention reinforcement	**Contingent praise statements or reliance on compliance culture to control behavior**	**Least to most punishment**

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https://cuspemergence.com/2020/09/08/contraindicated-behavioral-procedures-after-trauma/

Take special care with…

= Do a risk v benefit analysis first and take care!

2.14 and 2.15 in Code: 2.14 Selecting, Designing, and Implementing Behavior-Change Interventions Behavior analysts select, design, and implement behavior-change interventions that: (1) are conceptually consistent with behavioral principles; (2) are based on scientific evidence; (3) are based on assessment results; (4) prioritize positive reinforcement procedures; and (5) best meet the diverse needs, context, and resources of the client and stakeholders. Behavior analysts also consider relevant factors (e.g., risks, benefits, and side effects; client and stakeholder preference; implementation efficiency; cost effectiveness) and design and implement behavior-change interventions to produce outcomes likely to maintain under naturalistic conditions. They summarize the behavior-change intervention procedures in writing (e.g., a behavior plan). 2.15 Minimizing Risk of Behavior-Change Interventions Behavior analysts select, design, and implement behavior-change interventions (including the selection and use of consequences) with a focus on minimizing risk of harm to the client and stakeholders.

Why **might we do behavior analysis differently?**

- Avoid doing harm
- Assess risks before they happen
- Better match clients with agencies
- Better match needs with procedures
- Minimize counter-indicated procedures
- Make a huge difference
- Feel good about working!

Descriptions included in a Trauma-Informed FBA

Supportive timing and delivery

Adverse or aversive experiences

Historical relationships

Triggers and responses

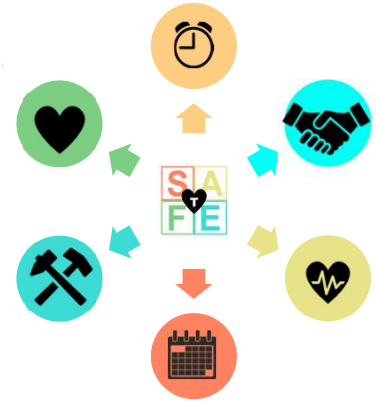
Medical needs

Important times for the person

Possible Features of a Trauma-Informed Behavior Plan

Preventive time in

Include safe person



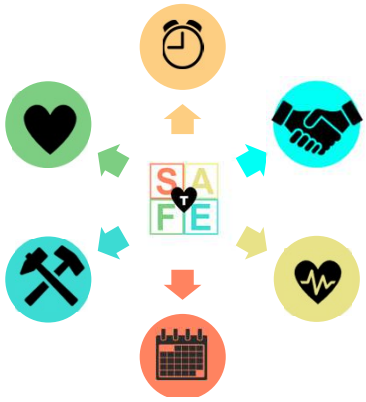
Building relationships

Build repertoires toward values

Medical related recommendations

Preventive procedures and training for difficult times

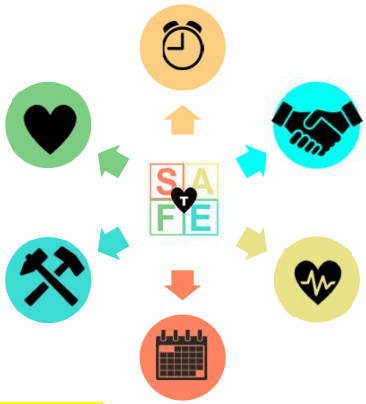
Possible Features of a Trauma-Informed Behavior Plan



- Assess risks, contraindications
- Follow the research
- Use trauma-informed practices to select needed skills
- See examples of curricula

Buffering items

Possible Features of a Trauma-Informed Behavior Plan



**Buffering items* are the 6 components that Nadine Burke Harris (2017) and others suggest can protect AFTER trauma:

- **adequate exercise, sleep, nutrition**
- **good relationship, stress relieving skills**
- **mental health support**

Notes on procedures that target appropriate repertoire development:

- Assess all procedures for risks/benefits, reducing contraindicated procedures.
- Use research-based techniques, include targets needed after trauma
- Consider missing skills (e.g., flexibility, defusion, social emotional skills, self advocacy, problem solving, correspondence between verbal behavior and actual events (e.g., "telling the truth" and "self-awareness"; see Dymond and Barnes (1997); tolerating appropriate demands. Some compatible and behavioral approaches or programs may include the following:
  - ❑ DNA-V (includes free resources on the developmental model acceptance and commitment therapy) https://thrivingadolescent.com/dna-v-free-resources/
  - ❑ TAPS/ (talk aloud problem solving; work by Joanne Robbins): https://talkaloudproblemsolving.com/
  - ❑ AIM/ work by Mark Dixon: https://www.acceptidentifymove.com/about
  - ❑ IISCA/ work by Greg Hanley: https://practicalfunctionalassessment.com/
  - ❑ Flexible and Focused (book by Adel Najdowski targeting executive functioning skills)

"Use trauma-informed practices to select needed skills "

TOUCH AND THE BODY

BOUNDARIES

ANOTHER IMPORTANT INTERSECTION FOR OUR CLIENTELE

- More likely to experience isolation in education or therapy
- Skill differences: difficulties assertive
- Experiences where they are viewed as "not credible" or accurate reporters

ASD

Sexuality: needs and environment

- Lack of models; explicit teaching for important skills
- Increased opportunities to be alone with others
- Excessive power differential (child v therapist/educator/job coach/ boss)

- Increased rate of experiencing sexual exploitation
- Culture of compliance and being socialized to comply

Trauma

The Culture of Consent with Individuals with Intellectual and Developmental Disabilities

30 NOV 2019 SBRPSIG LEAVE A COMMENT

by Robin Moyher, Ph D, BCBA-D, LBA, George Mason University

Consent is defined as giving assent or approval (Merriam-Webster Dictionary). Often and especially in the current state of #metoo, we think of consent as giving permission or agreement between two (or more) people to engage in sexual activity. Without consent, sexual behavior becomes criminal with a perpetrator and a victim. There are a few particularly vulnerable populations where sexual violence is significantly higher. This includes women, LBGTQ, children, American Indians, prisoners, and individuals with disabilities. If you are a member of more than one of these groups, your chances of becoming a victim increases. This article will focus on individuals with Intellectual and Developmental Disabilities (IDD).

POSSIBLE TOPICS/SKILLS FOR PREVENTIVE TEACHING FOR TIBA, SEX, AND AUTISM

TOUCH AND THE BODY

- Body parts, functions, names
- Who, how, where, when
- All categories of people
- Good/bad, confusing
- No secrets about touch

BOUNDARIES

- Consent (giving, getting)
- Refusal (including nonverbal cues)
- Respect for boundaries (yours/ others; physical, sexual)
- Discrimination training for non/consensual scenarios
- Public/ private

POSSIBLE TOPICS/SKILLS FOR PREVENTIVE TEACHING FOR TIBA, SEX, AND AUTISM

RELATIONSHIPS

- Yourself: your autonomy, your body is your own
- Others: what and who a trusted adult is
- How and why to begin, maintain, end relationships
- Relationship health (including media influences on)
- Realistic/ unrealistic

Also see resource: www.sexaba.com

SKILLS

- Self-advocacy
- Self-regulation
- Detect emotions, situations that are safe, uncomfortable, confusing, or unsafe

You can do this kind of approach for any combination of factors your clients face.

POSSIBLE TOPICS/SKILLS FOR PREVENTIVE TEACHING FOR TIBA, MEDICAL FACTORS, AND AUTISM

Look up resources on assent and consent!

MEDICAL NEEDS

- Taking medications
- Staying still in the presence of medical equipment
- etc

PROCEDURES

- Collaborating with professionals (2.10, 3.16)
- Document and assess for medical variables (consider medical needs, 2.12)
- Do task analyses
- Notice I didn't write "tolerate all medical procedures"… be subtle and individualize! Don't go back to culture of compliance…
  Instead, teach assent, REFUSAL, negotiation etc

You can do this kind of approach for any combination of factors your clients face.

POSSIBLE TOPICS/SKILLS FOR PREVENTIVE TEACHING FOR TIBA, MEDICAL FACTORS, AND AUTISM

Look up resources on assent and consent!

MEDICAL NEEDS

DIGNITY AND ASSENT FOR CLIENTS

AN ACTIVITY WORKSHOP

CASSI BREAUX M.A., M. S., BCBA, LBA

Cbreaux@uwf.edu

PROCEDURES

- Collaborating with professionals (2.10, 3.16)
- Document and assess for medical variables (consider medical needs, 2.12)
- Do task analyses
- Notice I didn't write "tolerate all medical procedures"… be subtle and individualize! Don't go back to culture of compliance…
  Instead, teach assent, REFUSAL, negotiation etc

REVIEW

1. We can expand our boundaries of competence and repertoires in this critical area
2. Collaborate with others, and operationalize important concepts in their areas (trauma, medical variables, etc)
3. Select and teach behavioral cusps for both team members and clients
4. Use risk versus benefit tools to enhance practices for individuals with autism, AND to minimize harm of using procedures that are contraindicated.

- Screening (behaviors, situations, buffering items, opportunities)
- Risk assessment
- Risk documentation
- Risk mitigation

ANIYAH'S EXAMPLE

- Screening identified hidden trauma
- Risks were outlined clearly in her plan
- Some procedures were put on hold
  - "Requiring appropriate requests" was changed to: *"noncontingent reinforcement" schedule for escape (similar to Ricciardi et al. paper (2006) on shaping without extinction*

J Appl Behav Anal. 2006 Winter; 39(4): 445–448.
doi: 10.1901/jaba.2006.158-05
PMCID: PMC1702337
PMID: 17236342

Shaping Approach Responses as Intervention for Specific Phobia in a Child with Autism

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Few controlled studies describe effective treatment of fears in people who have developmental disabilities (cf. Erfanian & Miltenberger, 1990; Rapp, Vollmer, & Hovanetz, 2005). One approach, termed *contact desensitization*, exposes an individual to the phobic (avoided) stimulus by gradually shaping approach responses. Positive reinforcement is presented contingent on completion of steps in an exposure hierarchy. Preventing escape from the phobic stimulus sometimes is a component of treatment (e.g., Rapp et al.), although this strategy might be difficult to implement and might evoke or elicit challenging behavior (e.g., resistance, agitation, struggling). In the present study, we evaluated contact desensitization with a child who had been diagnosed with autism and specific phobia, using positive reinforcement without escape prevention, and measuring approach responses within and between intervention sessions.

There are many clinical differences between ABA-typical and ACE-affected populations

Note: ACE stands for Adverse Childhood Experiences

1. Differences in typical behaviors, skills, characteristics
2. Differences in typical response to treatment
3. Differences in family and parent skills
4. Differences in team support needed
5. Differences in risks to clients and community

EXAMPLES OF OTHER TRAUMA FACED BY CHILDREN AND ADULTS WITH WHOM OUR TEAM WORKS

- Natural disasters, long term illnesses, accidents, or medical issues/ treatment
- War; PTSD; systemic racism; discrimination and bullying; challenges facing indigenous people; genocide
- Poverty, homelessness
- Immigration related challenges
- Violence, drug abuse, and/or alcoholism in family
- Deaths of family members
- Witnessing or perpetrating violence; incarceration
- Childhood experiences (ACES; see **Nadine Burke Harris' TED talk)**
  - Abuse, mistreatment, neglect
  - Being treated inappropriately while growing up with mental illness, autism, intellectual differences
  - Foster care; adoption; multiple placements; abandonment

There are many clinical differences between ABA-typical and ACE-affected populations[110]

Note: ACE stands for Adverse Childhood Experiences

1. Differences in typical behaviors, skills, characteristics
2. Differences in typical response to treatment
3. Differences in family and parent skills
4. Differences in team support needed
5. Differences in risks to clients and community

cuspemergence.com

Some clinical differences between ABA-typical and ACE-affected populations [111]

Note: ACE stands for Adverse Childhood Experiences

1. **Differences in typical behaviors, skills, characteristics**
   - Higher risk of "sexualized", "parentified" and "team- or family-splitting" behaviors
   - Learning differences lead to school trouble (for example, retention of information may be challenging, related to drug exposure in utero or disruption of early learning)
   - Sensory differences; increased pain threshold
2. **Differences in typical response to treatment**
   - Inconsistent history leads to inconsistent response to praise or social-mediated stimuli
   - Disruption of acquisition of communication skills and age appropriate skills

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Some clinical differences between ABA-typical and ACE-affected populations [112]

3. **Differences in family and parent skills:** Typical caregiving skills often not effective (doesn't mean placement is inappropriate; may mean training needed); client cannot trust adult models (may have had abusive and challenging behaviors modeled by multiple adults)

4. **Differences in team support needed**: Role clarifications (examples: client may be guardian of another entity or person; state or legal agency may be involved); intense collaboration/support, medical and mental health collaboration, social workers and other team members unfamiliar to BCBAs

5. **Differences in risks to clients and community**: Risks of sexual behaviors, physical/sexual trauma; risks because of missing skills (example: decreased advocacy/reporting of crime or trauma/recognizing and reporting pain); Dangerous behaviors may have been modeled and valued (e.g., were useful prior to the removal from unsafe situations)

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After trauma, our client is still…

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- a person with preferences, interests, feelings, desires; joys
- someone who uses behavior in the CONTEXT of their current and past environments… like everyone else
- capable of growth and deserving of love (and meaningful social interaction, even if their current behaviors reduce the likelihood and quality)
- at risk of being exposed again to abuse or trauma by well-meaning people
- a human being who matters. (And some of their needs may be outside the realm of behavior analysis)

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After trauma, our client may…

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- have skill gaps because of their history or medical impact of trauma
- use behaviors that have problematic "functions", but that were once useful (and maybe even their only hope)
- not always be capable of the same thing all the time
- have experienced behavior analysis that was part of harmful treatment
- have had a member of their behavioral, mental health, or educational team who abused them - or didn't stop it

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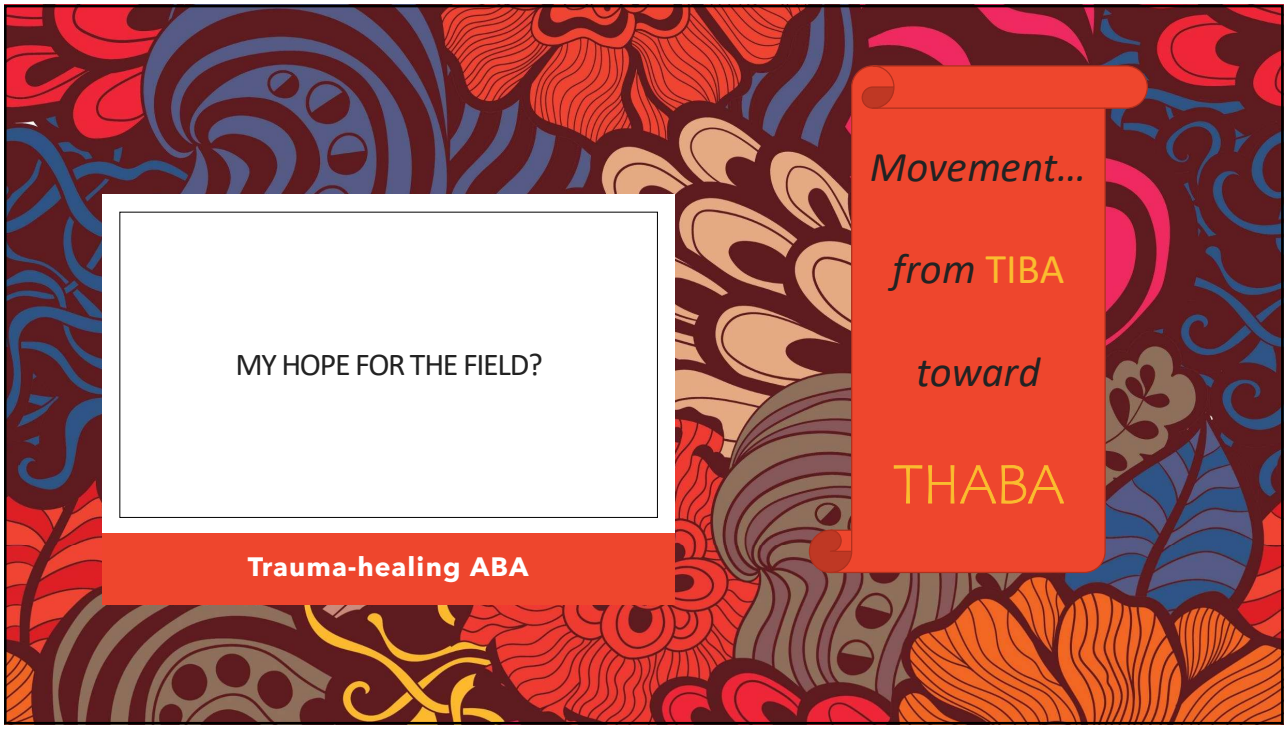

THANK YOU, TASN-ATBS!

Thank you Terri and all those who are attending or watching this topic.

***Thank you** to those of you **providing** support.*

*And, most especially, thank you to each person we are **entrusted** to support.*

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2. See this website for an interview with Joe Layng (many other excellent analysts as well): https://www.domesticatedmanners.com/woofspeakers

3. See Dr. Kolu's website for series of articles on trauma-informed behavior analysis: https://www.cuspemergence.com

4. Rosales-Ruiz, J. and Baer, D.M. (1997) Behavioral Cusps: A Developmental and Pragmatic Concept for Behavior Analysis. Journal of Applied Behavior Analysis, 30, 533-544.

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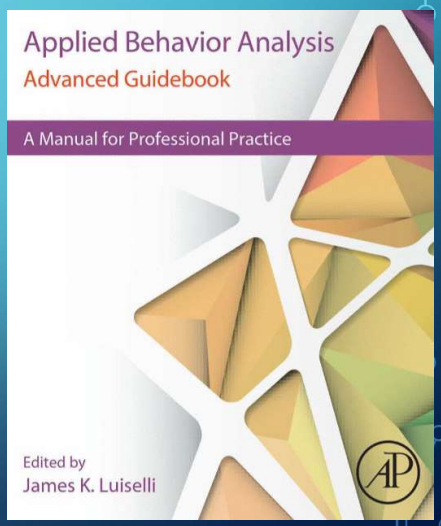
Other selected references and further reading (see next pages for articles)

Important books:

- The Boy Who Was Raised As a Dog (Dr. Bruce Perry, psychiatrist)
- The Deepest Well (Dr. Nadine Burke Harris, pediatrician)
- ABA Advanced Guidebook (Ed. Luiselli, see ch. 5 on Behavioral Risk Assessment)
  - Includes a behavioral screening tool
    - Not trauma-informed, but a good place to start when developing your own process if you don't have access to a tool that is **both trauma-informed and behavioral**
  - Discusses risk mitigation and cases in which outside specialties must be considered



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