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
This presentation covers ASD, trauma, children...
... and adults

On the overlap between autism and trauma
On the overlap between autism and trauma

**Autism spectrum disorders co-occur with trauma**

About **50%** of individuals with autism may have experienced 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)

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


---Rumball, Happé, and Grey (2020)

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

---Cidav, Xie and Mandell (2018)

---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?

- for experiencing “the system”
- for experiencing inappropriate prompting
I'm really distracted in class today. I keep zoning out. I am not sleeping at night. We have a new foster brother and he is molesting me. I don’t know how to tell or ask for help. My para… she’s nice, but she keeps touching me. It makes me cringe. I can do this myself! I’m just trying to swat her away… I’ll try saying “NO”.

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
Programming experiences:

**Inappropriate targets**

**Could include...**
- Compliance
- Eye contact
- Sitting still
- Appropriate requesting

“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
Programming experiences:

Non individualized programs

Could include...
- Token/ level system/ clip chart
- Same prompt hierarchy for everyone
- Same behavior reduction program for everyone who uses a given behavior

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 Prother

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”

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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. He had not done this before. He had been very careful to follow the research. While he had looked at the data before, he had never seen many times before. They had
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

“It’s not maladaptive... it’s not dysfunctional... it’s functional and highly adaptive”
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.

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

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

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

“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/
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

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

**ASD**

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

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
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

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

TREATMENT OPTIONS:
• Follow through on demands?
• Go back to FCT; honor “appropriate asking”?
• Bring school demands to hospital and continue them?

Avoidance? Attention?
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

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.
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.
Mike comes in
Patient uses behavior that occasions a medical emergency
Mike leaves. Guard is no longer needed. Aniyah is sedated and hospitalized.

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

Example

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

CMO-S HAS 2 EFFECTS:
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

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?

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**Are you selecting and programming**

*behavioral cusps?*
Constructional Programs Ask:

- Where do you want to go?
- The behavior to be established, or constructed

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!
Why does it matter?

- 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

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

Where does it matter?

- 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

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

Look at this from another perspective
How might we do things differently?

We could screen for trauma.

SAFE-T Screening Tool

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

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acts out aggressively or sexual roles with others</td>
<td></td>
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<tr>
<td>Using alcohol, cigarettes or drugs</td>
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<tr>
<td>Challenging behavior when asked to leave or when being taken to the bathroom</td>
<td></td>
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<tr>
<td>Denies aggressive events in their writing or drawing</td>
<td></td>
<td></td>
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<tr>
<td>Challenges with appropriate meal times</td>
<td></td>
<td></td>
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<tr>
<td>Trouble responding to caregiver's instructions</td>
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<td></td>
</tr>
<tr>
<td>Challenges with transitioning to rest or nap</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deports sexual events with drawing or coloring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inconsistency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating much less than others this person's age and sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating much more than others this person's age and sex</td>
<td></td>
<td></td>
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<tr>
<td>Eating out of the garbage or eating anything simple</td>
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<td></td>
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<tr>
<td>Makes false accusations about others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posts and displays personal items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal hygiene</td>
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</tbody>
</table>

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

- Everyday caregiving techniques seem to make challenges worse
- Client exposed to drugs in clinic
- Client homeless as a child
- Client shows natural eye contact with caregivers but not other people
- There is documentation of maltreatment, 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 as a client witnessed family violence
- The client was abandoned as a child or young adult
- Client was in foster care
- Client was adopted
- Client was in multiple foster care placements
- Client was in foster adoption
- Personal primary care was interrupted by a caregiver's hospitalization or arrest
We could document “hidden triggers”.

**IPASS**
(Inventory of Potential Aversive Stimuli and Setting Events)

**TOOL**

We could TRULY INDIVIDUALIZE reinforcers and learn about how stimuli function for individuals, instead of making assumptions (like “praise should just be a reinforcer!”)
Adult Attention Preference Assessment

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

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 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).

<table>
<thead>
<tr>
<th>ID</th>
<th>PAST</th>
<th>NOW</th>
<th>ITEM</th>
<th>RISK</th>
<th>FOLLOW UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td></td>
<td></td>
<td>Abuse or trauma survivor therapist</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td></td>
<td></td>
<td>Adoptive caseworker</td>
<td>R</td>
<td></td>
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<tr>
<td>A3</td>
<td></td>
<td></td>
<td>Behavior support by a behavior therapist or specialist</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>A4</td>
<td></td>
<td></td>
<td>Behavior support by a Board Certified Behavior Analyst</td>
<td>R</td>
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<tr>
<td>A5</td>
<td></td>
<td></td>
<td>CASA (Court Appointed Special Advocate) support</td>
<td>R</td>
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<tr>
<td>A6</td>
<td></td>
<td></td>
<td>Day program staff</td>
<td>R</td>
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<td>A7</td>
<td></td>
<td></td>
<td>Dentist</td>
<td>R</td>
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<td>A8</td>
<td></td>
<td></td>
<td>Dietician</td>
<td>R</td>
<td></td>
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<tr>
<td>A9</td>
<td></td>
<td></td>
<td>Drug abuse counselor</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>A10</td>
<td></td>
<td></td>
<td>Family therapy</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>A11</td>
<td></td>
<td></td>
<td>Foster care</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>A12</td>
<td></td>
<td></td>
<td>General education teacher</td>
<td>R</td>
<td></td>
</tr>
</tbody>
</table>
Domains of the SAFE-T checklist

A. Professional Support
Team records about 200 items and makes referrals to appropriate professionals

B. Family variables
Risks related to the items are documented and flagged for monitoring

C. Behaviors of Concern
Risks related to the items are documented and flagged for monitoring

D. Development, Learning, and Repertoire
The results are integrated in FBA's, plans, and training documents

E. Interaction with Caregivers

F. Exposure to Possible Adverse Experiences

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 |
**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

<table>
<thead>
<tr>
<th>Items in RISK area or CLUSTER</th>
<th>Description of potential caregiver related risk or need</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2, E20, E23, E24, E38, E40, E42</td>
<td>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</td>
</tr>
<tr>
<td>E38, E39, E40, E41, E42, E43</td>
<td>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</td>
</tr>
</tbody>
</table>
We could use all this information to move toward using fewer counter-indicated procedures...

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

<table>
<thead>
<tr>
<th>Edible reinforcement</th>
<th>1:1 without oversight</th>
<th>Toilet training procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>attention related EXT, differential reinforcement of appropriate versus inappropriate requests, or time out from attention reinforcement</td>
<td>Contingent praise statements or reliance on compliance culture to control behavior</td>
<td>Least to most punishment</td>
</tr>
</tbody>
</table>

= 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
- Build repertoires toward values

**Building relationships**

**Medical related recommendations**

**Preventive procedures and training for difficult times**

---

### Checklist to assess and document momentary and historic environmental functions and determinants of behavior

### 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* are the 6 components that Nadine Burke Harris (2017) and others suggest can protect AFTIER 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.

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/](https://thrivingadolescent.com/dna-v-free-resources/)
- **TAPS/ (talk aloud problem solving; work by Joanne Robbins):** [https://talkaloudproblemsolving.com/](https://talkaloudproblemsolving.com/)
- **AIM/ work by Mark Dixon:** [https://www.acceptidentifymove.com/about](https://www.acceptidentifymove.com/about)
- **IISCA/ work by Greg Hanley:** [https://practicalfunctionalassessment.com/](https://practicalfunctionalassessment.com/)
- **Flexible and Focused (book by Adel Najdowski targeting executive functioning skills)**
**Possible Features of a Trauma-Informed Behavior Plan**

**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.
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  - TAPS/ (talk aloud problem solving; work by Joanne Robbins): [https://talkaloudproblemsolving.com/](https://talkaloudproblemsolving.com/)
  - AIM/ work by Mark Dixon: [https://www.acceptidentifymove.com/about](https://www.acceptidentifymove.com/about)
  - IISCA/ work by Greg Hanley: [https://practicalfunctionalassessment.com/](https://practicalfunctionalassessment.com/)
  - **Flexible and Focused** (book by Adel Najdowski targeting executive functioning skills)

*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

“Use trauma-informed practices to select needed skills “

**TOUCH AND THE BODY**

**BOUNDARIES**
ANOTHER IMPORTANT INTERSECTION FOR OUR CLIENTELE

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

**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)

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

---

The Culture of Consent with Individuals with Intellectual and Developmental Disabilities

*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, LGBTQ, 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).
I think I’m supposed to say “ok” to all adults…

My CASA volunteer gives me all these presents and hugs me really tight… it makes me feel weird but I’m supposed to hug back, right? We go in their car and have confusing interactions.

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

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

Also see resource: www.sexaba.com

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

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.
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

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

DIGNITY AND ASSENT FOR CLIENTS
AN ACTIVITY WORKSHOP

CASSI BREAUX M.A., M. S., BCBA, LBA
Cbreaux@uwf.edu

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
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

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
Some clinical differences between ABA-typical and ACE-affected populations

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

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)
After trauma, our client is still…

- 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)

After trauma, our client may…

- 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
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.

Contact:
Dr. Camille Kolu, Ph.D., BCBA-D
www.cuspemergence.com
kolubcbad@gmail.com
REFERENCES

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.cuspmeregence.com

https://doi.org/10.1901/jaba.1997.30-533

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
Some selected references and further reading

Some selected references and further reading

