

STRAIGHT TALK

About **Autism**

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Behavior is Not the issue

An Emotional Regulation Perspective on Problem Behavior

Part Two of a Two-Part Article

In part one, we reviewed the importance of addressing problem behavior from an emotional regulation perspective. We also asserted that individuals with ASD are at high risk for problem behavior because of the many challenges they experience in maintaining a well-regulated emotional state. We will now outline the characteristics of an emotional regulation approach (ERA), and illustrate its implementation for two children with ASD.

Characteristics of an Emotional Regulation Approach

- An ERA works best as a team effort, including service providers, parents and family members, and other significant partners in a person's life.
- In an ERA, most problem behaviors are viewed as outcomes of a dysregulated emotional/physiological state. For example, disruptive behavioral patterns (such as screaming or repeated questioning); harmful behavior (such as kicking or biting); or attempts to disengage (such as shutdown and bolting) are considered the individual's response to dysregulation.
- The overarching goals of an ERA are to support an individual's emotional well-being to maximize availability for active engagement and learning; expand emotional regulatory abilities; and foster the development of secure, trusting relationships. Since the focus is not simply on reducing problem behavior, a plan is implemented prior to the occurrence of problem behavior.
- Priority goals in an ERA include self-regulation goals (i.e., expanding independent ability to self-calm and/or increase alertness), and mutual-regulation goals (i.e., expanding ability to respond to and seek assistance from others).

- Accommodations and supports in the physical and social environment are implemented to reduce risk factors and are included in an emotional regulation (ER) Support Plan.

Comprehensive ER Support Plans

- An ER Support Plan should result in increased social participation and engagement in daily activities, and should also serve to lessen the intensity, duration, and frequency of problem behaviors. Therefore, plans are created with a hierarchy of strategies in an effort to provide comprehensive support. These strategies include:
 - **Generic Prevention Strategies** to assist with maintaining a well-regulated state. These strategies are often focused on reducing risk factors associated with dysregulation (e.g., uncertainty and lack of control). Examples include the consistent use of schedules, scheduled breaks, opportunities for choice, environmental accommodations, and use of interactive styles calibrated to a person's abilities (e.g., simplified language, positive support)
 - **Strategic Prevention Strategies** are implemented once patterns of problem behavior occur, and efforts are focused on preventing their continued occurrence. The specific functions of problem behavior are addressed by teaching replacement behaviors (e.g., communication supports for mutual regulation; sensory fidgets for self-regulation). Strategies are also implemented to increase protective factors (e.g., providing regulating information or sensory stimulation).
 - **In the "Heat of the Moment" Strategies / Recovery Strategies** are used in reaction to escalating and more

extreme dysregulation (i.e., meltdown, tantrum, shut down), with the goals of preventing further escalation and helping a person return to a better regulated state. Reducing language complexity and input, offering breaks, gross motor activities, and using visual cues are examples of appropriate strategies. Additionally, recovery strategies may include use of comfort objects, and going to a quiet area or “safe haven.”

Robert — 7 years old

Robert is a student who spends half of his school day in a special class for students with ASD, and half in an inclusive first grade classroom. After the first month of school, his team identified the following issues and concerns: 1) during lunchtime in the cafeteria with his first grade class, it was difficult to get Robert to sit down and have his lunch, which his team hypothesized was likely due to the noise and activity level. He would insist on running over to the window and rolling a toy car up and down the full length of the window. When staff attempted to provide visuals indicating “first lunch, then play,” or to physically support him in going back to his table to eat lunch, he would often resist, dropping to the floor, and at times, pushing and hitting. This often resulted in Robert eating very little if at all. A second related issue had to do with Robert’s high level of arousal after leaving the cafeteria, or any environment that involved a high degree of stimulation. Following these circumstances, he would require 1:1 staff support, since he would often attempt to bolt in the hallway or pace in the classroom. If his teacher or paraprofessional attempted to structure his time by giving him an activity such as a puzzle or worksheet, he would push it away, scream in protest, and continue to move around quickly. Often, such demands would result in extreme dysregulation. His parents reported similar challenges after Robert had spent time in over-stimulating environments. His team devised an ER plan to address these concerns:

Generic Prevention Strategies—Robert’s team already used a variety of approaches to support a well-regulated state, such as simple language input and a picture schedule; however, they determined that they also needed to increase choices, provide more opportunities for Robert to ask for a break, and provide a “safe haven” when stimulation became too challenging.

Strategic Prevention Strategies—The following strategies were put into place to maintain a well-regulated state and thereby prevent and reduce the identified problem behaviors:

The specific functions of problem behavior are addressed by teaching replacement behaviors

1. In the cafeteria, a quiet table away from much of the stimulation was provided where Robert could sit with his classmates.
2. Robert was also provided with opportunities to use and request the use of headphones in noisy environments.
3. Across all settings, Robert was taught to ask for a break, the length of which was defined by a visual timer, after which he could return to his previous activity if deemed to be in a better regulated state.
4. Prior to leaving the cafeteria, Robert was presented with a visual choice board of preferred activities from which to select one to engage in upon returning to the classroom. After selection, this was put into a first-then sequence (first, back to class; then, ____). Visual reminders were provided during the transition to the classroom, if necessary.

Note: If Robert’s arousal state was perceived as too high, rather than enter the classroom immediately, he was allowed to walk down the hallway with a paraprofessional to get a drink of water, and then return to the classroom after the children had settled in.

“Heat of the Moment”/ Recovery Strategies—If Robert was escalating or was already in a state of extreme dysregulation (no longer available for learning or engaging), the first priority was to keep him safe, and direct him to a quiet area away from the sources of stimulation. Since playing with his car was an effective self-regulatory strategy, it was offered to him. Staff would use visuals, very simple language, and provide physical support only if safety was an issue. In the latter case, this was done in a positive manner that would not perpetuate or increase dysregulation

Outcome: After two months of implementing the ER plan, the following outcomes were documented:

1. Increased ability to stay at his table in the cafeteria and eat lunch.
2. An increase in appropriate requests for headphones or breaks with successful reengagement following breaks.
3. A decrease in refusal/protest behaviors such as dropping to the floor or bolting; increased proportion of time in well-regulated state (active engagement); and decreased instances of high-arousal, dysregulated states.

Allison — 15 years old

Allison is a ninth grade mainstreamed student diagnosed with Asperger Syndrome. Allison demonstrates difficulties with social understanding; interpretation of non-verbal communication and non-literal language (e.g., metaphors, sarcasm); and sensory processing difficulties, posing challenges to her participation and engagement in class despite her cognitive and verbal strengths. She frequently experiences considerable anxiety and frustration. Her team identified the following issues and concerns related to Allison's behavior:

1. Incessant questioning, "correcting" the teacher, and arguing
2. Calling out during teacher-guided activities
3. Excessive and unsafe physical activity (e.g., standing on chairs, running to the back of the room, and moving classroom furniture).

When such behavioral patterns occurred, the learning environment was disrupted for all students, and Allison often was escorted from the classroom crying and screaming, "It's not fair!!" and "I hate school."

The team recognized numerous factors that contributed to Allison's dysregulation and problem behavior: difficulties predicting the actions of others; violations of routine (e.g., classes not starting on time); and literal interpretation of language. In addition, highly directive interaction styles (e.g., demanding or negative language, loud voice) used by partners often triggered anxiety leading to escalating behavior.

Finally the team discussed the problem of overestimating Allison's abilities when she was challenged, due to her high-level verbal and problem-solving abilities when she was well-regulated. For example, as her dysregulation quickly increased, some partners used exclusively verbal means to try to reason with her. Notwithstanding Allison's high-level verbal abilities when well regulated, as her emotional arousal escalated her language processing and expressive abilities quickly degraded along with her ability to use even the few conventional regulatory strategies that she was able to use when in a more regulated state. Her team devised the following ER plan to address these concerns.

Generic Prevention Strategies—Team members reiterated the need for: greater consistency in following schedules; using regularly scheduled movement breaks and providing jobs requiring movement and "heavy work;" and the availability of a trusted person in proximity of Allison in high-risk situations. Furthermore, staff was asked to avoid the use of

abstract, non-literal, or negatively-toned, demanding language, as Allison reacted negatively to this.

Strategic Prevention Strategies—

1. Explicit instruction and role-playing opportunities were provided for Allison to increase her social understanding of classroom rules of participation, and to expand her self-regulatory strategies when she was feeling anxious. A graded visual system detailing behavioral indicators of levels of dysregulation was developed (see Table 1), a) to help staff understand the importance of calibrating specific regulatory strategies to levels of dysregulation, and b) for Allison to use as a reference.

Level of Dysregulation	Behavioral Indicator	Strategic Prevention Strategy
Mild	Repetitive questioning	Check schedule, write down steps or expectations
Moderate	Calling out, increase in self-talk	Use note pad to write down ideas to share with teacher at later time
Moderate	Fidgeting, tapping on desk, fingers twirling hair	Chair pushups, brief movement in room, relaxation strategies
Extreme	Physical restlessness/ getting out of seat, loud argumentative speech	Request or provide movement break out of room

Table 1.

2. Focus on successes building positive emotional memories and positive self-talk related to active engagement and regulation

"Heat of the Moment"/ Recovery Strategies —

1. Staff would assist in identifying level of dysregulation and provide support for Allison to take a break and engage in regulating activity. Choices were provided to run track or use tumbling mats in the gym.
2. Following more extreme dysregulation, Allison was given the choice to spend time in the resource room with a

Episodes of extreme dysregulation decreased by 80% from baseline.

trusted staff member or engage in relaxation strategies or regulating activities, and when ready, return to class.

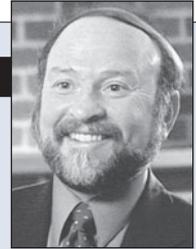
Outcome: After three months of implementing the ER plan, the following outcomes were documented:

1. Allison was able to identify her level of dysregulation and choose appropriate regulatory strategies from her visual list. Episodes of extreme dysregulation decreased by 80% from baseline.
2. She engaged more successfully in classroom conversations, demonstrating increased understanding of social rules.
3. While her need for breaks decreased, if she needed to leave the classroom, she did so proactively, thus preventing more extreme dysregulation.
4. Staff also saw dramatic increases in the following: self esteem; attitude towards school; self control; self confidence; and self advocacy.

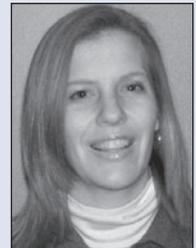
Final Thoughts

We have argued that an ER approach provides a person-centered alternative to approaches that focus primarily on the behavior itself, rather than on supporting emotional regulation. It is hoped that this discussion will support educational practice that incorporates a developmentally-based, emotional-regulation approach because behavior is *not* the issue. 🌊

BIO



Dr. Barry Prizant is the Director of Childhood Communication Services and an adjunct professor in the Center for the Study of Human Development, Brown University. Barry has more than 35 years of experience as a researcher and international consultant to children and adults with ASD. He has published more than 90 articles and chapters on childhood communication disorders and has given more than 500 seminars and workshops at national and international conferences. He also serves on the Editorial Boards of six scholarly journals. Barry is a co-author of the SCERTS Model (Prizant, Wetherby, Rubin, Laurent & Rydell, 2006—www.SCERTS.com). In 2005, Barry received the Princeton University-Eden Foundation Career Award “for improving the quality of life for individuals with autism”. For further information about Barry’s work, go to www.barryprizant.com, or contact Barry at Bprizant@aol.com.



Amy C. Laurent, Ed.M, OTR/L is a pediatric occupational therapist who holds a Master’s degree in Special Education. Currently in private practice, Amy specializes in the education of children with autism spectrum disorders (ASD) and related developmental disabilities. The majority of Amy’s work involves collaborating with and supporting school teams and families. Her consultative services focus on the creation of educational programs and environments that facilitate children’s active engagement and learning at home, in schools, and throughout their communities. The SCERTS Model, of which she is a coauthor, along with differentiated instruction and developmental theory guide her practice. She works with educational teams in K-12 schools, pre-schools, and early intervention programs. Amy is also an adjunct faculty member at the University of Rhode Island and Emerson College in Boston, Massachusetts. Her private practice is affiliated with Communication Crossroads, Childhood Communication Services, and Childhood Communication Seminars. Website: www.amy-laurent.com