DECREASING TANTRUMS, AGGRESSION, AND OTHER PROBLEM BEHAVIORS pdf

1: Aggression in autism spectrum disorder: presentation and treatment options

So the goal with a child prone to tantrums is to help him unlearn this response, and instead learn other, more mature ways to handle a problem situation, like compromising, or complying with parental expectations in exchange for some positive reward.

These are behaviors that are used to get out of something. To get out of what you ask? These bad behaviors can continue for a long time because guess what? When a child acts out in class and gets time out, gets a lecture from the teacher, gets taken to the principal, gets given a break etc. They got exactly what they wanted â€" escape from the task! So you better believe they will keep those bad behaviors up! Here are some strategies: There are a lot of ways to provide access to breaks. You could provide a regular access to breaks non-contingently â€" so on a time schedule, no matter what the child is doing. The idea behind this intervention is that since the child is getting regular breaks, he will not have to misbehave to get one. You could even use a visual timer to show when breaks are coming. Some of our kids might not know how to ask for a break! For students who are nonverbal you can use a break card. When you start this intervention, give them the break every time they request it! I know â€" crazy talk! You need to build this skill at first and then you can working on limiting it. For example you can use a visual to show how many breaks you have. Once you ask for all of them you are done. Maybe the tasks are too hard? Try making tasks easier and building up to more challenging work. Have the student complete shorter work sessions. You can include more work sessions â€" just shorter ones! If you are like me, you are trying to make the most of every minute if your classroom. I am guilty of throwing too many tasks too quickly at my kids. The second we are done with one task BAM onto the next. This could be overwhelming to some students. Consider reducing the speed you present work. This is a super easy to implement and effective strategy â€" ask the students which tasks they want to work on. Or you can ask them to choose the order of the work they are doing. Do you want to work on math or reading first? Do you want to do this worksheet or work in this workbook? Show me what you want to work on first. I have seen this greatly decrease behaviors! Sometimes I like to get the annoying things out of the way first arghâ€¦ laundry and other times I prefer to procrastinate a little and do the things I like first. Some of my students escape demands. For some of my students, complying with requests are difficult. Today provide reinforcement for checking your schedule. Tomorrow provide reinforcement for sitting at the table for 1 minute. The next provide reinforcement for opening your binder. The next reinforcement is for completing the first page â€" you get it. This especially great for kids who have a lot of problem behaviors and who are far from completing the whole task. Start with several easy tasks and then switch into the hard task. The student gets caught up in complying with the easy requests and then comply with the difficult request. Give breaks when specified tasks are completed. Students may be motivated to complete work if they know it will get them out of other work! Using schedules and visuals to show how much work the student needs to do can be a successful intervention. Sometimes students get upset because they cannot receptively understand how much work they have to do. The surprise factor can be upsetting. Imagine if at the end of your work day when you are all ready to go home, your principal came over and asked you to teach for 5 more hours. Consider using visuals and schedules to show how much they have to do. When a student has an inappropriate behavior â€" they need to complete an effortful behavior to fix the damage caused by the inappropriate behavior. Overcorrection can also involve extra work. For example â€" if a student rips up a worksheet, he needs to sweep up the floor and clean all the tables. If they knock over a bookshelf in a tantrum, they need to clean the books and clean the break area. This is probably only applicable with younger children try hand over handing a 14 year old to complete a work task â€" yea right. But with little guys â€" hand over hand prompting is an effective strategy. Basically any way of ensuring that the student completes the task at hand. Either use hand over hand prompts or block any attempts to escape the work time. If a child is trying to get out of doing a puzzle, â€" you can sit right behind them, move their hands to put puzzle pieces in the board, physical guide

the student back to their seat if they run away, block attempts to get out of chair, etc. This prompting procedure may be punishing for some students and could encourage them to do the work on their own next time. Or they will keep doing it!!

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2: How to Limit Bad Behavior - Aggressive Behavior in Young Children

WebMD provides tips and strategies to help you navigate a normal childhood behavior. your child if both of you are screaming at each other. calmly but firmly letting him know that tantrums.

Instagram Using Extinction to Reduce Problem Behavior Extinction refers to a procedure used in Applied Behavioral Analysis ABA in which reinforcement that is provided for problem behavior often unintentionally is discontinued in order to decrease or eliminate occurrences of these types of negative or problem behaviors. While this procedure is most commonly used in children with Autism and Down Syndrome, it can also be used very successfully to address a broader array of problem behaviors, including those exhibited by individuals without developmental disabilities. Extinction procedures often take three different forms depending upon the functions of the behavior i. What is causing the behavior. One of the forms is to use extinction with behaviors maintained by positive reinforcement. Her mom smiles at Dannie, picks up the toy and hands it back to her. As a result, she will continue to engage in this type of behavior in order to receive the positive reinforcement that her mom provides. Another form of this procedure is extinction on behaviors maintained by negative reinforcement. Initially, these tantrums will increase as Dannie becomes more and more frustrated, but eventually her tantrums will decrease as long as her actions do not provide her with the desired outcome. The third form of this procedure is extinction on behaviors maintained by automatic reinforcement. Dannie likes to turn the light switch on and off because she is visually stimulated by the fan starting and stopping. Over time, Dannie will decrease engaging in this behavior of flipping the light switch because it no longer provides the automatic reinforcement she is seeking. More facts about extinction procedure: Typically, extinction bursts will increase initially and the child will engage in this negative behavior more frequently before the behavior goes away or decreases to an appropriate level. Extinction bursts can also happen after a long period during which the child does not engage in problem behavior. This is referred to as Spontaneous Recovery. Instead of getting something good to strengthen the behavior, or having something added or taken away to suppress the behavior, nothing happens. From the perspective of the child, the behavior no longer works to get the desired reinforcement any more. Their level of frustration varies from learner to learner in each specific situation. This is generally tolerable if the behavior is mildly protesting or attention seeking, such as whining or crying. In these situations, implementing an additional procedure to increase the desired behavior, e.

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3: Temper Tantrums

A number of textbooks and professional volumes in applied behavior analysis suggest that interventions designed primarily to decrease a problem behavior should routinely be accompanied by efforts to increase the frequency of at least one appropriate behavior. Some sources describe the objective of.

Toddlers are becoming aware that they are separate individuals from their parents and the other important people in their world. This means that they are eager to assert themselves, communicate their likes and dislikes, and act independently as much as they can! At the same time, they still have limited self-control and are just beginning to learn important skills like waiting, sharing and turn-taking. Consider the following example: Sherman, aged 2, grabbed the red bucket and began shoveling sand into it. Jojo follows Sherman, pushes him, grabs the bucket, and returns to the sandbox. When Sherman approaches the sandbox once more, Jojo carefully guards his bucket, wrapping his arm around it and watching Sherman closely. Please get it for me. Like most aspects of development, there is a wide variation among children when it comes to acting out aggressively. Big reactors rely more heavily on using their actions to communicate their strong feelings. As parents, one of your most important jobs is to help your toddler understand and communicate her feelings in acceptable, nonaggressive ways. This is no small task. It requires a lot of time and patience. But with your support and guidance, your child will learn to manage her strong emotions and reactions over the next months and years. What to Think About No two children or families are alike. Thinking about the following questions can help you adapt and apply the information and strategies below to your unique child and family: What kinds of situations usually lead to your child acting aggressively? Why do you think this is? When your child acts in ways that seem aggressive, how do you typically react? Do you think this reaction is helpful to your child or not? What to Expect from Birth to 3 From Birth to 12 Months Lacey, aged 11 months, wants a bite of the cookie her mother is eating. Lacey kicks her feet, waves her arms, and makes lots of sounds. But her mother just gives her another spoonful of squash. Squash on the wall! Lacey bangs her hands on the high chair and starts to cry. One of the greatest challenges in dealing with aggressive behavior is that it can feel very hurtful to parents, both emotionally and physically. However, babies do not mean to hurt or upset their loved ones. They are simply exploring the world around them through their senses. They learn how the world works by biting, mouthing, grabbing, shaking and dropping, and swatting and seeing what happens as a result, which is usually a pretty big reaction. From 12 to 24 Months Try not to negotiate. Having consistent rulesâ€”about things like holding hands in a parking lot, sitting in a car seat, or brushing teethâ€”actually helps children feel safe and secure. He presses buttons and makes all kinds of pictures come up on the screen. This is not for kids. When his dad picks him up to calm him down, Justin kicks again with both feet. Aggression hitting, kicking, biting, etc. They are just beginning to develop empathyâ€”the ability to understand how others feel. So, they cannot yet say, Mommy, I am mad that Zachary grabbed my favorite doll. But I know he just wants to play with me. So how about I offer him a different doll to play with? Instead, your toddler may bop Zachary on the head with a toy truck. From 24 to 36 Months Bella, aged 30 months, is having a hard time saying goodbye to her mom at child care. Bella surprises her by roughly pushing her arm away and running to her cubby. Bella sits curled up under her coat hook, crying. When Talisa, one of the teachers, approaches Bella to see if she wants to read a story, Bella hits her. She then helps Bella get involved in an activity with her friends. Aggressive acts, such as punching a parent, often emerge when toddlers are overwhelmed by a distressing situation or by difficult feelings like anger or jealousy. These moments can be extremely challenging for parents because they are hurtful. Parents often expect that as their older toddles become more and more verbal and advanced in their thinking skills, they are capable of more self-control than they really are. At this age, emotions still trump thinking skills almost every time. The bottom line is that when a toddler is aggressive, it is an important sign that he is out of control and needs help to calm down before any teaching or learning can take place. Staying calm yourself is the best response as it helps your child calm down more quickly. Read

below for ways to handle aggression in your young child. How You Can Respond to Aggression in 3 Steps Aggressive acts, such as punching a parent, often emerge when toddlers are overwhelmed by a distressing situation or by difficult feelings like anger or jealousy. You can use this information to decide the best way to respond. Where is the behavior happening? If it is only happening in one setting, could there be something about that environment i. Is the behavior directed toward one specific person or a small group of people? When does the behavior usually happen? For example, right before nap time, when your child is tired? At times of transition, such as going from one activity to another? These kinds of stressors are common triggers for aggressive behavior. For example, had you just announced it was time to stop playing and get in the car? Had another child just taken a toy out of his hands? Has there been a recent change in her world that is making your child feel upset, out of control, sad, or perhaps less safe and secure overall? Events like switching rooms at child care, moving homes, a new baby or the loss of a pet can make your child feel insecure and therefore less able to control her impulses. Other important factors to consider: For example, some hitting and biting is normal for toddlers, but biting multiple times during the week would be more of a concern. For example, a very intense, sensitive child may feel overwhelmed in settings where there is a lot of stimulation, such as free playtime at child care. He may bite as a way to copeâ€”perhaps to keep people at a distance to protect himself. A slow-to-warm-up child may hit a parent when left with a new babysitter. Fear often gets expressed as anger in young children not to mention many adults. Your Own Temperament and Life Experiences: Is this behavior particularly difficult for you? How do you handle your own feelings when your child acts out aggressively? Are you able to calm yourself before you respond? How effective do you feel you are in helping your child to manage his aggressive feelings? What do you feel your child is learning from the way you respond when he is aggressive? Respond to your child based on your best understanding of the behavior. Use what you know about your child to plan ahead. For example, if you know that she feels very shy when meeting new people, you may want to start flipping through the family photo album during the weeks before you attend a big family picnic so she can start to recognize extended family members. During playtime, you might have a pretend picnic with her Aunt Laila and Uncle Bert. You are helping her manage what, for her, is a very challenging situation. This helps her learn how to cope when she encounters new people in a new setting, such as school. Give advanced notice of an upcoming change. Which book do you want to read? Help your child understand her feelings and behavior. This self-awareness helps him learn to manage his feelings in positive ways. For example, you might say to an older toddler who has a difficult time moving between activities: Which do you want to do? With younger children, put words to their feelings and then redirect them. But look at this cool ball and how it bounces. They are not offered as prescriptions, but ideas that can be adapted to meet the needs of your individual child and family. This is the essential first step. Try taking some deep breaths. Staying in control makes it more likely that your child will calm down more quickly. Let your child know that you understand what he wants to do: You want to play with the water, but you cannot spill the water from your sippy cup on the floor. Or, You are really angry. You want to stay longer at the playground, but it is not okay to hit mommy.

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4: Behavior Week: Attention Maintained Behaviors - The Autism Helper

Forty years of single-subject-design research testifies to the efficacy of time-limited, focused applied behavior analysis methods in reducing or eliminating specific problem behaviors and in teaching new skills to children and adults with autism or other developmental disorders.

Lack of adult supervision Mirroring the aggressive behaviors of other children around them One place to begin is to watch your child for cues to see if any of the situations described above brings about aggressive behavior. Learning as much as you can about the factors that trigger bad behavior is the best way to combat it when it occurs next time. Some questions you should ask yourself: Who does my child hit, bite or kick? Does he do it to one friend in particular? Does he only do it to me? Or does he tend to be aggressive with whomever he is with? Also, what seems to cause your child to act out in an aggressive fashion? Is it triggered by frustration, anger, or excitement? Notice if there are patterns. If you observe the situations carefully, you will likely notice patterns. Finally, how is his aggressiveness expressed? Is it through angry words or through angry behaviors? Does he become verbally aggressive first and then physically aggressive, or is his first response to strike out and hit? In my experience, consequences are imperative to ending aggressive behavior in young children. They teach your child that all behaviors have a consequence, whether good or bad, and will help him make better choices in the future when he is with his friends. Step in and Stop it Immediately At the first sign that your child is about to become aggressive, immediately step in and remove him from the situation. Be careful not to give too much attention to your child so that you do not give any negative reinforcement for the bad behavior. Young children are not able to hear long explanations of why their behavior was offensive. Other examples of too much attention include yelling at your child while attending to the victim, forcing your child to apologize immediately or continuing to talk to the other parents around you about how embarrassed or angry you are. Make a point of consoling the victim and ignoring the aggressor. If your child cannot calm down, remove him or her from the situation without getting angry yourself. When they are calm and ready to talk, you can discuss what happened. By walking an age-appropriate distance away from your child after he has acted out, you are sending the message that you will attend to him when he can calm down. In doing so, you are teaching your child that it is his responsibility to learn to calm himself and act appropriately. While it can be terribly embarrassing to have a child that continues to act out towards their friends, keep in mind that their negative behavior is most likely happening because they are still navigating their way through their social circles. This can be very difficult for some kids, so try not to over-react or personalize it. One technique that works very well for some children is to change the tone and volume of your voice. You can help your child stay calm by immediately lowering your voice when attending to the victim as well as to your child. I am going to help Josh and when I am done I want you to be done screaming. It hurt Josh and he is sad. If this does not work for your child and he simply cannot calm down, leave him where he is again, at an age-appropriate distance and ignore the tantrum. Most young children will not continue to act out if they no longer have an audience. Before you enter into a potentially difficult social situation, review the consequences with your child about what will happen if he cannot control his anger. In a steady voice, explain to your child that hitting, biting, kicking, and other aggressive behaviors are wrong. For younger children, those between 18 months and 2 years, keep it simple. Be firm and consistent each time your child becomes aggressive. Have a plan in place for consequences if aggressive behavior starts. At home, this can include a time-out chair away from the rest of the family where your child can stay until he can calm down. If you are away from home, pick a safe place, such as a time-out in a car seat or another place where your child is removed from the fun. This reinforces that you are not tolerating aggression in any form. For older children, those between 3 and 7, remember that they may be experimenting with cause and effect. In other words, they want to see what you will do when they act out. Since older children are more verbal, you can use a variety of phrases when they misbehave. You need to stop. Consequences can include leaving a play date immediately or

losing video time. For a young child, biting or hitting someone is a whole lot easier! Plus, aggressive behaviors often give children a false sense of power over their peers. Help your child find their voice when they feel like acting out. By explaining and then practicing using their words, you are helping them to trade off aggressive behavior in favor of more socially acceptable behavior. Too often a child reacts negatively to a friend or sibling instead of asserting themselves. Give your child a series of phrases to use with their friends when they are feeling angry or frustrated. Before you enter a situation that you know may cause your child to act aggressively i. If you know that your child targets a particular child at play group, you may have to hold off going to play group for a few weeks until he learns to control himself. Finally, if your child is exhausted, hungry, or over-stimulated, respect that and engage in low-key, slow-paced activities that will make aggression less likely. With your older, more verbal child, talk openly about situations that make him angry and work together to come up with solutions to help him through the problem next time. Be Appreciative of their Efforts When you catch your child being good, be sure to praise their hard work and efforts. For instance, if you observe your children in a power struggle over a toy that ends in them working it out peacefully with their friend, tell them how proud you are that they chose to use their words instead of resorting to aggression to get their way. Look for and continue to praise good behavior as a way to motivate your children to do better next time. What Not to Do Never bite or hit back. It can be tempting to want to teach your child a lesson in how it feels to be the victim of aggression, but when you succumb to a childlike form of communication, you are teaching your child that aggression is the answer to resolving a conflict. Do not expose your child to violent television or video games. Too often TV and videos portray the most violent character as the hero, which sends the message that violence is a means to an end for problem-solving. This message can easily be avoided if you are on top of their viewing habits. While TV or video violence may not affect some kids, it may greatly influence others who have a tendency to act out aggressively with their friends. If you have an aggressive child, switch your focus towards helping them express themselves in a more appropriate way and follow through when an incident occurs. Look for the following signs in your child: A pattern of defiant, disobedient, or hostile behavior towards you or other authority figures such as teachers or day care providers. A pattern means behavior that is not fleeting, but is chronic and does not respond to the above interventions. Loses their temper easily Deliberately engages in activities that knowingly annoy others Blames others Acts annoyed or is chronically touchy Exhibits ongoing anger Acts spiteful or vindictive It is important to recognize that all young children may exhibit any or all of the above problems at some point during their development. However, if your child persistently displays these behaviors and it affects their daily functioning, such as their ability to behave at school or maintain friendships, contact your pediatrician, as it may indicate that they have other psychological problems that need attention. In this case, you will need to have your child evaluated by a mental health professional. Parenting an aggressive child can be one of the greatest challenges you will face as you weave your way through the maze of his or her development. The key is developing a clear, uncomplicated, consistent plan and following it in a composed manner. Show Comments 69 You must log in to leave a comment. Create one for free! Responses to questions posted on EmpoweringParents. We cannot diagnose disorders or offer recommendations on which treatment plan is best for your family. Please seek the support of local resources as needed. If you need immediate assistance, or if you and your family are in crisis, please contact a qualified mental health provider in your area, or contact your statewide crisis hotline. We value your opinions and encourage you to add your comments to this discussion. We ask that you refrain from discussing topics of a political or religious nature. Joan Simeo Munson Dr. Joan Simeo Munson earned her Ph. She has worked with incarcerated individuals, families, adolescents, and college students in a variety of settings, including county and city jails, community mental health centers, university counseling centers, and hospitals. She also has a background in individual, group, and couples counseling. Munson lives in Colorado with her husband and three energetic children. She currently has a private practice in Boulder where she sees adults, couples and adolescents.

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5: Aggressive Behavior in Toddlers â€¢ ZERO TO THREE

Target Problem Behaviors Student cries and/or tantrums easily when upset or when they do not get their way Student cries and/or tantrums when told to do something they do not want to do or when confronted with a challenging task.

Temper tantrums can be frustrating for any parent. But instead of looking at them as disasters, treat tantrums as opportunities for education. Why Kids Have Tantrums Temper tantrums range from whining and crying to screaming, kicking, hitting, and breath holding. Some kids may have tantrums often, and others have them rarely. Tantrums are a normal part of child development. Tantrums may happen when kids are tired, hungry, or uncomfortable. Learning to deal with frustration is a skill that children gain over time. Tantrums are common during the second year of life, when language skills are starting to develop. As language skills improve, tantrums tend to decrease. Toddlers want independence and control over their environment â€” more than they can actually handle. This can lead to power struggles as a child thinks "I can do it myself" or "I want it, give it to me. Here are some ideas that may help: Give plenty of positive attention. Get in the habit of catching your child being good. Reward your little one with praise and attention for positive behavior. Try to give toddlers some control over little things. Offer minor choices such as "Do you want orange juice or apple juice? This makes struggles less likely. Or simply change the environment. Take your toddler outside or inside or move to a different room. Help kids learn new skills and succeed. Help kids learn to do things. Praise them to help them feel proud of what they can do. Also, start with something simple before moving on to more challenging tasks. Consider the request carefully when your child wants something. Tantrum Tactics Keep your cool when responding to a tantrum. Remind yourself that your job is helping your child learn to calm down. So you need to be calm too. Tantrums should be handled differently depending on why your child is upset. Sometimes, you may need to provide comfort. Other times, its best to ignore an outburst or distract your child with a new activity. If a tantrum is happening to get attention from parents, one of the best ways to reduce this behavior is to ignore it. Move on to another activity with your child. But be sure that you follow through on having your child complete the task after she is calm. Kids who are in danger of hurting themselves or others during a tantrum should be taken to a quiet, safe place to calm down. This also applies to tantrums in public places. If a safety issue is involved and a toddler repeats the forbidden behavior after being told to stop, use a time-out or hold the child firmly for several minutes. Rather than setting a specific time limit, tell your child to stay in the room until he or she regains control. This is empowering â€” kids can affect the outcome by their own actions, and thus gain a sense of control that was lost during the tantrum. However, if the time-out is for a tantrum plus negative behavior such as hitting , set a time limit. This will only prove to your little one that the tantrum was effective. Instead, verbally praise your child for regaining control. Use statements such as "I like how you calmed down. Make sure your child is getting enough sleep. With too little sleep, kids can become hyper, disagreeable, and have extremes in behavior. Getting enough sleep can dramatically reduce tantrums. When to Call the Doctor Talk to your doctor if: You often feel angry or out of control when you respond to tantrums. You keep giving in. The tantrums cause a lot of bad feelings between you and your child. The tantrums become more frequent, intense, or last longer. Your child seems very disagreeable, argues a lot, and hardly ever cooperates. Your doctor also can check for any health problems that may add to the tantrums, although this is not common. Sometimes, hearing or vision problems, a chronic illness, language delays, or a learning disability can make kids more likely to have tantrums. As kids mature, they gain self-control. They learn to cooperate, communicate, and cope with frustration. Less frustration and more control will mean fewer tantrums â€” and happier parents.

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6: Escape Behaviors {Behavior Week} - The Autism Helper

In this Article: Handling Meltdowns Handling Tantrums Using the ABCs of Tantrums Helping Your Child Communicate Trying Other Strategies Community Q&A Most autistic children are not aggressive, but many will melt down and throw enormous "tantrums" when they are exposed to difficult situations or don't get what they want.

Second-generation antipsychotics Risperidone Risperidone is a robust D2 receptor antagonist initially developed as a treatment for schizophrenia. Numerous case reports, open-label studies, and double-blind, placebo-controlled trials have demonstrated its efficacy as a treatment for ASD-associated aggression, self-injury, and severe tantrums, and risperidone became the first medication approved by the FDA to treat irritability in youth with ASD. Thirty-one adults aged 18â€”43 years 15 risperidone, 16 placebo enrolled in the study, with 24 individuals completing 12 weeks of treatment. Seven subjects withdrew prior to study completion because of adverse effects including extrapyramidal symptoms [EPS] and agitation. The subjects in the risperidone group who completed the trial showed a significant global improvement measured by the Clinical Global Impression-Improvement scale CGI-I and a decrease in physical aggression, self-injury, and property destruction as measured by the SIB Questionnaire SIB-Q. In , the Research Units on Pediatric Psychopharmacology RUPP Autism Network published the results of an 8-week, randomized, double-blind, placebo-controlled trial of risperidone in youth 5â€”17 years with ASD and comorbid aggression. Subsequently, a 8-week, randomized, double-blind, placebo-controlled trial in 79 children aged 5â€”12 years old with ASD confirmed the effectiveness of risperidone for treating irritability and aggression in ASD. In , as a follow-up to their study, the RUPP group examined the longer-term benefits of risperidone. Finally, 32 youth were enrolled in a placebo-controlled 8-week discontinuation study, which resulted in the return of aggression, SIB, and tantrums in No study showed a significant difference in rates of EPS with risperidone treatment. Risperidone was generally well tolerated, and side effects were manageable by dosage and dosing schedule modifications. Following these positive results, the FDA approved risperidone as a treatment for irritability associated with autism in children and adolescents aged 5â€”16 years old. Although uncontrolled and naturalistic, the high rate of continued use suggests therapeutic benefits as perceived by caregivers and clinicians. There were no significant changes in complete blood count, lipid and glucose levels, urinalysis, or electrocardiogram. Although risperidone appears effective for up to 21 months of treatment, weight gain, excessive appetite, and enuresis were common adverse effects and pose a challenge to long-term treatment adherence and safety. Aripiprazole appears to differentially act as an agonist or antagonist depending on local dopamine concentrations. A case series describes five subjects 5â€”18 years with ASD and irritability. In a retrospective chart review of 32 patients aged 5â€”19 years old treated with aripiprazole mean dose: In , a week open-label, prospective study of aripiprazole was conducted in 25 subjects aged 5â€”17 years old with ASD and significant irritability. Many subjects experienced weight gain, and EPS was reported in nine of 25 subjects. There were no changes in lipid levels, and serum prolactin declined. Also in , the first large-scale, 8-week placebo-controlled trial of aripiprazole in youth aged 6â€”17 years with ASD and significant irritability was completed. All treatment groups experienced significant weight gain. Discontinuation rates due to adverse effects were 9. The second multisite, double-blind, placebo-controlled trial employed flexible dosing of aripiprazole. At week 8, Significant weight gain was common, and mean serum prolactin decreased. As a follow-up to the two large trials, Marcus et al 59 conducted a week open-label extension trial to assess longer-term safety and tolerability of aripiprazole. Subjects included both those from the previous trials and subjects from new sites. Aripiprazole was flexibly dosed with a mean dosage of All subjects were diagnosed with ASD, but de novo subjects did not have a minimum requirement for baseline irritability. Of the subjects enrolled, Improvements made by subjects in the treatment arms of the 8-week trials were maintained. Weight gain, increased appetite, vomiting, and insomnia were the most common adverse effects, and Study results suggest that aripiprazole is effective for reducing ASD-associated irritability in individuals aged 6â€”17 years

old for up to 52 weeks, although treatment may be limited in some patients by significant weight gain, higher rates of EPS, and sedation. Aripiprazole is also not associated with prolonged corrected QT QTc interval, 60 and prolactin levels decline with treatment. Rapid titration of clozapine has recently been shown to be safe and effective for the treatment of drug-refractory bipolar disorder and schizophrenia. Clozapine treatment was associated with a twofold reduction in aggressive behaviors and resulted in the reduction of number and dose of concomitant psychotropic medications prescribed. Subjects reported no extrapyramidal side effects, and no cases of agranulocytosis occurred. Despite evidence of effectiveness as a treatment for aggression, particularly to rapidly control symptoms, there have been no controlled studies of clozapine in individuals with developmental disability. Because blood draws can be especially difficult in highly irritable or aggressive individuals with ASD, clozapine is rarely used in this population. Since then, several small studies and case reports have examined olanzapine as a treatment for ASD. One double-blind, placebo-controlled trial has studied olanzapine in ASD. Eleven subjects enrolled and eight completed 8 weeks of treatment two withdrew because of noncompliance and one from parental disagreement regarding study participation. However, the CGI-I rating scale showed a significant improvement in global functioning compared to placebo. The most common side effects were significant weight gain and sedation. No subjects developed EPS or dyskinesia. The average dose was 7. On the contrary, another week, open-label trial in 25 subjects demonstrated minimal clinical effects with olanzapine treatment and significant weight gain. Olanzapine was well tolerated and, interestingly, the study did not show significant weight gain with treatment. Studies of olanzapine as a treatment of aggression in ASD show mixed results, but generally suggest that it may be somewhat effective. Olanzapine appears relatively safe and well tolerated, with significant weight gain and sedation as the most common side effects. The aforementioned studies did not report any cases of EPS or tardive dyskinesia. Quetiapine Quetiapine is an SGA that functions as a dopamine, serotonin, and adrenergic antagonist and was FDA approved for the treatment of schizophrenia in In ASD, double-blind, placebo-controlled trials of quetiapine are lacking, but several open-label studies and case series have been completed. In a small open-label study, six children aged 6â€”15 years old with ASD were treated with quetiapine for 16 weeks. Four of the subjects withdrew: The two subjects who completed the 16 weeks of treatment were deemed responders on the CGI-I, but the authors concluded that quetiapine was poorly tolerated and generally not effective in the study. Side effects also included increased appetite and weight gain. Another open-label study in nine adolescents, aged 12â€”17 years old, with ASD looked at quetiapine treatment for 12 weeks. Six subjects completed the trial, and two were considered responders based on the CGI-I. Weight gain was the most significant side effect. Although the open-label studies do not demonstrate quetiapine as being particularly effective in ASD, two retrospective studies provide evidence that suggests otherwise. In the first case series, 20 patients aged 5â€”28 years old were treated clinically with quetiapine for 4â€” weeks mean treatment length: The second case series examined ten patients aged 5â€”19 years old. Adverse events included mild sedation, sialorrhea, and weight gain. These open-label studies demonstrated global improvement rather than improved aggression symptoms, and the response rates reported with quetiapine are notably lower than risperidone rates. Nevertheless, quetiapine may still be of some benefit to individuals with ASD and aggression. Double-blind, placebo-controlled studies of quetiapine are needed to better understand its efficacy, side effects, and optimal dosing. To date, no randomized, placebo-controlled trials have studied ziprasidone in subjects with ASD. However, several open-label trials, case reports, and retrospective studies suggest that it may be a weight-neutral treatment option for ASD-associated irritability symptoms. Two case reports of young males with ASD that were nonresponsive to other medications, including risperidone, guanfacine, amphetamine salts, sertraline, and valproic acid VPA , improved with ziprasidone. Five subjects lost weight, five subjects had no change in weight, and one subject gained weight. The weight loss in five subjects was likely weight previously gained on other atypical antipsychotics. The most common adverse effect was sedation. In a 6-week open-label trial of ziprasidone in subjects with ASD mean dose: A known risk of ziprasidone treatment is prolongation of cardiac QTc, which is associated with potentially fatal ventricular

arrhythmia. Changes in heart rate and QTc interval have also been reported in children treated with low dose ziprasidone. Therefore, it may be an effective treatment option in those for whom weight gain poses a serious health risk. All patients treated with ziprasidone should be monitored for QTc interval changes and cardiac events. Paliperidone Paliperidone, the major active metabolite of risperidone, is FDA approved for the treatment of schizophrenia in adults. The first case report described a year-old male with ASD and severe aggression and SIB who had not responded to treatment with haloperidol, quetiapine, lithium, chlorpromazine, fluvoxamine, or mirtazapine. The second case report described a year-old female with ASD and intermittent explosive disorder. She had previously tried quetiapine, risperidone, aripiprazole, and VPA with no improvement. While on a regimen of risperidone, naltrexone, and diazepam, she switched from risperidone to 6 mg of paliperidone. Four subjects experienced mild-to-moderate EPS. It is important to note that 21 of the subjects had previously been on risperidone either immediately before the study or at an earlier time. Twenty of this subset had discontinued risperidone because of nonresponse, but all of them responded to paliperidone. Although limited, evidence suggests that paliperidone may be effective and well tolerated for treating aggression in ASD and could provide an alternative treatment option for patients who do not respond to risperidone. Double-blind, randomized, placebo-controlled trials are needed to further understand the effectiveness of paliperidone in ASD. Lurasidone was recently studied in a multicenter, double-blind, placebo-controlled trial targeting irritability in youth with ASD. Rates of adverse effects were higher in the active treatment groups, with reported incidents of vomiting and somnolence. This study of lurasidone is the first large-scale negative trial of an SGA targeting irritability in ASD, suggesting that lurasidone is not a viable treatment option for this target symptom cluster. First-generation antipsychotics Haloperidol Haloperidol is the only first-generation antipsychotic with significant evidence to support its use in youth with ASD. Although other first-generation antipsychotics are also potent dopamine antagonists, haloperidol is associated with fewer adverse cognitive effects, less sedation, and fewer EPS. These initial studies did not focus on aggression specifically, but rather described significant improvement in withdrawal and stereotypy in children with ASD, and additionally demonstrated positive impact on learning when haloperidol treatment was combined with language training. Although haloperidol has been shown to have long-term safety and efficacy, 95 it is associated with a significant risk of dyskinesias. In a prospective study of tardive and withdrawal dyskinesias, children with ASD were treated for cycles of 6 months of haloperidol plus 4 weeks of placebo. Most were withdrawal dyskinesias, and all were reversible.

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7: 5 Ways to Reduce Meltdowns and Tantrums in Autistic Children

Behaviors such as aggression and destructiveness may be exciting, and thus appealing, to some of these individuals. If one suspects behavior problems are due to underarousal, the person should be kept busy or active.

Whining, fighting, talking back, swearing, and yelling out can all be attention seeking behaviors. Attention can come in many forms from teacher reprimands to student ridicule to praise. There are a variety of strategies and interventions you can utilize to decrease attention seeking behaviors. Often attention behaviors occur when the student does not know the correct or appropriate way to ask for attention. Teach appropriate ways to ask for attention. For nonverbal, students create a visual for attention. Use role playing and written scripts to practice asking for attention. Students with autism may want specific types of attention â€" I have a little guy who loves going on walks with an adult and another that likes to sit near certain people. Sometimes the student needs attention in the form of help. Again a visual can be useful here. Social stories are useful to use as scripts to teach and prompt the appropriate way to ask for help. Why do many kids yell out instead of raising their hand? The inappropriate behavior might be more successful than the appropriate option. The appropriate way of getting attention might be hard for some students. Many students with autism struggle with language and socializing. Getting attention in the correct way by asking is very difficult for them. If they do, build that skill! Make the appropriate response significantly more effective than the inappropriate behavior. You can fade it later. Right now you want to make that response their go-to. Along with building up that appropriate response, you can ignore the inappropriate response. This is not always possible. Some responses are too dangerous to ignore self-injurious behavior , too disruptive a child throwing items during class time , or impossible to ignore when you have a class full of children. But some responses you may be able to ignore. If this behavior is not working any more â€" ie. It may initially get worse before it gets better, but it will likely decrease if it is not working any longer. A student will be less likely to use attention seeking behaviors if they are already getting attention. This strategy involves giving students a regular schedule of attention no matter what they are doing. I have used a timer system where I set a timer on my iPhone to a set interval and at every interval I go and provide attention to a student. Time out can be an appropriate punishment for attention seeking behaviors because it removes attention. A time out does not need to be in a corner or in the hallway â€" just any time away from attention. It can be brief. If attention is a powerful reinforcer, this intervention can work quickly. For extreme behaviors, some school use a time out room mine does not. However you use time out â€" make sure that the reinforcing aspect of attention are actually removed! Figure out if you will have criteria for leaving time out â€" ie. Time out should not be ended will inappropriate behavior is occurring. Will you start time out immediately or will you start once disruptive behaviors has ended. Check out my freebie for my time out visual. I sometimes use this visual timer: Some behaviors are too dangerous to ignore. Self injurious behavior such as head banging or hand biting could be occurring for attention. Physically blocking the response can be done without making eye contact or providing verbal attention but can still stop the response from completing. There are tons of different systems for token economies! Basically a token economy is a behavior change system that provides tokens or points for desired behaviors and can be exchanged for reinforcing items at a set time. This is a great way to work on skills at a class or group level and build up the appropriate responses! Some time-based interventions can be used for attention seeking behaviors. I really like interval schedules for providing reinforcement. An intervention that could be used would be setting a specific time interval start with something achievable! Another use for a visual timer! I have also used timer apps on the iPods for kids using this intervention! This can be a very effective and easy to implement intervention! Behavior Management Freebies and more!

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8: 10 Problem Behaviors | Educating Children with Autism | The National Academies Press

What may work for decreasing aggression in a toddler may be very different for treating a six foot tall teen who feels rage and is acting upon that emotion. Channel the aggression to other.

An expanded definition of this proactive rather than reactive process brings together four interrelated components that draw on aspects of many of the interventions described above. Positive behavioral interventions and supports include Turnbull et al. The expected outcomes from positive behavioral interventions and supports are increases in positive behavior, decreases in problem behavior, and improvements in life-style Horner et al. This includes the expectation of systems change, including changes in the behaviors of oth- Page Share Cite Suggested Citation: Educating Children with Autism. The National Academies Press. Many of these features are implemented as standard practice in the comprehensive or focused behavioral programs reviewed above and in Chapter The concept of positive behavioral interventions and supports represents a theoretical, scientific, and legal attempt to bring all aspects of these successful, positive interventions to bear on resolving behavior problems in children with autism or other disorders. These outcomes included outcomes for children from birth to age 12; they addressed problems of aggression, self-injurious behavior, property destruction, tantrums, and combinations of problem behaviors. Good maintenance rates were observed for a substantial majority of outcomes Males and females scored equivalent successes. A similar review of a differently defined, overlapping data set Horner et al. Reductions of 80 percent or greater were reported in one-half to two-thirds of the comparisons. Some reductions of 90 percent or greater were reported for individuals with all diagnostic labels and all classes of problem behaviors. The lowest success rate A review of applied behavioral analysis interventions specifically for children with autistic spectrum disorders from birth to age 8 Horner et al. This targeted review found, for 37 comparisons, mean rates of reduction in problem behaviors of 85 percent with a median reduction level of Fifty-nine percent of the comparisons recorded problem behavior reductions of 90 percent or greater, and 68 percent of the comparisons reported reductions of 80 percent or greater. Though these are very positive findings, evaluating studies, and their results, requires cognizance of the prevailing scientific trend, adopted by many journal editors, that favors publication of studies that report successful, rather than unsuccessful, interventions. Thus, the results summarized above, represented as percentages of published comparisons, represent possible outcomes when these procedures are carefully implemented and progress monitored; they do not reflect the number of unsuccessful interventions, which are not reported. As described above, research concerning problem behaviors in individuals with developmental disabilities has generally been strong and plentiful. However, there are relatively few studies directly addressing issues for young children with autistic spectrum disorders. In many cases, interventions that were successful with other populations may be appropriate for young children with autistic spectrum disorders Wolery and Garfinkle, Studies testing this assumption with appropriately described and diagnosed children are crucial before it can be accepted. Using the guidelines established by this committee, published research concerning positive behavior approaches to young children was relatively strong in measurement of generalizability and in internal and external validity see Figures 1â€”1 , 1â€”2 , and 1â€”3 in Chapter 1. Limitations in the existing studies are not due to a generally poor quality of research, but to changes and differences in standards of reporting and research designs in applied behavior analysis and those of the more general, educational and clinical guidelines for treatment evaluation see Chapter 1. These limitations in these studies were particularly apparent in the selection and description of subjects, random assignment to treatment conditions, and independence of evaluation. As for other areas, these limitations also related to differences in the contexts in which methods were developed. For behavioral interventions that addressed such targets as dangerous self-injury in institutionalized adolescents with profound mental retardation, random assignment, accurate diagnosis, and independence of evaluation may have been of less concern than developing an immediately implementable effective individualized program.

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However, in order to evaluate treatments for milder difficulties in young children with autistic spectrum disorders, provision of standard, descriptive information about subject selection, subject characteristics and other aspects of research design is crucial in determining what approaches will be most effective for which children. With these caveats in mind, consistent findings across reviews of published studies indicate several conclusions about current positive behavioral interventions and supports: Page Share Cite Suggested Citation: If positive behavioral interventions and supports is seen as a rebuttable assumption, it means that an IEP team can consider other intervention strategies only in comparison with positive behavioral interventions and supports and must have adequate cause for adopting a different strategy. Evidence for the efficacy of positive behavioral interventions and supports presented above , although encouraging, also indicates that current positive behavioral interventions and supports strategies, as presently implemented, may be ineffective or only minimally effective for up to one-third of all problem behaviors and for up to three-quarters of those problem behaviors maintained by sensory input. In these cases, different or additional strategies may be required, after first considering positive behavioral interventions and supports. Although research indicates that reinforcement-based procedures are often not as effective in eliminating severe problem behaviors as quickly as are punishment-based procedures Iwata et al. The increase in efficacy of positive interventions, when based on functional behavioral analysis, reduces the need for punishment-based procedures Neef and Iwata, When a behavior is not maintained by social reinforcement, however, it may be difficult to treat effectively with reinforcement-based procedures only Iwata et al. Suppression of competing problem behaviors may sometimes be needed before reinforcement of functional alternative behaviors can be effective Pelios et al. In any case, there is agreement New York State Department of Health, that physically intrusive measures e. The use of physical aversives such as hitting, spanking, or slapping is not recommended. Medications to Reduce Behavior Problems Although a comprehensive review of medications and medical interventions is beyond the scope of this report, because of the widespread use of psychoactive medications, they are addressed briefly as they relate to problem behaviors in young children with autistic spectrum disorders. Psychoactive medications alter the chemical make-up of the central nervous system and affect mental functioning or behavior. Most were developed to treat a variety of psychiatric and neurological conditions other than autistic spectrum disorders; all may have benefits, side effects, and toxicity Aman and Langworthy, ; Gordon, ; King, ; and McDougle et al. There are currently no medications that effectively treat the core symptoms of autism, but there are medications that can reduce problematic symptoms and some that play critical roles in severe, even life-threatening situations, such as self-injurious behavior. Medications have been shown in some instances to enhance and to be enhanced by systematic, individualized behavioral intervention programs Durand, ; Symons and Thompson, More than articles have been published on the use of psychoactive medications for autistic spectrum disorders. A more limited number of published reports include double-blind, placebo-controlled studies with young children with autism. Double-blind studies of haloperidol Cohen et al. In addition, newer medications, including selective serotonin uptake inhibitors, atypical neuroleptics, other antidepressants, and stimulant medications such as methylphenidate, have been studied, although most not yet in double-blind studies. The key findings from the published studies include: Haloperidol was effective in reducing aggression and agitation and had mixed results for improving learning with long-term users, but it carries significant risk of involuntary muscular movements dyskinesias. Naltrexone-treated groups showed less irritability and hyperactivity than placebo groups on some measures, particularly global ratings, did not differ from placebo groups on others, and showed increases in particular problem behaviors in some instances. Clonidine-treated subjects showed improvements in hyperarousal but reported increased drowsiness, decreased activity, they showed increasing tolerance when used to treat attention deficit disorders. Risperidone shows promise in treating aggression and agitation with less concern about the development of dyskinesias than for the older neuroleptics. Open trials of serotonin selective uptake inhibitors have shown promise in treating stereotypic or perseverative behavior, possibly because of effects on anxiety.

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9: Using Extinction to Reduce Problem Behavior - Special Learning Article

Temper tantrums range from whining and crying to screaming, kicking, hitting, and breath holding. They're equally common in boys and girls and usually happen between the ages of 1 to 3. They're equally common in boys and girls and usually happen between the ages of 1 to 3.

Antecedent Interventions What are Antecedent Interventions? Antecedents are events, people or things that immediately precede problem behavior. Antecedents can be related to the time of day, the physical environment, people who are present, or activities that are occurring within a setting. Being yelled at or teased by other children, being told to complete an assignment, having a toy taken away, or being told to stop engaging in a preferred activity are possible antecedents. Antecedent events can also include the absence of something. The absence of attention, being ignored by peers or adults, or the absence of a favored activity can be an antecedent event. Once the antecedents that trigger problem behavior are identified, several types of interventions can be used. These strategies involve reducing the future occurrence of problem behavior by eliminating the antecedent event, modifying the content or by changing how the content is presented. What kinds of Antecedent Interventions are available? Eliminate the Antecedent Event Sometimes an antecedent event can be eliminated. In one study, a high school student with disabilities engaged in problem behavior to escape from a vocational task. The antecedent event was negative rule statements made by the teacher "Remember, you need to work without whining," or "There is no hitting". Sometimes, it is not possible or appropriate to completely eliminate a task or event. For example, if a child has difficulty learning how to read and engages in problem behavior to escape from the task, it would not be appropriate to eliminating reading instruction. One type of Antecedent Intervention involves identifying student preferences and modifying a task associated with problem behaviors so that it incorporates student interests. The purpose of this type of intervention is to decrease the aversive characteristics of an activity. One research study described an antecedent intervention for a young student who engaged in aggression, talked out loud during quiet periods, made noises from in class, left his seat without permission, and destroyed property. After tracing the letters, the student then colored the objects that corresponded to each letter of the alphabet. These pictures included balloons, animals, and other objects. Instead of balloons, animals, and objects, the student was asked to color pictures of different types of cars and motorcycles. There is a clear relationship between task difficulty and problem behavior. Difficult tasks are associated with more student errors, frequent corrective feedback, and lower rates of positive reinforcement all of which can result in higher levels of frustration, decreases in student responding, and escape-maintained problem behavior. Antecedent interventions that address task difficulty involve modifying instruction to ensure the student experiences higher levels of academic success. In one study, an antecedent intervention was implemented for a fourth grade student who engaged in aggression, property destruction, made negative verbal comments, and frequently walked away from tasks and activities. Whenever the student was asked to complete an English worksheet that focused on the use of capital letters, punctuation, and abbreviations, she engaged in problem behavior. The functional behavioral assessment determined that the student was reading at a first grade level. However, her academic reading and writing tasks were at the fourth grade level. Sometimes the adaptations needed to decrease the difficulty of a task does not involve lowering expectations of the work. Instead, some interventions involve prompting the student before errors occur in order to decrease mistakes. Prompting procedures can involve verbal, physical, or gestural prompts that are systematically faded until the student is independently able to complete a task. Make the Task More Meaningful. Choosing activities that produce immediate reinforcement can naturally increase academic responding and reduce problem behavior. For instance, instead of requiring a student to copy letters from a handwriting book real letters can be written and mailed to a pen pal. Antecedent Interventions could involve asking a student to write captions in a photo album instead of practicing his writing skills in a standard handwriting book. Teaching an isolated skill out of context of a meaningful activity makes it harder for the

student to understand the importance of learning the particular task. In one study, an academic activity that involved the student handing coins to a teacher upon request was changed so that students purchased items using correct change. This process is called behavioral momentum. One study showed that it is important to vary the high-probability requests each time they are used. When high-probability requests are always presented in the same order, student responding decreases and problem behavior increases, possibly because the requests become associated over time with the less-preferred task Task Length. Another strategy is to present a variety of brief activities instead of one longer task. Research studies report that giving a student a variety of activities instead of one task of longer duration has been shown to decrease problem behavior and increase student engagement. Decreasing the length of the task and providing more frequent breaks has also been shown to decreases problem behavior. In one study a teacher used the exact same spelling assignment but instead of one long worksheet and a spelling activity the student received a shorter worksheet followed by a writing assignment that took only ten minutes to complete. Another strategy is to intersperse tasks that have already been mastered with more difficult activities in order to increase student engagement and decrease the aversiveness of a challenging assignment. Increasing the Probability of Desirable Behavior. Activities can be organized in a way that prevents problem behavior. Re-scheduling a high-energy activity right so that it does not occur right before a quiet reading activity is an example of an Antecedent Intervention. Instead, a more proactive approach is to schedule a high-energy activity like recess after reading class. Some interventions use behaviors that are more likely to occur to increase those that are less likely to occur. For instance, a teacher may tell a student that he can spend time finishing a preferred activity after his in-class assignment is completed. Increase Opportunities for Choice. A number of studies have demonstrated that giving the student a choice of possible tasks can increase on-task responding and decrease problem behavior These research studies indicate that opportunities to make choices in between assignments reduces problem behaviors that are maintained by escape and avoidance. Providing a student who engages in problem behavior several choices at the onset of an activity can decrease problem behavior and increase academic responding, even when the choices between tasks are not preferred In one study, a teacher evaluated whether problem behavior decreased and academic engagement increased when students were able to choose their academic activities when compared to a task chosen by the teacher. Two fifth grade students were given an individualized menu containing a list of tasks that were on their desk throughout the class period. The teacher found that when the students had an opportunity to choose their assignments, problem behaviors decreased and engagement levels increased. Sometimes problem behavior occurs during transitions between activities. A student may be more likely to engage in problem behavior while waiting for the next class activity. For instance, a student may have a preferred activity that she works on when she completes her in-seat assignment and is waiting for her classmates to finish. Some Antecedent Interventions are a natural part of classroom management. Good classroom managers create a comfortable pace and flow of activities in order to keep students engaged and decrease problem behavior. Smooth transitions between activities decreases off-task behavior since students are less likely to be distracted by other events. Keeping the interval between student responses and the next teacher request is associated with correct responding and less off-task behavior. Many students with disabilities show improved engagement in academic tasks and are less likely to engage in problem behavior when they can predict upcoming events. Many of the Antecedent Interventions described in the research studies are designed to decrease escape-motivated behavior. However, these same strategies can be used to address problem behaviors that are maintained by access to preferred events, attention, or physiological factors. How are Antecedent Interventions identified? Information that can be used to design Antecedent Interventions is gathered during a functional behavioral assessment. Ideas for Antecedent Interventions are generated when the student and his or her team meets to brainstorm possible interventions using the PBS Planning Tool. The University of Kansas.

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