Three Approaches for Altering Behavior: *Socially Mediated vs. Emotionally Driven Behavior*

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All approaches to address behavior strive to change how the student behaves by three methods:
1) altering what the individual does;
2) altering the "meaning-making" errors the student makes of environmental and social events, i.e., faulty thoughts; or;
3) altering how the person feels in response to environmental, internal, remembrance of trauma or current social events. The IDEA has emphasized the behavioral approach, whereas those providing related services have emphasized the thinking and feeling interventions for disturbed social emotional functioning.

DO: Functional assessment is used to determine how to change the behavior when "default behavioral interventions" (such as behavior contracts, mentoring programs, self monitoring, etc.) have not been successful.

Behavior analysis interventions alter what the student does, by manipulating antecedents and consequences so an acceptable behavior is used by the student to get his/her desired outcome and the competing undesired behavior is eliminated or reduced. Functional behavioral assessment begins the process of analysis, and behavior intervention and support plans outline the necessary changes. This approach is mandated for use in schools when students with IEPs have behavior that is a "manifestation of disability" following a manifestation determination meeting, as well as when a behavior "impedes the learning of the student or peers," and a determination of positive behavioral interventions and strategies must be considered to address the problem.

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THINK: Cognitive behavior therapy addresses faulty processing. For example, students with emotional disturbance sometimes attribute "negative intention to neutral stimuli," e.g., "You hate me and want to put me down!" attributed to a staff member attempting to help the student correct a math problem, or "See how he's looking at me! He wants to fight with me!" attributed to a casual glance from a peer without the intent to fight. This approach is typically used when default behavior interventions and function-based behavioral interventions have not successfully changed the behavior. It is often considered a "related service" provided by trained implementers

FEEL: Medication, systematic desensitization and other direct treatments directly addressing feeling states are sometimes used with students whose anxieties or affectual disregulation impact their behavior. These direct treatments are provided by skilled implementers with specialized training, following evidence based treatment protocols. Medication is not provided by school districts, however systematic desensitization and other treatments can be provided as part of the education program for a student with an IEP if the team has identified an individual goal that needs to be met through this service.

Systematic Desensitization Procedures may mean different things to different people. It is NOT forcing a person to confront a stimulus. Systematic desensitization is a specific behavior therapy technique that breaks the link between the anxiety- provoking stimulus and the anxiety response. This treatment systematically exposes a feared or anxiety provoking stimuli in very small doses, allowing the person to cope with the internal state produced by the stimuli *slowly*. This technique is used in behavior therapy to treat phobias and other behavior problems involving anxiety. The client is exposed to the threatening situation under relaxed conditions until the anxiety reaction is extinguished *If you move too fast, or do not have adequate training or attempt this procedure not under relaxed conditions, the behavior can become much worse.* This treatment requires the patient to gradually confront the aversive or uncomfortable or fearful situation or object of fear. There are three main elements to the process. Do not use these procedures if you have not been well trained.

Examples of systematic desensitization gone wrong: A student with autism ran every time the school bell rang. The plan called for blocking him and holding "so he could get over the fear." (Non-systematic, non-relaxed condition, not in small doses or under his control to terminate). This resulted in hitting to escape, and school staff containing him near the bell, "so he could get over it." Staff holding a student in circle to "desensitize him to aversion to singing," and forcing a student to taste undesired foods "to expand the diet" are other examples of non-skilled erroneous intervention.

A hypothesized "self esteem deficit" is not a periodically occurring internal state fluctuation. Behavior therapy does not address "self esteem" directly. Through provision of a Tier 1 reinforcing environment and/or success in learning activities "self esteem" may be altered because mastery has been achieved.

"Self Esteem" is an abstract term not addressed in behavior analysis nor in behavior plans because it attempts to very indirectly affect behavior rather than focusing on direct behaviors to be taught and reinforced. There currently is no evidence based specific intervention to address self esteem for the purpose of altering behavior.

Treatment Protocols for Internal Functions may include:
- Medical Treatment (may include medications or titration of current medications) - Although medication or medical interventions do not significantly affect most behaviors, at times they do, and should be considered.
- Direct Mental Health Assessment and Services - Cognitive Behavior Therapy
  i. Externalizing: Aggression, such as "Coping Power" protocol (see   references)
  ii. Internalizing: Anxiety, such as "Coping Cat"
- Family Therapy - Other direct treatment (see below)
- Direct Treatment: Systematic Desensitization Procedures - This treatment can be used for school and other phobias, school refusal, anxiety, heightened arousal due to touch sound or visual input, and for selective mutism.
- Altering or controlling antecedents to reduce occasions that trigger internal states (may be included in an accommodation plan) - Stimulus satiation - Environmental engineering - Altering stimulus control
- Altering consequences - Stimulus change following the behavior
- Direct Treatment: Teaching behavior modulation (reducing intensity and duration) - Feedback Systems - Relaxation, breath control - Anger Management
- Coping Strategies - Mindfulness Treatment

Does the behavior really need to be addressed?
Behavior plans in school need to be developed when behavior impedes learning of the student or his or her peers and other Tier 1 or Tier 2 interventions have not been successful. These are appropriate for behaviors which are externally motivated, and for which a functionally equivalent replacement behavior can be identified, taught and reinforced.

For behavior that serves an internal function, affecting quality of life or for medical reasons, treatment may be provided (see above) to reduce the negative impact, if any, of the behavior. If this behavior is to be addressed in school, the following guidelines may be helpful.

- Is addressing this behavior necessary for the student to benefit from the provision of special education? If so, the IEP team must consider "related services" to address the behavior. This may include medical services (for diagnosis only), mental health, occupational and physical therapy, speech and language services, etc.

- If the student does not have an IEP, and the school has determined that no disability is present, provision of treatment, if necessary, can be given as a general education service, if resources permit, e.g., school counseling. Alternatively, the school can refer the parents, at their request, to outside agencies or providers.

- For psychiatric conditions, e.g., selective mutism, separation anxiety, bipolar disorder, psychosis, etc., the primary treatment is mental health services. The school may, however, develop a treatment protocol to reduce the impact of behaviors associated with the disorder, and/or an accommodation plan that describes how the staff will respond to exhibited behaviors. These conditions require good home/school/medical management team communication to assure information flows smoothly between all parties. A case manager is required.

- For medical conditions, such as Tourette's Syndrome, repetitive behaviors such as tongue clicking, swearing, facial grimacing, touching others, etc. may occur. With Diabetes, disorientation may occur when blood sugar is low. With allergies, repetitive throat clearing or eye rubbing may occur. In Obsessive Compulsive Disorder, a strong drive to engage in a repetitive behavior such as pencil sharpening, using the bathroom, touching, etc. may be observed as the student attempts to address the underlying anxiety of a non completed ritual. These students may require accommodations outlined in either a 504 plan, or another accommodation plan to address negative impact of the condition on educational performance. See accommodation planning at www.pent.ca.gov. They will also likely require good home/school/medical team communication. Often a case manager is identified to facilitate this process. It is important to remember, however, that students with these conditions may be using behavior to achieve an external function as well and also will benefit from behavior plans with functionally equivalent replacement behaviors!

- For students with seizure disorders and migraine patterns, sometimes the approaching internal state results in a strong behavioral response, such as running around the room, hitting people, moaning, screaming and other behaviors not associated with environmental conditions or social interactions. The student knows the internal state currently being experienced will intensify as the condition advances. These students require staff to be able to "read" the purpose or function of their behavior. Under the condition of an approaching internal undesired event, the student may be unresponsive to supports that work under other conditions and require an accommodation plan.

- For medical conditions, such as encopresis (bowel movements, including persistent leakage/diarrhea in underwear after toilet training has been attained) and enuresis (bladder "accidents" after toilet training has been achieved) careful assessment is required. These conditions often have a purely medical basis (e.g., sequelae of an impacted bowel/constipation or parasites or of urinary tract or bladder infection). However, on occasion these conditions can also be indicative of a life trauma, or life transition or a more enduring problem, such as emotional disturbance. Determining the school based intervention will require careful assessment and rule out of medical reasons before other interventions are developed or assessment is conducted.

- For students with behaviors associated with attention deficit/hyperactivity disorder it is important to remember that not all of these students will require either an IEP or a 504 plan. Accommodations may be specified to address problems associated with the condition, if necessary, either as part of Tier 1/Tier 2 school interventions or as part of an IEP/504 plan. To require an IEP not associated with a learning disability, the student must need "specialized instruction in terms of content or methodology due to the nature of the disability" (i.e., special education for OHI, Other Health Impairment).   PENT Forum 2009 Section 3 Page 10 of 28

For example, students with AD/HD often blurt out answers during a class discussion. Sometimes these behaviors are externally motivated, e.g., to get attention from peers and/or teacher. Sometimes, however, these behaviors are internally motivated, due to a heightened arousal and a short auditory memory span. The student blurts out because the thought will not be available when his or her turn finally comes. The motivation to speak under heightened arousal is great, and although the teacher may attempt to punish blurting out, it may not be effective in suppressing the behavior. This behavior is often seen when the student is engaged in social interactions as well. She may not wait her turn to speak, and may blurt out the comment, talking over her peers in response to an internal state. An accommodation plan as well as using more active responding techniques during class discussions, e.g. turn to your partner, etc., may not only reduce blurting, it may increase all students' active engagement!