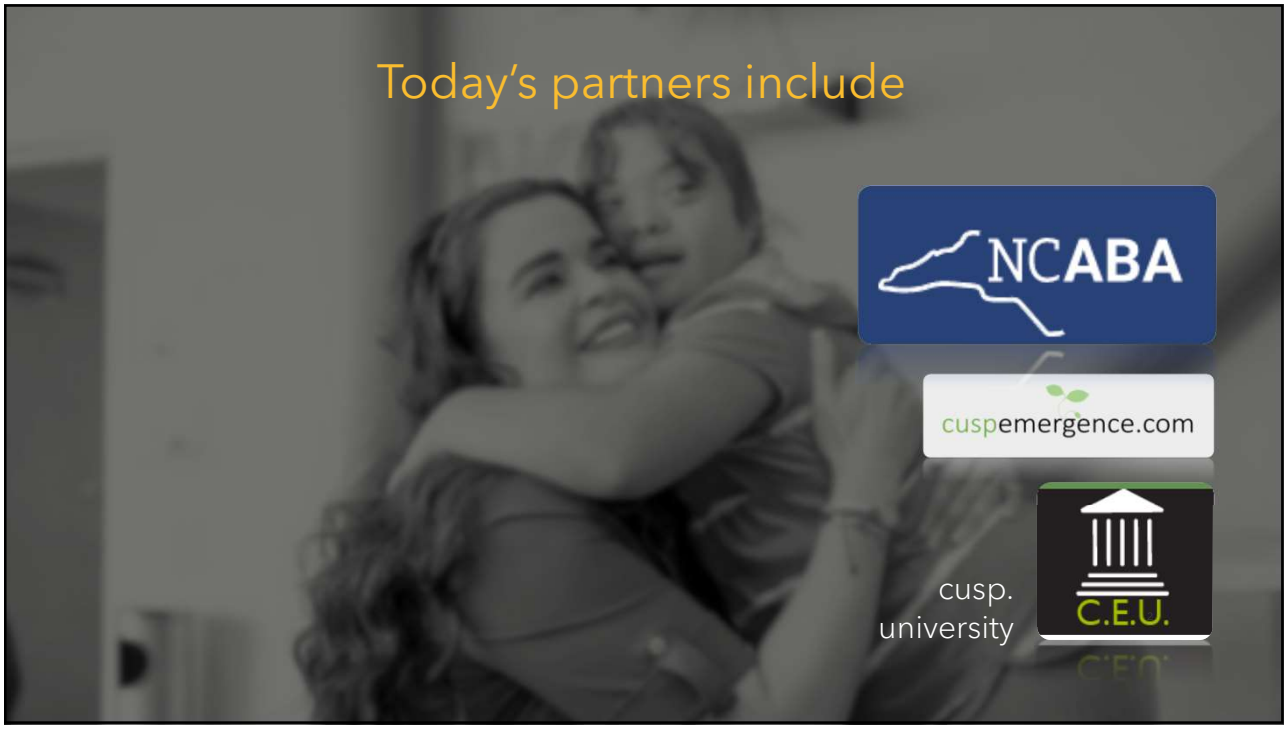
ADAPTING OUR PRACTICE TO NEW NEEDS:

A POST-TRAUMA APPROACH TO SUPPORTING INDIVIDUALS USING BEHAVIORAL TOOLS IN DIVERSE SETTINGS

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



ABSTRACT

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Abstract

Despite the cultural movement to extend the inclusive principles of trauma informed services to behavior supports and related areas, many of us lack the training or support to apply this idea. Many practitioners have not yet acquired meaningful experience teaming with the many essential disciplines that make up a supportive environment after a student has been through trauma. At the same time, some of the practices we think of as "best" for other clients, may be contraindicated for someone with a significant history of adverse childhood, therapeutic, or educational experiences (BACB Ethics Code 2.09). This workshop aims to empower clinicians and behavior analysts to understand some of the links between what individuals need after trauma, and how behavior analysis can help (BACB Ethics Code 2.12). It is presented in a context rich with collaboration, risk documentation and mitigation practices, and an understanding of how past experiences can shape and inform current needs of both individuals and team members facing difficult conditions. Participants will be equipped with useful tools that may support those with both significant and minor histories of trauma—and those in between, for whom a trauma history may be suspected but cannot be documented (BACB Ethics Code 2.15).

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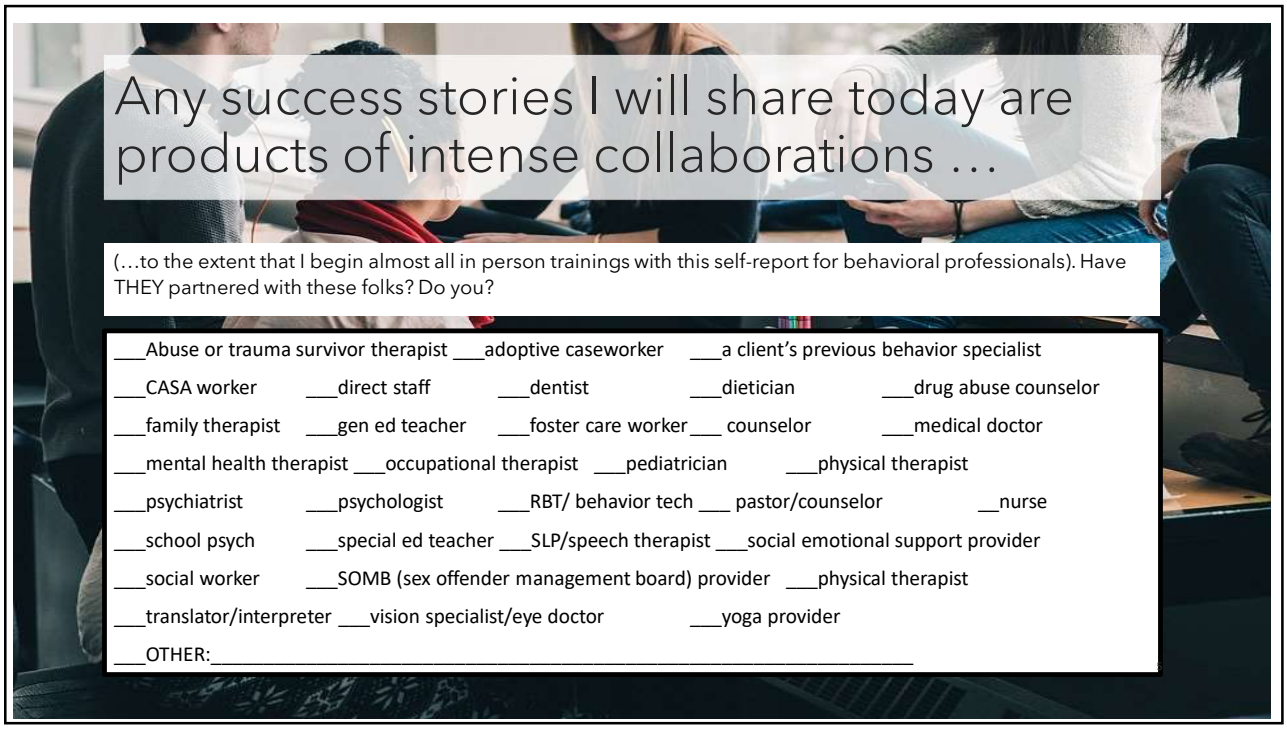

Any success stories I will share today are products of intense collaborations …

(…to the extent that I begin almost all in person trainings with this self-report for behavioral professionals). Have THEY partnered with these folks? Do you?

___Abuse or trauma survivor therapist ___adoptive caseworker ___a client's previous behavior specialist
___CASA worker ___direct staff ___dentist ___dietician ___drug abuse counselor
___family therapist ___gen ed teacher ___foster care worker ___ counselor ___medical doctor
___mental health therapist ___occupational therapist ___pediatrician ___physical therapist
___psychiatrist ___psychologist ___RBT/ behavior tech ___ pastor/counselor __nurse
___school psych ___special ed teacher ___SLP/speech therapist ___social emotional support provider
___social worker ___SOMB (sex offender management board) provider ___physical therapist
___translator/interpreter ___vision specialist/eye doctor ___yoga provider
___OTHER:_____

- Dissemination
- Address social validity
- Community reach-out
- Continuing Education
- Trauma-Informed Training
- Consultation and mentorship

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LEARNING OBJECTIVES

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1. Describe at least three procedures that may be **contraindicated** for some clients with trauma backgrounds.
2. Identify at least two **tools** to enhance behavior support practices with people affected by trauma, with specific histories presented in case studies.
3. State at least three features of **multidisciplinary case studies** in which behavior analytic procedures are supportive components after trauma.
4. State at least one **example of a behavioral cusp** and a skill that helps individuals (and team members) after trauma.
5. Identify at least **two examples of ACT** (acceptance and commitment training) being used to support teams and individuals after trauma.
6. State at least **three examples of resources** to support individuals and teams after trauma.

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LEARNING OBJECTIVES

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BUT FIRST, A CASE STUDY

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A BIG QUESTION:

And is *this* trauma?

How does a client's history of significant "adverse conditioning experiences" already affect your work with that client and their team?

What about this?

Janine thrived in her autism class. Then COVID hit.

Her grandparents were no longer allowed to care for her. Her single mother had to "school" her at home. She was found during a social worker visit dirty, hungry, and making whimpering sounds as she played repetitively with a broken toy.

Her overwhelmed mom was in another room trying to work from home (and check in on her own parents who were ill and isolated themselves).

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Aniyah's case study

Some Problems

- Other staff didn't like, approach, or trust behavior analysts
- Staff were being asked to change behaviors that were related to respondent conditioning and trauma history using operant techniques,
- sometimes making behavior worse *and conditioning ourselves as aversive,*
- setting up students to be taken advantage of by the way we used coercive techniques, unindividualized procedures, and inappropriate plans (like least to most punishment), and
- building rapport with students who didn't trust us, getting them to trust us, then leaving and using our knowledge to teach another staff member to do that (eroding trust)

Educators and behavior analysts wanted consultation to understand why "nothing was working" although they'd identified functions of behavior

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F-1 Review records and available data (e.g., educational, medical, historical) at the outset of the case.

Aniyah

- 14 y/o trans girl
- Living in hospital on "wait list" for residential treatment
- Kicked out of multiple schools
- Many run-ins with law, juvenile detention
- Drinking, prostitution, robbery, gang activity at 9 years old
- Once-adoptive parents "gave her back"; gang related abuse in bio home

Behavior analysts at school wanted consultation to understand why "nothing was working"; wanted training before bringing her back

Tool: Worst-Case Scenario

See related blog post:

https://cuspemergence.com/2017/08/04/ethical-friday-presents-the-power-of-a-worst-case-scenario/

What's the worst case scenario?

- For *your* practice, *your* client, and *your* situation together, what's the worst that could happen?
- What might be some of the BEST possible outcomes, given the *worst* case scenario?
- What are some options you have right now that could contribute in meaningful ways to those outcomes? (list alternatives)
  - What are some short-term outcomes of each option?
  - What are some long-term outcomes of each option?
  - What options would you choose if you weighed the outcomes of each option? (risk versus benefit analysis)
- If you can't think of any way to prevent the worst from happening, what could you do to make it a little more tolerable? (risk mitigation)

Some of the conversation people had

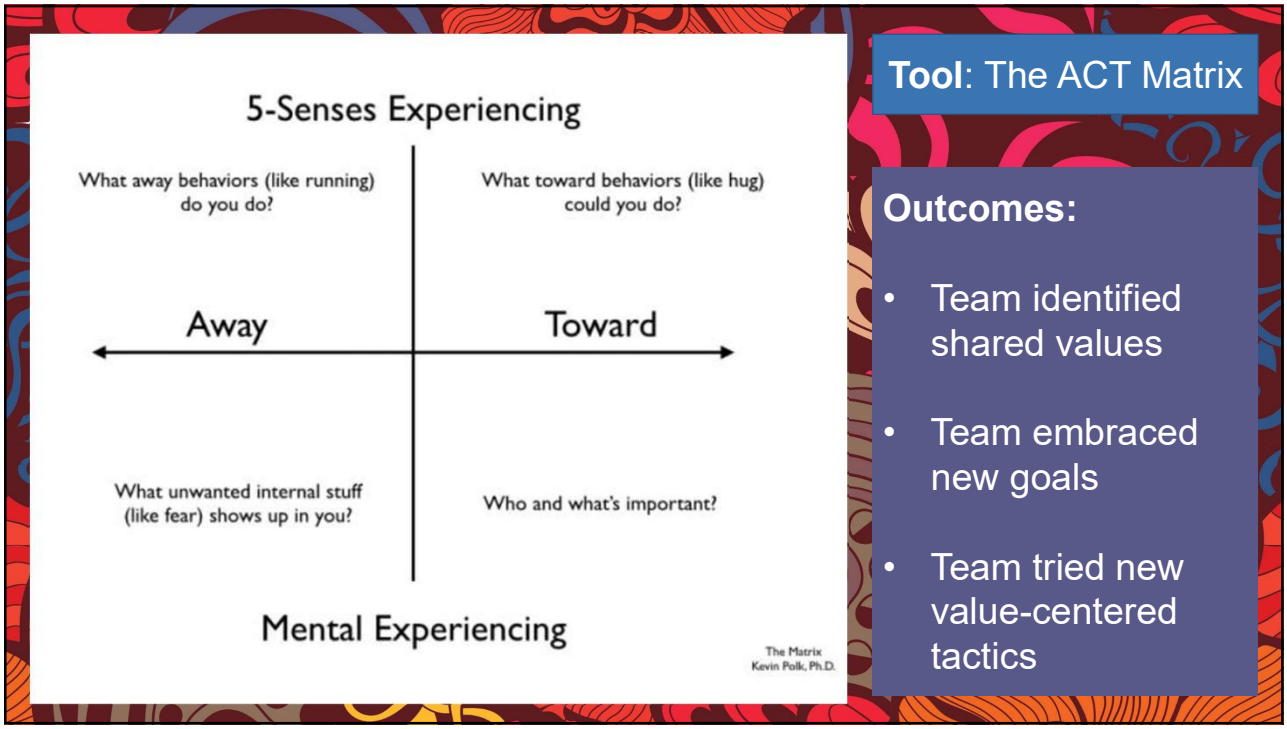
Worst case

- We try to intervene and we actually make behavior worse
- We re-traumatize our client
- She is kicked out of even our ABA school
- She goes back to living on the streets
- She is exploited or returns to prostitution and drinking
- She is killed

Best case

- We have tried all we could
- We learned ways to avoid re-traumatizing our client
- We all tried our best at the ABA school (exhausting less restrictive options)
- We taught her many skills she could use no matter where she ends up
- We worked on values with her and she makes her own choices…

Behavior analysts at school wanted consultation to understand why "nothing was working"; wanted training before bringing her back



Tool: The ACT Matrix

Outcomes:

- Team identified shared values
- Team embraced new goals
- Team tried new value-centered tactics

Some of the conversation people had

Reality

- We have been avoiding helping her with anything trauma related because we are afraid
- We avoid many topics and triggers, but we aren't sure how our behavior relates, so we accidentally seem to end up presenting MORE of them
- etc

Options

1. Do nothing (continue as usual)
2. Do not accept her back into our setting
3. Get training from a trauma-informed therapist and collaborate strongly with them
4. Bring in a specialist to work with her and do not collaborate; continue to operate in our silos
5. Accept into our setting but only after our staff receives training

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Risk Versus Benefit Tools

Supplement handouts for CuspEmergenceUniversity.com courses

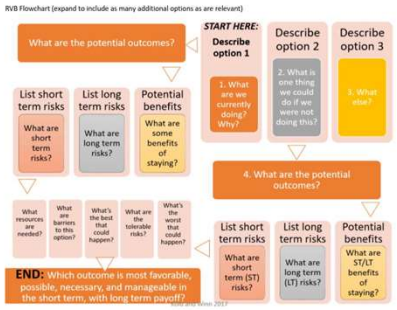
CUSP EMERGENCE

Considerations:

- On templates, duplicate signature lines and add space wherever appropriate.
- Try using these on google docs for teams to contribute to (copy and paste into a new doc there).
- These materials are compatible with online trainings and additional materials provided by cuspemergence.com and cuspemergenceuniversity.com.
- Risks and Our Role is a continuing education opportunity that provides considerably more detail on these forms and how to use them, and will be offered later this year.
- We typically conduct the risk versus benefit analysis together as a team and then generate a mitigation plan based on results. It is often helpful to provide a finished product on letterhead, summarized in a prior written notice in a document in education, or as a letter for a court.
- Please conduct all analyses in coordination with following the Ethics codes for your profession and the Behavior Analysis Certification Board.
- If conducting RVB on trauma-related behavior, consider a trauma-informed tool to assess and document risk, like SAFE-T Assessment (see website for more)

Please contact Dr. Camille Kolu at cuspemergenceu@gmail.com for more information.

Flowchart



Template items

10-Step RVB (Sample Items in Risk Versus Benefit Analysis Template)

Introduction

1. Overview of the document (e.g., include client name, the name and type of the document, its purpose, clarification that it is NOT a functional behavior assessment or behavior plan, suggested usage, person(s) who prepared it, etc. May include a list of documents or sources that were consulted. Note: This RVB may be included in the RVB or used in PWN (prior written notice in IEP)
2. Primary question the team is asking (see example question types above)
3. List of options being considered or potentially available

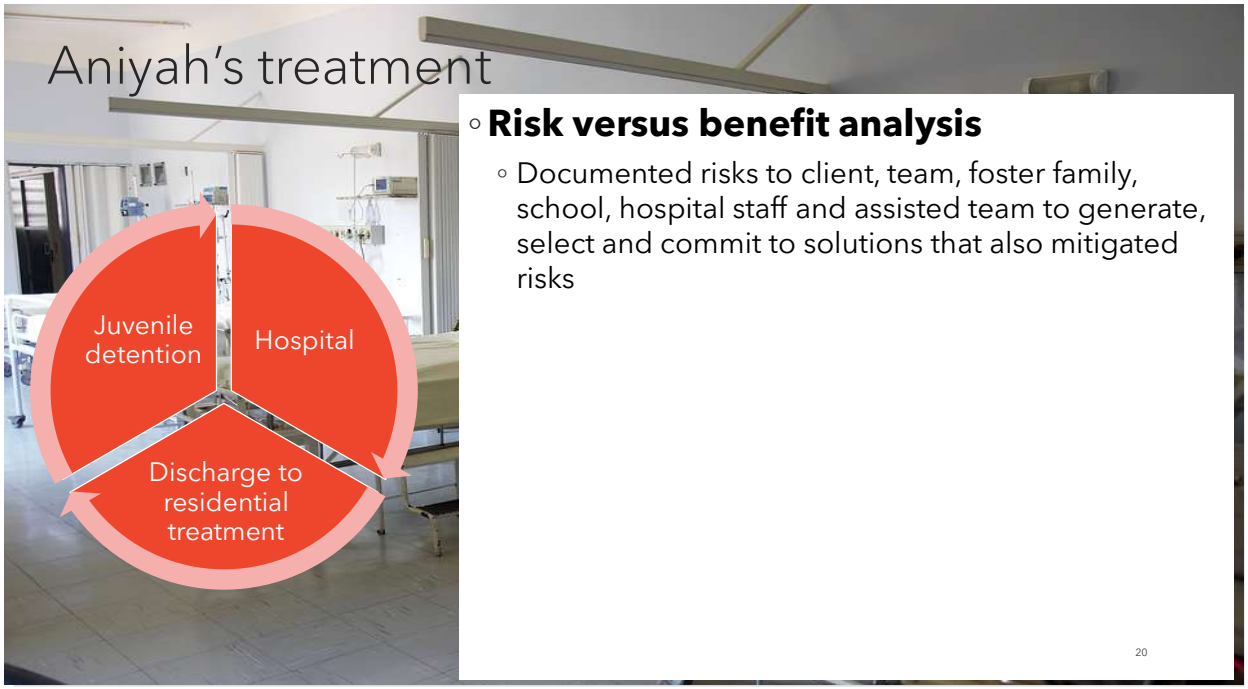
Option analysis

4. Describe Option 1
5. List all potential risks given Option 1 (include long-term risks, short-term risks; include 1 section for each RISK TARGET (see example risk target types above, such as risks to CLIENT, risks to TEAM members, etc)
6. List of potential benefits given Option 1 (include long-term benefits, short-term benefits)
7. Summary statement of risks for Option 1,
   a. Factors that would be required to mitigate risks
   b. Factors that would be required to realize benefits (e.g., include resources, training, education, cost, time, etc)
   c. Given all information for Option 1, overall statement of whether this option is too risky or potentially acceptable

(Repeat option analysis (Steps 4-7) for options 2, 3, 4, etc

Conclusions

8. Additional concerns or notes
9. Overall recommendations for Risk Versus Benefit Analysis (e.g., if person(s) preparing the analysis recommends one path over another)
10. Team input and signatures
    a. Place for additional team input (e.g., if they have anything to add after the risk versus benefit analysis is reviewed, put it in writing here)
    b. Date this Risk Versus Benefit Analysis was provided to team (repeat this section if discussions about risk were held multiple times)
    c. Y/N: Indicate whether the team supports any option at this time
    d. If yes, list option the team supports
    e. Signatures and roles and dates for each member who signed the document



Needs and Risks Assessment

- For every risk target, list risk(s)
- and potential long- and short- term outcomes if this risk is realized
- Prioritize the item
- Describe preventive steps that can be taken
- Discuss with team and decide how to act

Section C- Part 4. Potential risks to others in the community or society

RELATED ID NUMBERS *	Behavior related risk	Circle level of risk based on this client's behaviors (e.g., severe if more than 3 items (ID numbers) in the category are present, or if client engages in any behaviors that can cause immediate harm to others if not stopped	Description of preventative steps taken	Date risk discussed with team	Notes about reduction of risk
C1, C10, C11, C12, C21, C22	Risk of causing physical harm to others in the community	Low Medium High Severe			
C1, C11, C28, C29	Risk of causing sexual or social harm to others in the community	Low Medium High Severe			
C12	Risk of causing property damage in the community	Low Medium High Severe			

52 | Page DRAFT SAFE-T Model documents 2021 © Kolu

* *ID numbers come from SAFE-T Checklist*

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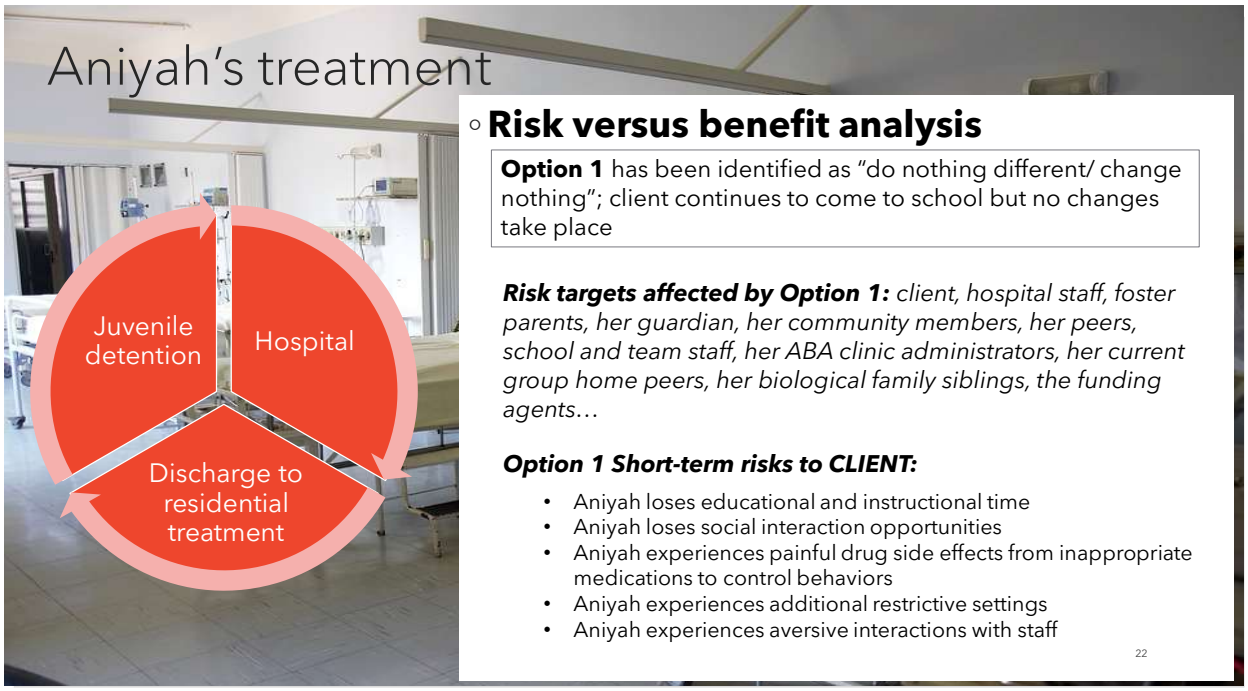

- **Risk versus benefit analysis**

Option 1 has been identified as "do nothing different/ change nothing"; client continues to come to school but no changes take place

Risk targets affected by Option 1: *client, hospital staff, foster parents, her guardian, her community members, her peers, school and team staff, her ABA clinic administrators, her current group home peers, her biological family siblings, the funding agents…*

Option 1 Short-term risks to CLIENT:

- Aniyah loses educational and instructional time
- Aniyah loses social interaction opportunities
- Aniyah experiences painful drug side effects from inappropriate medications to control behaviors
- Aniyah experiences additional restrictive settings
- Aniyah experiences aversive interactions with staff

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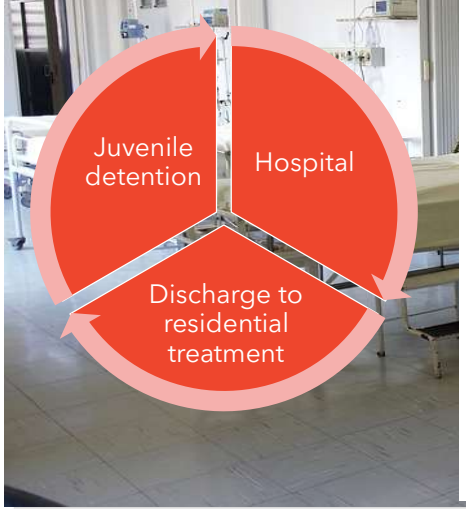
Aniyah's treatment



- **Risk versus benefit analysis**
  - Documented risks to client, team, foster family, school, hospital staff and assisted team to generate, select and commit to solutions that also mitigated risks
- **FBA:**
  - Local (immediate) functions of attention and escape
  - But ALSO, contributions of historical trauma
    - Several rapes in previous hospital-like settings, biological family home
    - Car accidents -> TBI -> behavioral sequelae
  - Beaten after reporting pain in home
  - Medical function of some of the assessed behaviors
    - Chronic unmanaged (and unreported) pain from previous assaults, early lack of medical care
- **Treatment began by training physical management staff**

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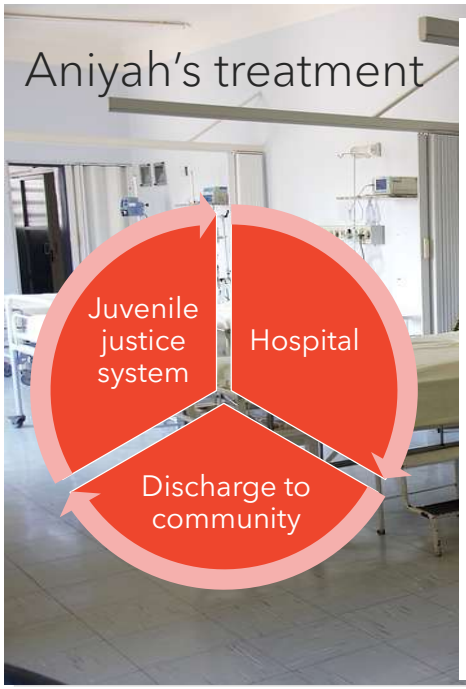
Aniyah's treatment



- **Aniyah experienced improvements once we**
  - **Included historical functions** in FBA-related treatments
  - **Incorporated interview information** on the physical characteristics of previous attackers, added **NCR** and conditioned approach as neutral, then did FT visits with police, staff
  - Used staffing huddles to **communicate with the whole team** every few days for about 5 minutes at a time
  - Used **TIP** (Teaching Interaction Procedure) to teach new staff (give rationale, instructions, examples, nonexamples for responding to client)

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What's behavioral about this slide?

- Goals and procedures are embedded for both Aniyah and staff
- Triggers in yellow
- Note the social validity piece and buy-in from the client
- Technology and graphics help guide staff (new staff click video icon)
- Two NCR-like schedules are built in (FT 15m staff attention; weekly police visits)

See Code Items

1.02 be accountable, practice within defined role (1.04) and scope of competence (1.05), and comply with requirements (4.01)

Use process for ethical decision making p. 5, see informed consent and risk p. 7; assess risks 2.12, 2.14, 2.15; communicate about services 2.08

2.12 consider medical needs

2.16 describe interventions before implementation, explain conditions necessary for effectiveness

3.11 document professional activity;3.13 make referrals; 2.10 collaborate

Is it SAFE to treat behavior yet?

- **S**upervision: Improved case supervision and systems support, including involving high levels of funding agents, law enforcement, hospital management
- **A**ssessment of risks: Added risk versus benefit analysis (for behaviors, skill acquisition and decrease targets in context of cultural factors, history, current needs); documented risks and teamed about them; began to make decisions based on risk mitigation plans
- **F**BA expanded to include historical and medical functions for all behaviors: Documented functions of historical variables; assessed appetitive AND aversive stimuli; discussed medical relationship to all behaviors; resolved all medical issues as much as possible
- **E**valuation and environmental management: Evaluated team's ability to implement plan, needs in current environment; taught preventive skills to all team members **before attempting to modify client's behavior**; continuously assessed environment for barriers to safety and treatment, etc
- **T**riage: Held preventative triage meetings regularly to keep entire team informed, incorporate new information about medical or behavioral concerns, and to maintain rapport (and establish stimulus control over complaints)

Use a trauma-informed approach to better apply "do no harm"

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

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Tools for Aniyah so far:

- ACT Matrix
- Risk versus benefit tools from Cusp Emergence
  - Flowchart
  - Worst case scenario (a tool for supervisors)
  - Risk versus benefit template
- Needs and risks assessment
- Client At A Glance (we'll see more on this later)
- SAFE-T Model acronym to remind us all to use solid supervision, to assess risks, to document historical functions of behavior, and look at environmental needs- all before we purport to "Treat behavior after trauma"

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BRIEF REVIEW

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1. Describe at least three procedures that may be **contraindicated** for some clients with trauma backgrounds.
2. Identify at least two **tools** to enhance behavior support practices with people affected by trauma, with specific histories presented in case studies.
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LEARNING OBJECTIVES

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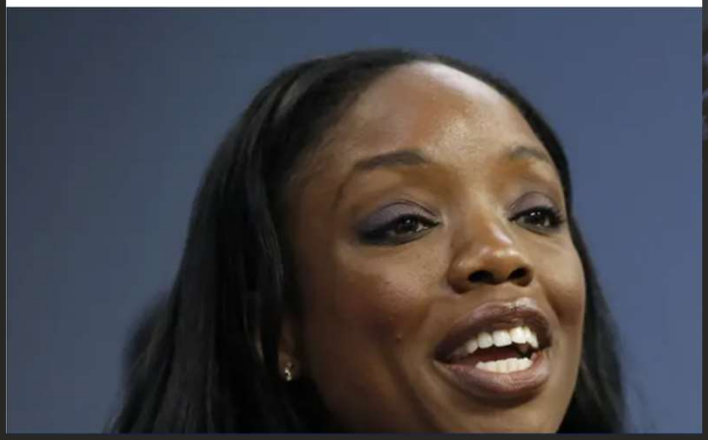
Later in Objective 6, I'm going to suggest you already have important resources for this work: your repertoire, and your knowledge.

We all know about the pandemic… how does it show up in our behavior stream?
Has it changed how you practice?
Should it?

COVID-19: Long-term stressor we all have in common

California's first surgeon general on Covid: 'Greatest collective trauma' of a generation



https://www.theguardian.com/us-news/2022/feb/19/covid-trauma-california-surgeon-general

COVID-19: Long-term stressor we all have in common

- Schedules
- Demands on caregivers
- Work environments combined with caregiving and FEWER resources to do either
- Lack of connection between therapists and clients
- Decrease in supervision of children
- Increase in social isolation
- Disrupted sleep and nutrition
- **200,000 children have lost their parents to COVID in the US***
  - (not even counting children whose lives have been disrupted by family illness, hospitalizations, and increased experiences of abuse, neglect, accidents related to the pandemic)

Increase in…

- Mental health problems
- Medical problems
- Medication gaps
- Missing dental and preventive care
- Behavior challenges

*https://www.theguardian.com/us-news/2022/feb/19/covid-trauma-california-surgeon-general

COVID-19: Long-term stressor we all have in common

- Reminds us all to consider medical factors …
- And the interaction between
  - behavioral,
  - medical,
  - environmental
  - and social concerns

- Trauma can cause, and be cause by, medical concerns.
  - Trauma can CONTRIBUTE to a medical problem
  - Medical problems can also contribute to TRAUMA

"SOME OF THE PRACTICES WE THINK OF AS "BEST" FOR OTHER CLIENTS, MAY BE CONTRAINDICATED FOR SOMEONE WITH A SIGNIFICANT **HISTORY** OF ADVERSE CHILDHOOD, THERAPEUTIC, OR EDUCATIONAL EXPERIENCES"

See BACB Ethics Code 2.09

We involve clients and stakeholders by…

- "selecting goals,
- selecting and designing assessments
- and behavior-change interventions,
- and conducting continual progress monitoring"

Perhaps our field is confused about the role of history! Maybe we should consult some experts

Lattal and Neef (1996). Recent reinforcement-schedule research and applied behavior analysis. *Journal of Applied Behavior Analysis, 29 (2),* 213-230.

"Paradoxically, applied behavior analysts have regarded the role of behavioral history as both paramount and irrelevant.

On the one hand, a tenet of behavior analysis is that history profoundly affects human behavior. In fact, it could be argued that for applied behavior analysts, arranging conditions to alter subsequent behavior is itself a matter, and goal, of generating a different history that will produce durable changes in the targeted behavior. On the other hand, until the development of functional analysis methods (Iwata, Dorsey, Slifer, Bauman, & Richman, 1982/1994), behavior analysts generally disregarded the historical conditions under which behavior developed."

Iwata et al. 1982/1994, page 198

Perhaps our field is confused about the role of history! Maybe we should consult some experts:

"…the conditions that are necessary to develop or maintain a response may be totally unrelated to the conditions that are sufficient to alter or eliminate it"

"But it may be … arbitrary to assume… that the relevance of history depends on whether or not we have arranged it."

"If we can arrange treatment conditions for desirable behavior to persist in the presence of disruptive events, then we also must appreciate that other conditions in the natural environment create a history in which problem behavior is resistant to change by our treatment conditions. **By understanding how and under what conditions history affects schedule controlled behavior, applied behavior analysts may be able to design interventions that mitigate or optimize those influences."**

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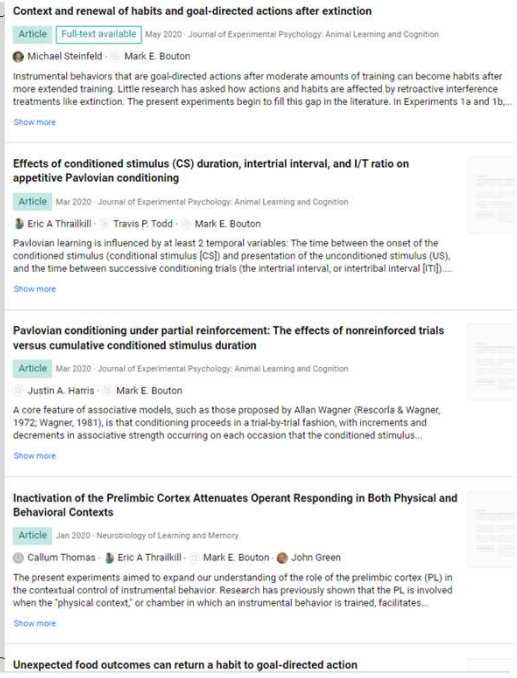
Related concepts:
Triggers, conditioning context, schedules, extinction-related processes…

Trauma Reminders: Anniversaries - PTSD: National Center for PTSD (va.gov)

- Laypersons might use the terms "anniversary triggers" or "slow triggers"
- We might say the "schedule of acquisition" is one of the contextual variables at the time conditioning occurred.
- See Mark Bouton's body of work if interested in the role of contextual variables in extinction-related processes…



Context and renewal of habits and goal-directed actions after extinction

Article · Full-text available · May 2020 · Journal of Experimental Psychology: Animal Learning and Cognition

Michael Steinfeld · Mark E. Bouton

Instrumental behaviors that are goal-directed actions after moderate amounts of training can become habits after more extended training. Little research has asked how actions and habits are affected by retroactive interference treatments like extinction. The present experiments begin to fill this gap in the literature. In Experiments 1a and 1b,...

Show more

Effects of conditioned stimulus (CS) duration, intertrial interval, and I/T ratio on appetitive Pavlovian conditioning

Article · Mar 2020 · Journal of Experimental Psychology: Animal Learning and Cognition

Eric A Thrailkill · Travis P. Todd · Mark E. Bouton

Pavlovian learning is influenced by at least 2 temporal variables: The time between the onset of the conditioned stimulus (conditional stimulus [CS]) and presentation of the unconditioned stimulus (US), and the time between successive conditioning trials (the intertrial interval, or intertribal interval [ITI])....

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Pavlovian conditioning under partial reinforcement: The effects of nonreinforced trials versus cumulative conditioned stimulus duration

Article · Mar 2020 · Journal of Experimental Psychology: Animal Learning and Cognition

Justin A. Harris · Mark E. Bouton

A core feature of associative models, such as those proposed by Allan Wagner (Rescorla & Wagner, 1972; Wagner, 1981), is that conditioning proceeds in a trial-by-trial fashion, with increments and decrements in associative strength occurring on each occasion that the conditioned stimulus...

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Inactivation of the Prelimbic Cortex Attenuates Operant Responding in Both Physical and Behavioral Contexts

Article · Jan 2020 · Neurobiology of Learning and Memory

Callum Thomas · Eric A Thrailkill · Mark E. Bouton · John Green

The present experiments aimed to expand our understanding of the role of the prelimbic cortex (PL) in the contextual control of instrumental behavior. Research has previously shown that the PL is involved when the "physical context," or chamber in which an instrumental behavior is trained, facilitates...

Show more

Unexpected food outcomes can return a habit to goal-directed action

Context

A loose definition of "Contextual Stimulus"

Non-discrete (e.g., diffuse) stimuli…

- that could include people, places, and sensory events (odors, views or visual stimuli, tastes, noises, even vestibular sensations)
- and other things (the timing, the schedule, the time of year, day, month)
- or biologically relevant variables (pain, illness, medications, or states such as deprivation (hunger, thirst) or needs)

…that were part of the background when learning occurred, but not part of the discrete US-US relation

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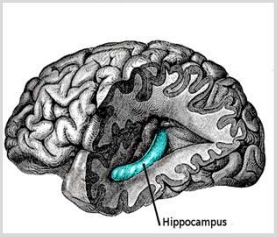
Using olfactory contextual conditioning, we (Parsons and Otto 2007, 2008) found that the hippocampus,



(named for this creature (see the similarity?)…

- is involved in learning the difference between contexts that are UNSAFE (something bad happened when I was here/ when I smelled this smell or heard this sound)

- versus SAFE (nothing bad has happened to me here/ in the presence of these stimuli

https://upload.wikimedia.org/wikipedia/commons/thumb/5/5b/Hippocampus_and_seahorse_cropped.JPG/220px-Hippocampus_and_seahorse_cropped.JPG

Context

A loose definition of "Contextual Stimulus"

Non-discrete (e.g., diffuse) stimuli…

- that could include people, places, and sensory events (odors, views or visual stimuli (Mary's example: "a ceiling fan was turning above me"), tastes, noises, even vestibular sensations)
- and other things (the timing, the schedule, the time of year ("it was almost Halloween when my brother raped me"), day, month)
- or biologically relevant variables (pain, illness ("I remember I had just eaten a certain food and kept throwing up afterward") or states such as deprivation (hunger, thirst) or needs)

…that was or were part of the background when learning occurred but not part of the discrete US-US relation

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Context

- (Mary's example: "a ceiling fan was turning above me"),)
- ("it was almost Halloween when my brother raped me")
- ("I remember I had just eaten a certain food and kept throwing up afterward")

Every one of these examples was part of the background information clients provided about sexual encounters that involved abuse, nonconsensual sex, or pain.

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Contextual Variables

Mary's example: "a ceiling fan was turning above me"

Visual stimulus: often followed by self injurious behavior (scratching and cutting breasts)

Jan: "it was almost Halloween when my brother raped me")

Time of year/ schedule effect: Jan experiences suicidal ideation during the fall as it gets closer and increased aggression in Nov

Ava: "I remember I had just eaten a certain food and kept throwing up afterward")

Internal state/ physiological condition (Ava vomited while trying to prepare for sex with her partner and eventually avoided dating)

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Operationalizing some sex related events in behavioral terms for Mary

- **Contextual variable**: Ceiling fan turning + lying underneath it may be a setting event in the presence of which,
- Another person's approach acts as an CMO-T with transient functions:

Operant functions:

- **Person acts as an SD** for response class of escape and avoidance
- **Escape and avoidance** is more reinforcing
- **Members of this response class (avoidance and escape related behaviors)** are temporarily more likely to occur
- And **S-delta in whose presence** "compliance related behaviors" are not likely to occur

Respondent functions:

- At the same time as conditioned physiological responses occur (her heart races; her mouth becomes dry)

Mixed: (and back to operant… Mary's use of SIB may relate to conditioned responses that were originally unconditioned responses to the unconditioned stimuli related to the assault)

44

When a contribution of *medical* trauma (see 2.12) is revealed,

45

we may have an easier time understanding and accepting how and why treatment may need to change

Sophie

46

An under-weight malnourished-looking child in foster care is court-ordered to receive **"feeding therapy" and behavior therapy** to address significant avoidance behaviors associated with it.

Sophie

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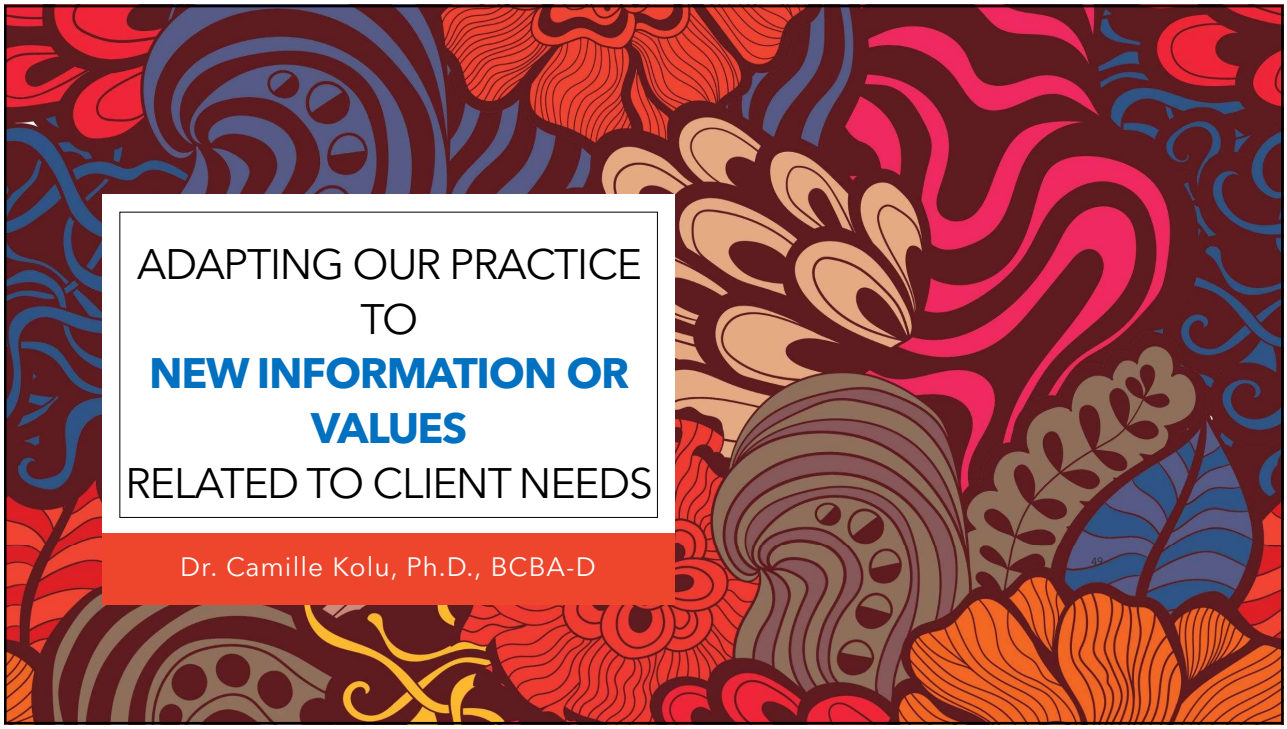
HISTORICAL context	LOCAL context	Antecedent variables	Behavior	C
Food presentation -> eating -> pain	Celiac disease diagnosis			
	It's lunchtime. Mom and a therapist are present.	Food on spoon is placed inside mouth	Sophie vomits and turns head	**Spoon/food placed back in mouth**
	room; adults; spoon; **learning history**	SDs; S-deltas; unconditioned and conditioned stimuli	CRs, operant responses	Extinction of avoidance behaviors? **Presentation of conditioned aversive stimulus?**

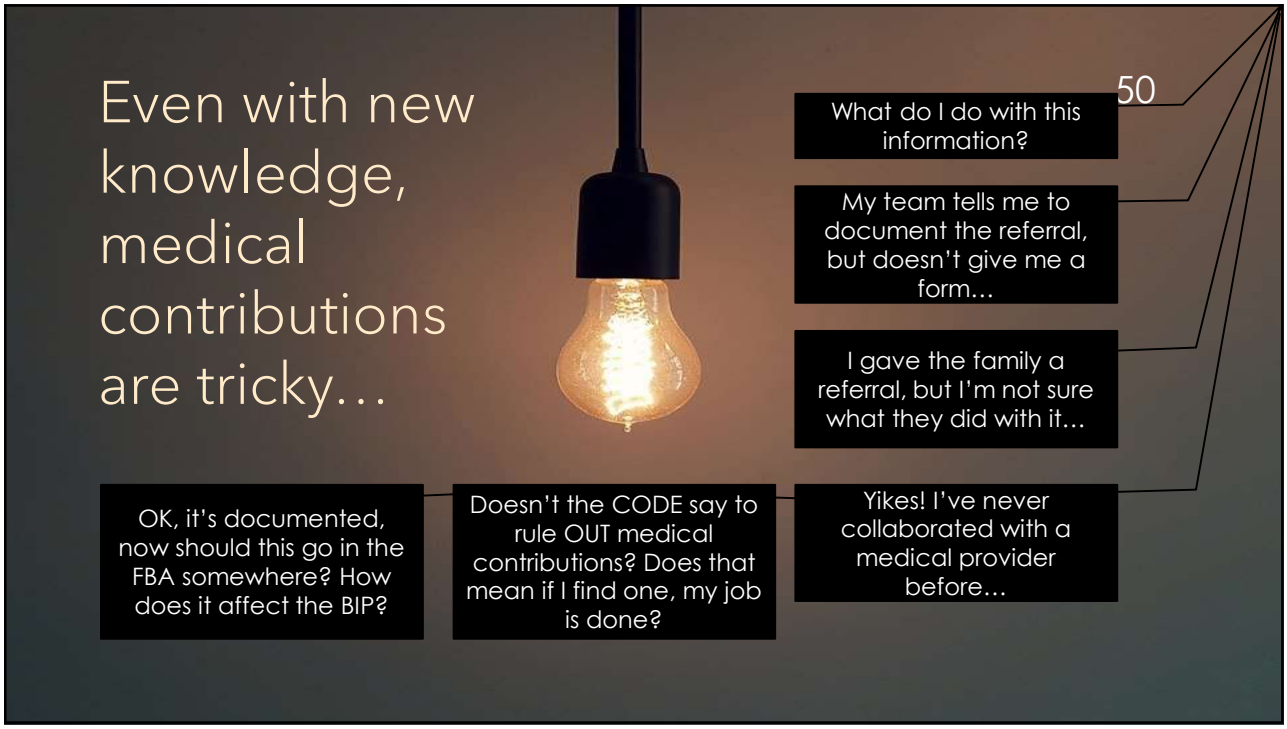
Celiac disease diagnosis

48

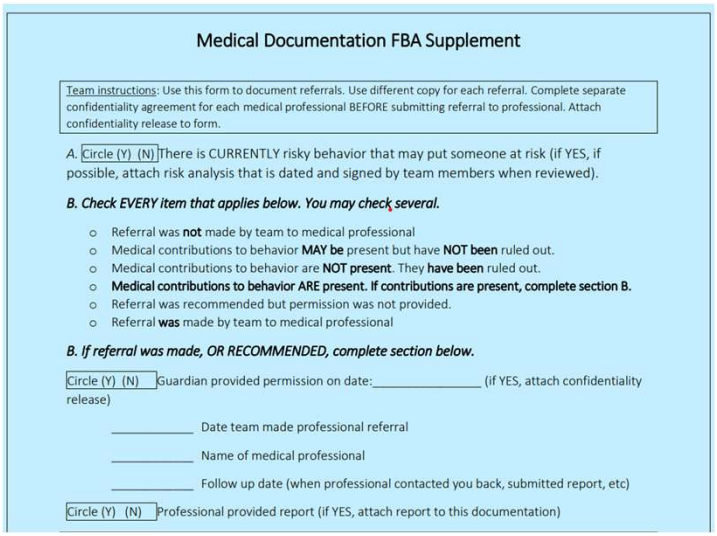
CELIAC DISEASE (and pain, etc) was present the entire time. But the **DIAGNOSIS** is new. That means that without realizing it, we have been

- Providing treatment that incorporates the repeated presentation of aversive stimuli
  - That are related to medical factors
  - And to Sophie's specific learning history


ADAPTING OUR PRACTICE
TO
NEW INFORMATION OR VALUES
RELATED TO CLIENT NEEDS
Dr. Camille Kolu, Ph.D., BCBA-D


Even with new knowledge, medical contributions are tricky…
50
What do I do with this information?
My team tells me to document the referral, but doesn't give me a form…
I gave the family a referral, but I'm not sure what they did with it…
Yikes! I've never collaborated with a medical provider before…
Doesn't the CODE say to rule OUT medical contributions? Does that mean if I find one, my job is done?
OK, it's documented, now should this go in the FBA somewhere? How does it affect the BIP?

When we make medical (or other) referrals, we need to document the referral and the response (and follow up/ collaboration) (2.10, 2.12, 2.15)



Medical Documentation FBA Supplement

Team instructions: Use this form to document referrals. Use different copy for each referral. Complete separate confidentiality agreement for each medical professional BEFORE submitting referral to professional. Attach confidentiality release to form.

A. Circle (Y) (N) There is CURRENTLY risky behavior that may put someone at risk (if YES, if possible, attach risk analysis that is dated and signed by team members when reviewed).

B. Check EVERY item that applies below. You may check several.

- Referral was **not** made by team to medical professional
- Medical contributions to behavior **MAY be** present but have **NOT been** ruled out.
- Medical contributions to behavior are **NOT present**. They **have been** ruled out.
- **Medical contributions to behavior ARE present. If contributions are present, complete section B.**
- Referral was recommended but permission was not provided.
- Referral **was** made by team to medical professional

B. If referral was made, OR RECOMMENDED, complete section below.

Circle (Y) (N) Guardian provided permission on date:_____ (if YES, attach confidentiality release)

_____ Date team made professional referral

_____ Name of medical professional

_____ Follow up date (when professional contacted you back, submitted report, etc)

Circle (Y) (N) Professional provided report (if YES, attach report to this documentation)

Tools for Aniyah so far:

- ACT Matrix
- Risk versus benefit tools from Cusp Emergence
  - Flowchart
  - Worst case scenario (a tool for supervisors)
  - Risk versus benefit template
- Needs and risks assessment
- Client At A Glance (we'll see more on this later)
- SAFE-T Model acronym to remind us all to use solid supervision, to assess risks, to document historical functions of behavior, and look at environmental needs- all before we purport to "Treat behavior after trauma"

- *Aniyah has avoided medical appointments for years because they remind her of sexual assaults.*
- ***So to tools, now we add the Medical Documentation Referral Form.***

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BRIEF REVIEW

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1

1. Participants will select procedures that may be contraindicated for some clients with trauma backgrounds

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LEARNING OBJECTIVES

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Let's tackle that phrase: "with trauma backgrounds"

Related concepts:

- Aversive control
- Reinforcement histories
- Values like compassion and caring
- Behavior analytic tenets like social validity

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

Dr. Nadine Burke Harris,
California Surgeon General

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

Why is trauma suddenly discussed so much?

- **Landmark** studies
- Adoption of **wide scale efforts to change educational practice, incorporate social justice**
- Recognition that it is affecting **large numbers of people** (and recent data show **COVID-19**-related issues have significantly increased those numbers)
- **Media and publications** that connect for people that trauma results in lifelong medical, mental health, and educational challenges

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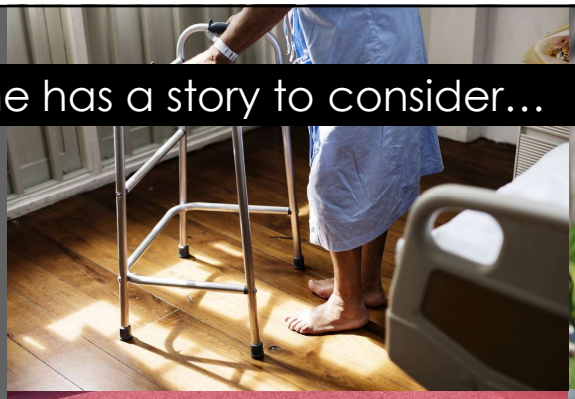
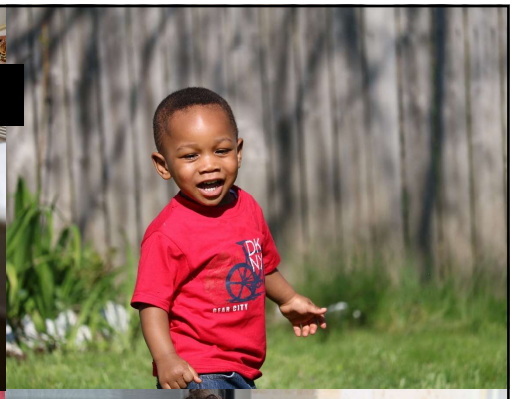
According to Chuck Merbitz…

https://behavioralobservations.com/how-to-work-well-with-others-session-63-with-chuck-merbitz/

In describing situations where people have endured far-reaching abuse and trauma, Chuck Merbitz mentions how distressing he finds an arrogant behavior analyst with no time for understanding that person's history. Loosely quoted below, he shared:

"It's not that the behavior analytic tools aren't useful in situations like that… it's the incredible human pain people bring to the situations is often lost on BA's who aren't prepared to work with people like that. Because you don't know their back story, and if you're lucky they'll tell you their back story… You know, there's a lot of wonderful people in the world. And there's a lot of people who have been treated very badly… This is a more pragmatic and human relationship grappling than a cut and dried having them count things. … There's a whole universe… out there that we don't have the tools to measure. These are valid experiences, these are things that shape the way people live and hurt and experience, and we as behavior analysts have to be able to grapple with that. We're a very young science…. shouldn't restrict your thoughts and activities to the stuff that's easy to measure and be afraid of the stuff that's not."

Everyone has a story to consider…

An ANALYSIS of behavior

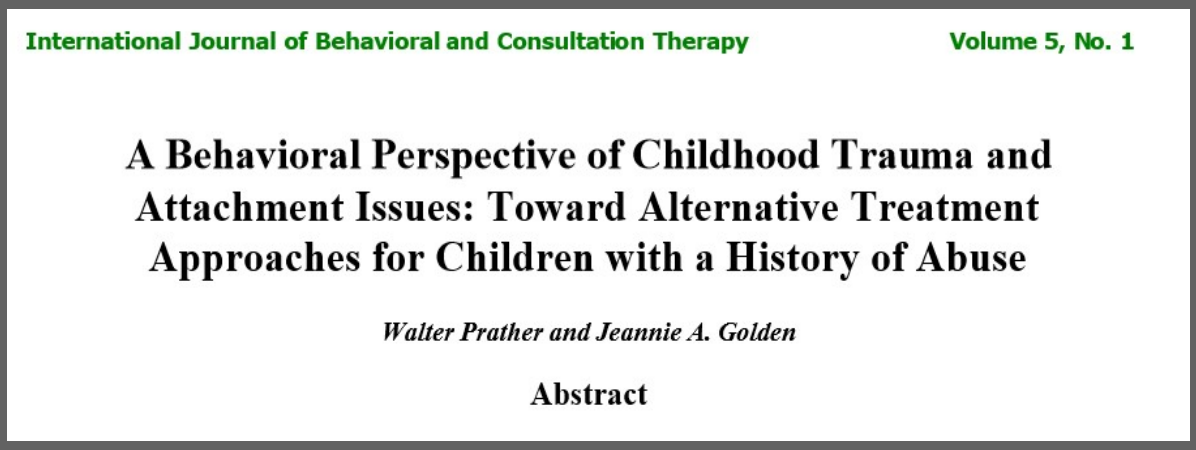
The PRACTICE of applied behavior analysis

What's behavioral about treating behavior after trauma?

Ok… but where is the literature SPECIFICALLY relating trauma and behavior analysis?

- Buckner, Lopez, Dunkel, and Joiner (2008). Behavior Management Training for the Treatment of Reactive Attachment Disorder. *Child Maltreatment, 13 (3),* 289-297.
- Franks, Mata, Wofford, Briggs, LeBlanc, Carr, and Lazarte (2013). The Effects of Behavioral Parent Training on Placement Outcomes of Biological Families in a State Child Welfare System. *Research on Social Work Practice, 23(4),* 377-382.
- Kurtz, Chin, Rush, and Dixon (2007). Treatment of challenging behavior exhibited by children with prenatal drug exposure. *Research in Developmental Disabilities, 29 (6),* 582-594.
- Prather (2007). Trauma and Psychotherapy: Implications from a Behavior Analytic Perspective. *International Journal of Behavioral Consultation and Therapy, 3 (4), 555-570.*
- Rajaraman A, Austin JL, Gover HC, Cammilleri AP, Donnelly DR, Hanley GP. Toward trauma-informed applications of behavior analysis. J Appl Behav Anal. 2022 Feb;55(1):40-61..
- Richman et al. (2015). Meta-analysis of noncontingent reinforcement effects on problem behavior. *Journal of Applied Behavior Analysis, 48 (1)*, 131-152.

Ok… but where is the literature SPECIFICALLY relating trauma and behavior analysis?



International Journal of Behavioral and Consultation Therapy Volume 5, No. 1

A Behavioral Perspective of Childhood Trauma and Attachment Issues: Toward Alternative Treatment Approaches for Children with a History of Abuse

Walter Prather and Jeannie A. Golden

Abstract

Kadiatou Koita , Dayna Long, Danielle Hessler, Mindy Benson, Karen Daley, Monica Bucci, Neeta Thakur, Nadine Burke Harris (2018)

PUBLISH ABOUT BROWSE

PLOS ONE

OPEN ACCESS PEER-REVIEWED

RESEARCH ARTICLE

Development and implementation of a pediatric adverse childhood experiences (ACEs) and other determinants of health questionnaire in the pediatric medical home: A pilot study

Kadiatou Koita, Dayna Long, Danielle Hessler, Mindy Benson, Karen Daley, Monica Bucci, Neeta Thakur, Nadine Burke Harris

Published: December 12, 2018 • https://doi.org/10.1371/journal.pone.0208088

Research cited in Koita et al. (2018) on dose relationships of ACES to their dose response relationship (also cited in Nadine Burke Harris' book)

From introduction: "The exposure to ACEs is thought to have a cumulative effect over the life course and found to increase the likelihood of disease [3], starting as early as childhood. In children and adolescents, ACEs have been associated with fair or poor general health [4–5] illness requiring a doctor [5], infections [6–7] cognitive and developmental delays [8–10], fair or poor dental health [11], asthma [4], [12–14], Attention Deficit Hyperactive Disorder (ADHD) [4], [15], sleep disturbance [16–18], autism [4], overweight or obesity [19–21], violent behavior (delinquent behavior, bullying, physical fighting, dating violence, weapon-carrying) [22], suicide-related behaviors [23], and learning difficulties [4], [24]."

"No intervention is guaranteed to work for every individual, every time, in every context."

-in panel discussion by Mark Galizio, Jason Travers, and Joel Ringdahl

47th Annual Convention; Online; 2021

All times listed are Eastern time (GMT-4 at the time of the convention in May).

Event Details

Previous Page

Invited Panel #121 **CE Offered: BACB – Ethics**

DEI **Exploring Publication Bias in Behavior Analysis Research**

Saturday, May 29, 2021

4:00 PM–4:50 PM

Online

A WORKSHOP GOAL: "EMPOWER CLINICIANS AND BEHAVIOR ANALYSTS TO UNDERSTAND SOME OF THE LINKS BETWEEN WHAT INDIVIDUALS NEED AFTER TRAUMA, AND HOW BEHAVIOR ANALYSIS CAN HELP "

See BACB Ethics Code 2.12

If there is "any reasonable likelihood" that a referred behavior is

- Influenced by medical variables
- Or influenced by biological variables…
  - We ensure medical needs are assessed **and addressed**
  - We **document referrals** made
  - We **follow up** after making the referral

Translational work* is going to be REALLY important if we are to understand, and move toward, truly applying behavioral science to trauma more broadly

- **Relevant connection:** applying knowledge of extinction-related phenomena to clinical practice (e.g., Epstein & Skinner 1980; Lattal et al. 2017; Franks and Lattal 1976; and Saini and Mitteer 2019)
- **Example**: Marsteller and St. Peter Pipkin (2014) used FT schedules to prevent the resurgence of extinguished behavior when DRA alone was not effective.

*For more on translational work see Mace & Critchfield, 2010

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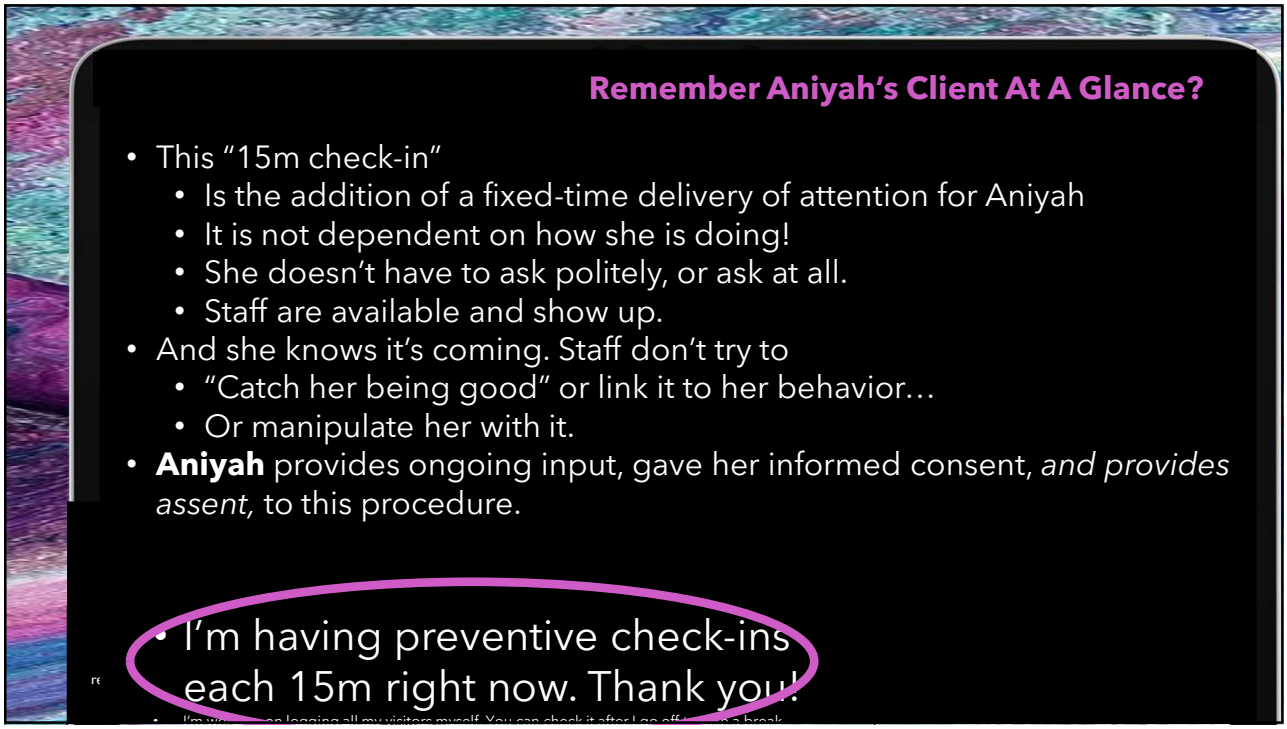

WE WILL LEARN TOOLS TO SUPPORT INDIVIDUALS WITH SIGNIFICANT, MINOR, AND EVEN UNKNOWN HISTORIES OF TRAUMA

See BACB Ethics Code 2.15

We only implement restrictive or punishment-based procedures

- When there has been a risk versus benefit analysis
- And the risk of harm to the client outweighs the risk associated with the intervention
- In compliance with any review procedures
- And with continual evaluation and documentation of the effectiveness

Toward a potential behavioral definition of trauma

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Conditioning experiences with both operant and respondent constituents,

-including contextual stimuli and variables (e.g., non-discrete (e.g., diffuse) stimuli…

- that could include people, places, and sensory events (odors, views or visual stimuli, tastes, noises, even vestibular sensations)
- and other things (the timing, the schedule, the time of year, day, month)
- or biologically relevant variables (pain, illness, medications, or states such as deprivation (hunger, thirst) or needs)
- and that were part of the background when learning occurred, but not part of the discrete US-US relation)

-As well as antecedents, conditioned stimuli, operant and respondent responses, response products, outcomes in the behavioral environment, and environmental changes), and the accompanying movements, biological and physiological changes), are involved in (and may be related to subsequent)

- Alterations in function
- Establishing repertoires characterized by escape and avoidance
- Often with respect to stimuli and outcomes that may be critical components of quality of life for others with similar needs or even for the person)

Toward a potential behavioral definition of trauma

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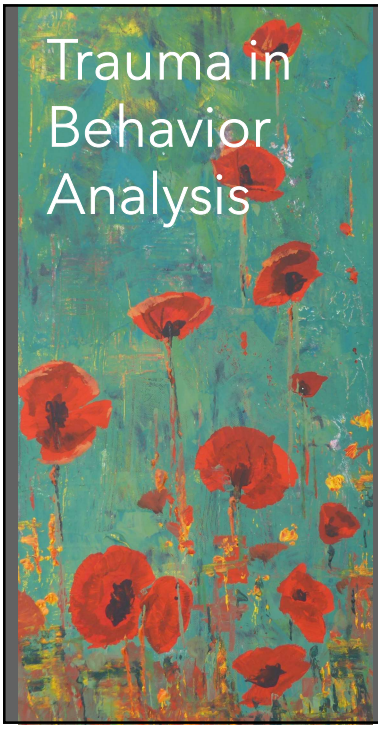
Short version:

A conditioning experience with both operant and respondent components that relates to subsequent adverse behavioral and biological/medical effects and long-term impacts.

Trauma in Behavior Analysis



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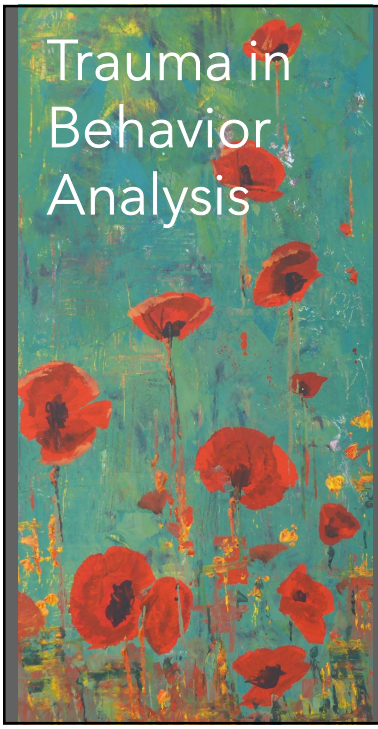
- What others call trauma may result from aversive experiences that reduce an individual's ability to cope with situations.
- These aversive experiences may include disruptions in caregiving and childhood, or exposure to circumstances that disrupt living situations, safety, or health.
- Outcomes of what others call trauma
  - may include neurological and behavioral changes including developmental disruption, regression; behavioral deficits and excesses, and skill loss or retardation in skill acquisition…
  - not explained by another diagnosis.


Trauma in Behavior Analysis
71
Trauma may take place given a behavioral history
in which appropriate, biologically relevant and social needs of an individual
were not met
or were violated repeatedly,
resulting in disrupted behavior streams
Kolu (c) 2018


Trauma in Behavior Analysis
72
Disrupted behavior streams may include
behavioral excesses
or deficits
that occur in response to environmental events,
including caregiver-paired or delivered stimuli,
and are not otherwise age appropriate
or explained solely by a developmental or medical diagnosis
Kolu (c) 2018



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- Some variables that give rise to disrupted behavior streams may include
  - extreme interruptions
  - in caregiving
  - or social interaction
    - (e.g., exposure to sexual
    - or drug abuse,
    - deprivation of food
    - or social contact)

Ethics Code Items 4.08 d (old); 2.15 (new)

2.15 Minimizing Risk of Behavior-Change Interventions

Behavior analysts select, design, and implement behavior-change interventions (including the selection and use of consequences) with a focus on minimizing risk of harm to the client and stakeholders. They recommend and implement restrictive or punishment-based procedures only after demonstrating that desired results have not been obtained using less intrusive means, or when it is determined by an existing intervention team that the risk of harm to the client outweighs the risk associated with the behavior-change intervention. When recommending and implementing restrictive or punishment-based procedures, behavior analysts comply with any required review processes (e.g., a human rights review committee). Behavior analysts must continually evaluate and document the effectiveness of restrictive or punishment-based procedures and modify or discontinue the behavior-change intervention in a timely manner if it is ineffective.

The SAFER Autism Checklist: Can your client with autism and trauma answer yes?

This is a checklist under the umbrella of the SAFE-T Model for safer treatment of behavior after trauma, by Dr. Camille Kolu Ph.D., BCBA-D.

Systems support, supervision and safety are present.

- ❑ My team has appropriate professionals on it who share values. They collaborate in robust ways and communicate effectively. I am important on my team and my opinions are taken into account. My team obtains my assent as we work together on things important to me.
- ❑ If my team has a supervisor or administrator, that person champions my needs and provides adequate training and support for the team members who support me. They think a few years ahead and build partnerships and collaborations and obtain mentorship and education to insure we are always moving toward our values.
- ❑ If I need special trauma related (or mental health, or medical, or any other kind of) support in addition to behavior analysis, I have it.
- ❑ I have at least one safe person and place. I have skills to request things that I need and people understand. I don't have to ask a certain way to get my basic needs met or to get out of a situation that is aversive or unsafe for me.

Assessment of risks takes place regularly.

- ❑ People around me look at me as a whole and individual person before recommending programs. My clinicians follow ethical guidance to do a risk versus benefit analysis to make sure a program is right for me and the benefits outweigh the risks. Even if the procedure is "best practice" for someone else, my team still does a risk analysis to make sure it's right for ME.
- ❑ If I have been through trauma, my team looks at the specific risks conferred by those situations and plan accordingly. My team puts risk mitigation plans into place
- ❑ I provide input into my assessments, including assessments of risks I might face because of my needs, behavior, and history.
- ❑ There are risks I face more than other people may because I have autism or that are related to experiences I've had as an

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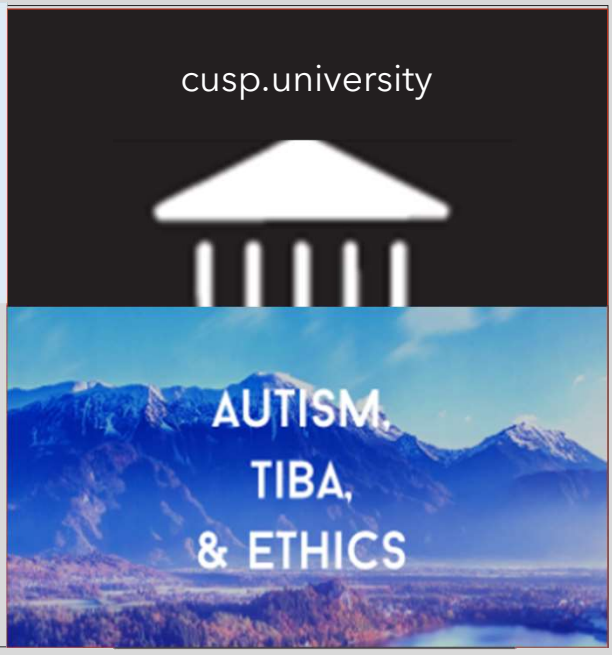
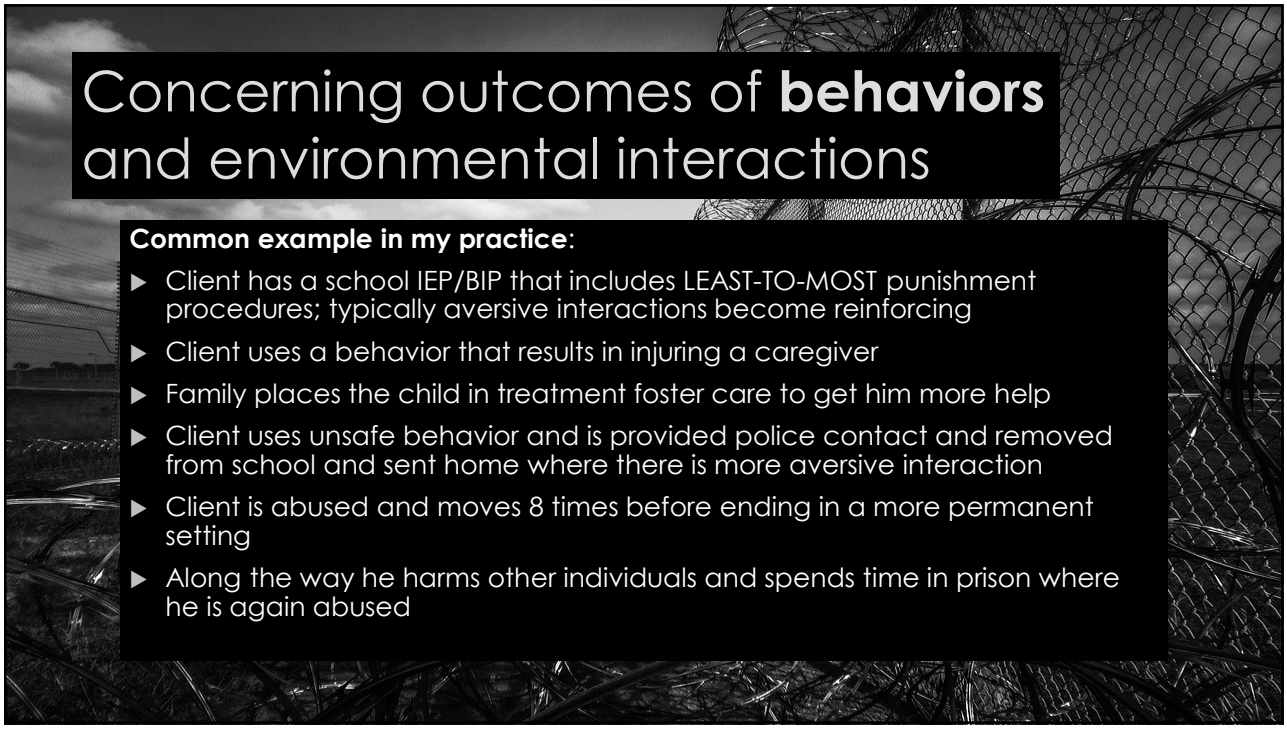


Examples of trauma faced by children and adults with autism, with whom our team works

- War; PTSD
- Poverty, homelessness
- Immigration related challenges
- Violence, drug abuse, and/or alcoholism in family
- Deaths of family members
- Long term illnesses or medical issues/ treatment
- Witnessing or perpetrating violence; incarceration
- Childhood experiences (ACES; see **Nadine Burke Harris' TED talk)**
  - Abuse, mistreatment, neglect
  - Being treated inappropriately while growing up with mental illness or disorders
  - Foster care; adoption; multiple placements; abandonment



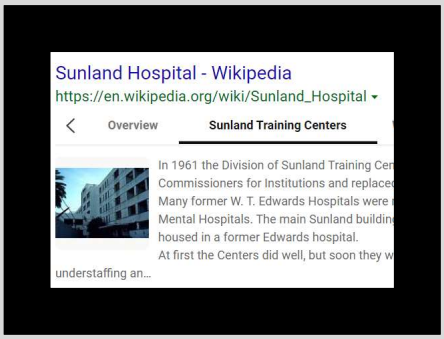
Concerning outcomes of **behaviors** and environmental interactions

Common example in my practice:

- Client has a school IEP/BIP that includes LEAST-TO-MOST punishment procedures; typically aversive interactions become reinforcing
- Client uses a behavior that results in injuring a caregiver
- Family places the child in treatment foster care to get him more help
- Client uses unsafe behavior and is provided police contact and removed from school and sent home where there is more aversive interaction
- Client is abused and moves 8 times before ending in a more permanent setting
- Along the way he harms other individuals and spends time in prison where he is again abused

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

Take special care with…



Reliance on tangible consequences for "good behavior"

And even preference assessments that require removing things someone loves

Also please see Bailey and Burch's text
Ethics for Behavior Analysts

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For Aniyah: some potentially contraindicated procedures

- Physical prompting was being used with Aniyah for noncompliance, but she had been through recent physical and sexual abuse
- Attention related extinction was being used, but she had just been neglected and "given back" by a family who had claimed they wanted to adopt her
- Preference assessments (MSWO) were resulting in self injury after the sessions, and might have been related to her loss of all tangibles during her long hospitalizations and foster care/neglect

Needs and Risks Resource: Potentially Contraindicated Procedures (e.g., procedures needing special care before implementation)

Potentially Contraindicated Procedures

It is recommended to request specialty provider input, rule out medical contributions, and document risks related to, these procedures when these behavioral or situational factors are present.

Clusters of Risk Factors	Related items in SAFE-T Checklist	Behavioral procedures or protocols that may require special care
Previous food insecurity, food related abuse or neglect, and/or severe food deprivation; or feeding related issues	**Possible behavioral factors include**: C16, C17, C18 (eating much less or more than others, or eating out of garbage) **Possible situational factors include**: F28 (food insecurity); F29 (starvation), F13 (e.g., life disrupted due to immigration or war; could be risk factor for food insecurity), F30 (food related abuse or neglect)	• Feeding treatment • Non-removal of spoon • Pairing appropriate behavior with food delivery/ Making food delivery contingent on appropriate behavior • Edible related preference assessments
Previous sexual abuse; Medical complications from sexual or physical trauma (could include incontinence, fecal smearing)	**Possible behavioral factors include:** C2, C11, C27, C28, C29 (sexual play behavior, sexual depictions, sexual aggression to others); C30 and C30 (in some cases smearing feces and/or toileting disruption may be related to physical or medical challenges after sexual abuse or physical trauma **Possible situational factors include**: Experiencing sexual abuse (FA5) or multiple instances of sexual abuse (F9)	• 1:1 support without oversight or additional precautions • Toileting procedures (toilet training) • Certain physical prompting procedures
Previous neglect or adverse circumstances (deaths of parents, removal from unsafe conditions, war, immigration or poverty related issues)	**Behavioral factors**: Person shakes (D33), freezes (E32), or there's developmental disruption around caregivers (E9) **Situational factors**: FA2 (parent an alcoholic or addicted to substances, or child was present	• Attention related extinction • Differential reinforcement of appropriate versus inappropriate requests

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

Note: ACE stands for Adverse Childhood Experiences

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

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

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

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

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

After trauma, our client is still…

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

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After trauma, our client may…

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

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

Take special care with…

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

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BRIEF REVIEW OF OBJECTIVE 1

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Contraindicated procedures may be

1

- Those that are not individualized
- Those that a risk versus benefit analysis suggests are risky
- Those that fail to take historical (and trauma related, but this could include medical) variables into account
- Those that could worsen behavior given someone's history
- Those that condition people (caregivers, educators) as aversive
  - Or that depend on a positive history between adults and students (without regard to how this may be absent for our client)
- Those that rely on consequence related procedures when the delivery – and WITHOLDING- of consequences would only increase punishment for a client
- ***Those that are not helpful at FIRST but that are able to be faded in later with careful planning and after data indicates it will be helpful***

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OBJECTIVE REVIEW

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2

2. Identify at least two tools to enhance behavior support practices with people affected by trauma, with specific histories presented in case studies.

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LEARNING OBJECTIVES

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Why both resources *and* tools?

- A resource is something that you have that you can use, like a supply of something, an ability, a place that provides something useful, or a thing.
  - Resources could include things like your own skillset- such as your set of leisure skills, your own array of reinforcement alternatives, your cognitive flexibility and noticing skills.
- Tools are more specific: a device that aids in accomplishing a task; a means to an end; something necessary in your profession
  - Tools we'll discuss today are the checklists and templates (etc) used at specific times in my practice
- Adapted from Resource Definition & Meaning - Merriam-Webster

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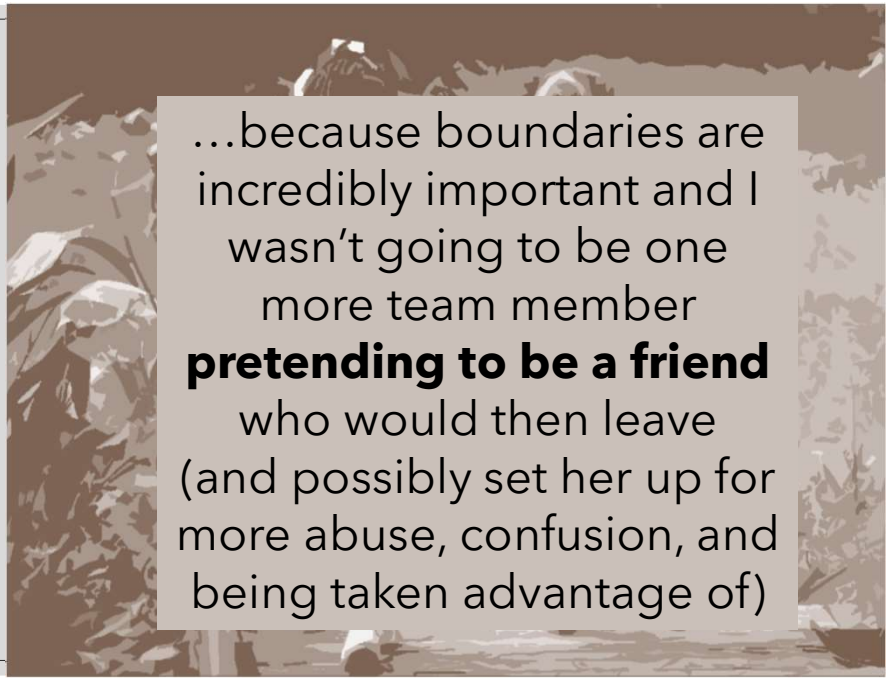
For Aniyah…

As much as her therapists enjoyed being around her, and as awesome as friends are…

We did NOT…

- Act like her friend

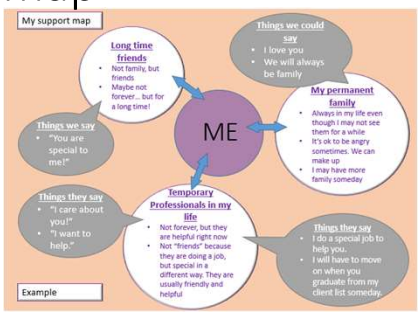


…because boundaries are incredibly important and I wasn't going to be one more team member **pretending to be a friend** who would then leave (and possibly set her up for more abuse, confusion, and being taken advantage of)

But how did we get there?
Tool: The client role map

This role map is a tool to help staff:

- Remind staff and other roles what things are helpful/ not helpful to do with client



It is also used to help the client:

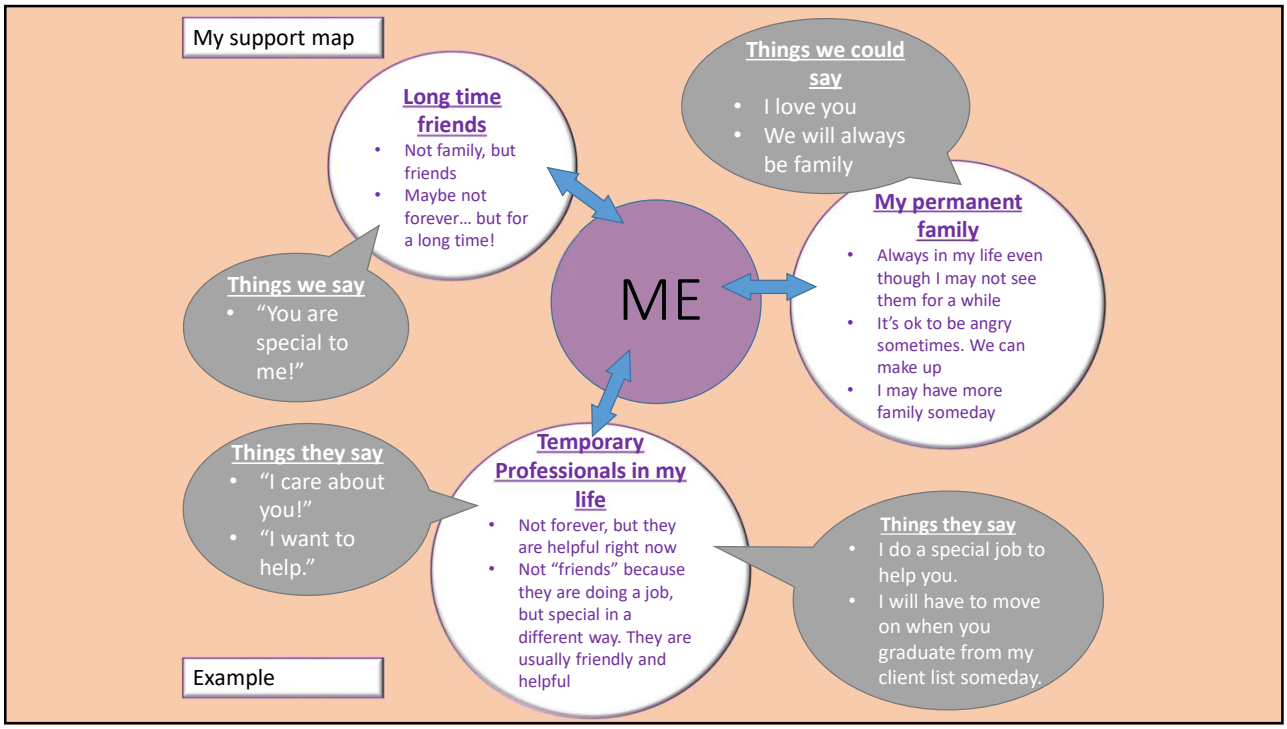
- With skills including: See face/state name; hear name/ select face;
- Provide discrimination training examples and practices for skills like:
  - Recognizing important people on their team
  - Stating person's role when they see their face or hear their name
  - Stating what the person does and does not do
  - Stating what the person might say (and should not do)

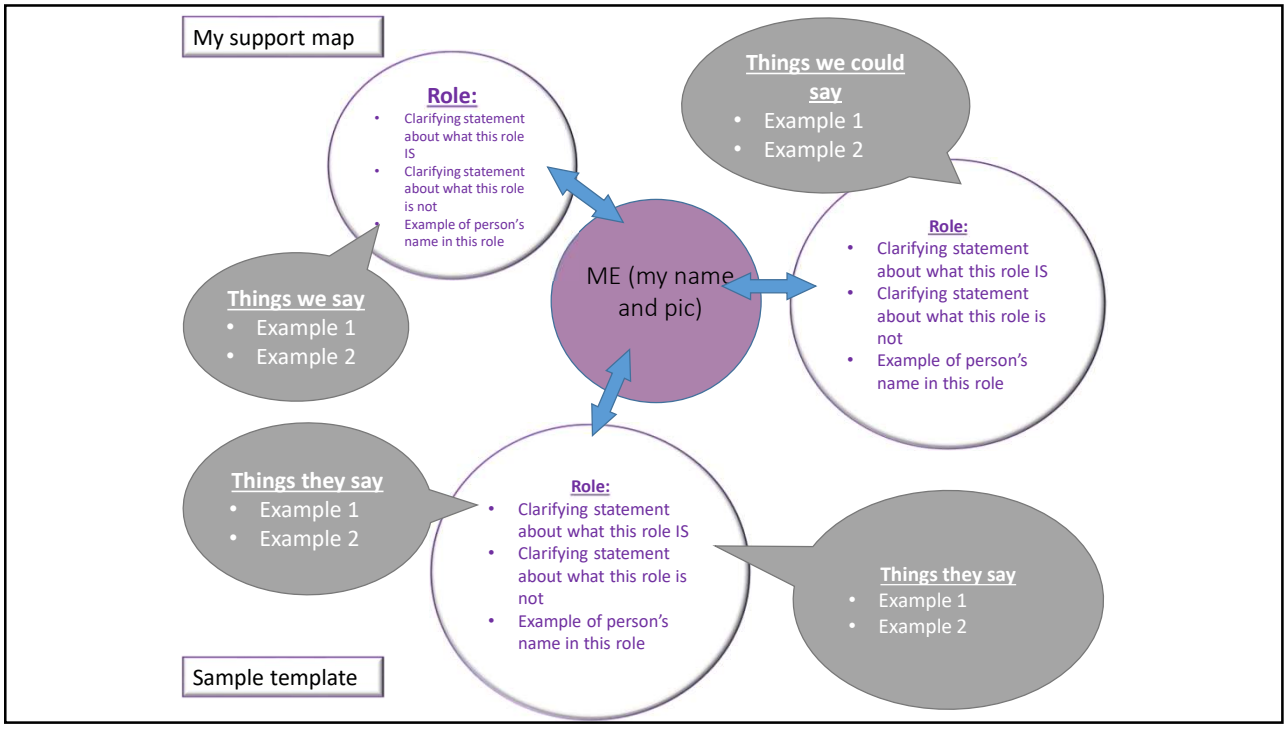
Prerequisite materials or skills may be helpful:

- Some clients and client teams may benefit when we list roles before we meet with the client, to get staff on same page first
- If there are specific boundaries that have been violated, teach the appropriate boundary using several examples and non-examples
- It might be helpful to practice "noticing" skills (ACT related skills to get calm, take deep breaths, notice surroundings) before using the tool

Notes for using the tool

- Before using, remind client (and caregivers!) it's ok to take a break or stop practicing the tool when needed
- We can practice the tool when things are calm
- It can be posted as a visual and referred to when calm
- Do all the above BEFORE **supporting** using the tool

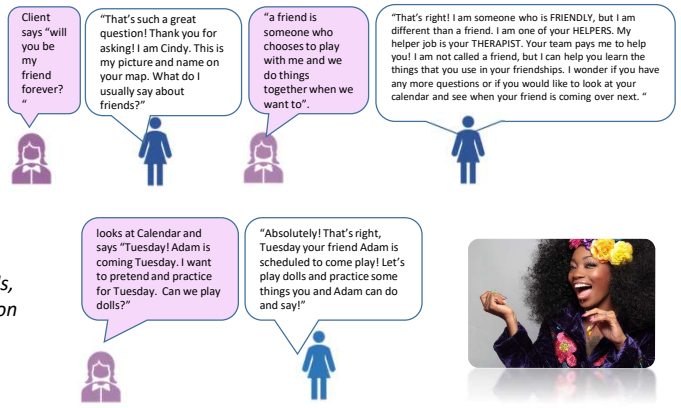

My support map
Long time friends
Not family, but friends
Maybe not forever… but for a long time!
Things we could say
I love you
We will always be family
Things we say
"You are special to me!"
ME
My permanent family
Always in my life even though I may not see them for a while
It's ok to be angry sometimes. We can make up
I may have more family someday
Things they say
"I care about you!"
"I want to help."
Temporary Professionals in my life
Not forever, but they are helpful right now
Not "friends" because they are doing a job, but special in a different way. They are usually friendly and helpful
Things they say
I do a special job to help you.
I will have to move on when you graduate from my client list someday.
Example


My support map
Role:
Clarifying statement about what this role IS
Clarifying statement about what this role is not
Example of person's name in this role
Things we could say
Example 1
Example 2
Things we say
Example 1
Example 2
ME (my name and pic)
Role:
Clarifying statement about what this role IS
Clarifying statement about what this role is not
Example of person's name in this role
Things they say
Example 1
Example 2
Role:
Clarifying statement about what this role IS
Clarifying statement about what this role is not
Example of person's name in this role
Things they say
Example 1
Example 2
Sample template

Example of **supporting client***, using the role map tool

** Note that this example is for a particular client, for whom these statements are developmentally appropriate and have been prefaced by skills assessment, acquisition and practice.*

The pictures, words, examples and lesson are adapted for individuals' needs.



TOOL

What about those pesky "I swear, it came out of the blue!" descriptions of behaviors?

Client:
Respondent:

INVENTORY of POTENTIAL AVERSIVE STIMULI and SETTING EVENTS (IPASS

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

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

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

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

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

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

And you remember Aniyah's Client At A Glance… this is a scaled back, lower-tech version on powerpoint (many teams find it helpful to try on google slides or an equivalent)

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Tool to share:

Client At A Glance

FRONT SIDE: About the client

PREVENTIVE TECHNIQUES

- ❑ **Be polite and respectful":** offer the best option but honor her appropriate requests.
- ❑ **Approach thoughtfully:** Be positive and friendly and smile.
- ❑ **Use momentum:** Give a compliment or use friendly small talk right before a request
- ❑ **Give options:** Use an approach that avoids open ended questions but embeds 2 alternatives
- ❑ **Come back and try again a little while later** if she politely refused earlier today but you still need to get

Meals (Client is diabetic but used to selecting food from a diabetic friendly menu)

- ❑ "Almost time to eat. Let me know if you want to sit in the dining room or computer room!"
- ❑ "Today we are having meatloaf, mashed potatoes and rolls. Does that sound good or would you rather check out this grill menu"
- ❑ "Here's your food. Let me know if there's anything else you need"

Showering/ Hygiene

- ❑ "Time to get clean and dressed up for the piano group! I can help do your hair after we get the shower done. Let's take a walk together and figure out which one you want to use today"
- ❑ (If "I don't want to shower": "Thanks for letting me know. We can clean you up in your room. Does it sound best before breakfast or before lunch?" (before lunch) "ok, I'll see you around 11!")

Meds and Medical Procedures

- ❑ "Time for lunch! (while showing her the needle) Let's get your blood sugar; show me which finger you want to use today."
- ❑ "Ooh, I love these flowers! Your room smells so nice. Time for meds, you can take _ or ___ first."
- ❑ I hear you that you wish you didn't have to take these meds. This is one the court says is important for your health and safety so you need to take it. You can take it now or I'll come back in 10 minutes.

Behavior notes

Honor refusals that are appropriate and safe (Examples: "I don't want to take these today"; "I don't want to talk about ___"; "I'm not hungry right now"; "No thank you" (the first time a med is offered)

If behavior escalates

1. Record signs of behavioral escalation and/or mental health symptoms: Using derogatory words; Higher voice volume; Refusing meds for more than 1 day; Talking about delusions/ hallucinations more often
2. Contact Mental Health provider and notify them
3. Continue to use preventative language, honoring any APPROPRIATE refusals/requests
4. Start unsafe refusal protocol

UNSAFE REFUSAL PROTOCOL (An unsafe refusal means she is refusing something and being unsafe (using unsafe behavior to staff including hurting someone, threatening or breaking things) OR refusing something that is medically necessary (refusing to take court ordered meds)

1. **Follow all preventative procedures and if possible, re-approach later with respect and options**
2. **Contact _____ and let (name) know what is happening: (email: ____ and phone: _____)**
3. **Call to inform _____(hospital name) Behavioral health unit**
4. **Call crisis unit at _____ and explain problem. If they cannot come out:**
5. **Call 911 and provide letter to emergency responders**
6. **Keep guardian (name, phone) informed**

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Tool to share:

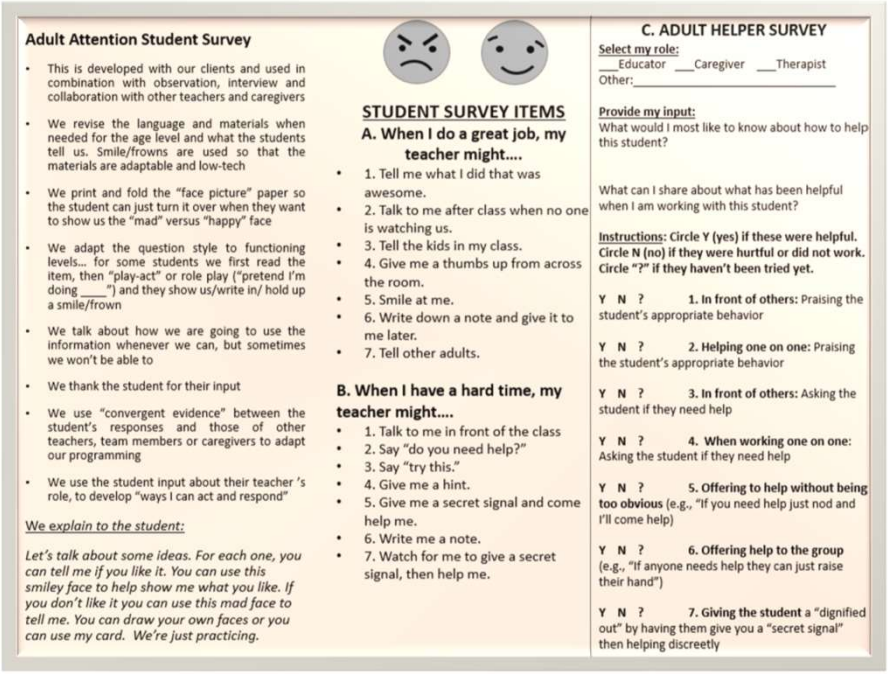
Client At A Glance

FRONT SIDE: About the client

BACK SIDE: About the plan

TOOL

Aniyah sometimes seemed to love attention. But delivered in the "wrong way" could really set her off…



Adult Attention Student Survey

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

We explain to the student:

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

STUDENT SURVEY ITEMS

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

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

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

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

C. ADULT HELPER SURVEY

Select my role:
___Educator ___Caregiver ___Therapist
Other:_____

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

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

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

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

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

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

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

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

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

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

Tools

What about when we don't have information on what trauma the student experienced? Can we still be trauma-informed? Look at all the tools we could use…

- **IPASS and Adult Attention Preference Survey**
- **SAFE-T Screening**
- **SAFE-T Assessment*** to learn more (a LOT more- 200 items)
- **Buffers Score**
- **Risks versus benefit (RVB)** and risk mitigation plan templates (see examples in this presentation)
- **TIBA BIP**
- **TIBA FBA**

*SAFE-T Assessment is the only tool not available free (due to the extensive training required- comes only with 4.5 CEUs and a booklet of resources)

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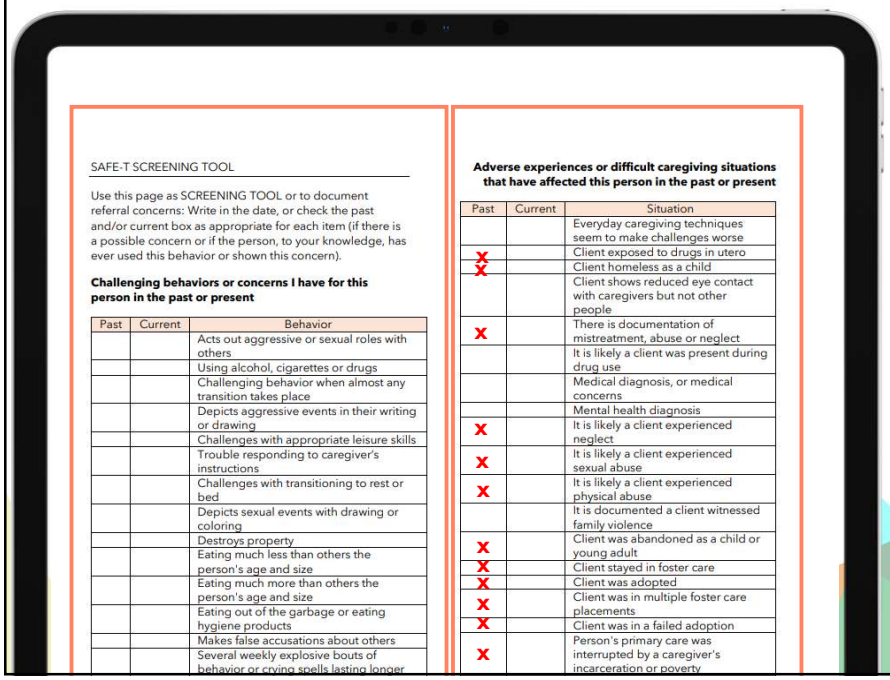

SAFE-T SCREENING TOOL

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

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

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

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

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

PART 1
SAFE-T Screening Tool

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

SCREENING FOR TRAUMA MAY BE HELPFUL FOR STAFF TOO!

- Identify with each other
- Identify with students
- Do values work
- Make individual brief support plans for staff (when do I need a break? What are some supportive things I do to calm down when working with really difficult student situations? What if I need to tap out and just take a moment? Etc)

TIPS and BIPS

Trauma Indicator Possibilities Screening (TIPS) and Buffering Item Possibilities Score (BIPS) *(NOTE: This is **NOT** an assessment or verification of trauma. It is only a tool to help a team look at factors indicating a person MAY need further support.)*

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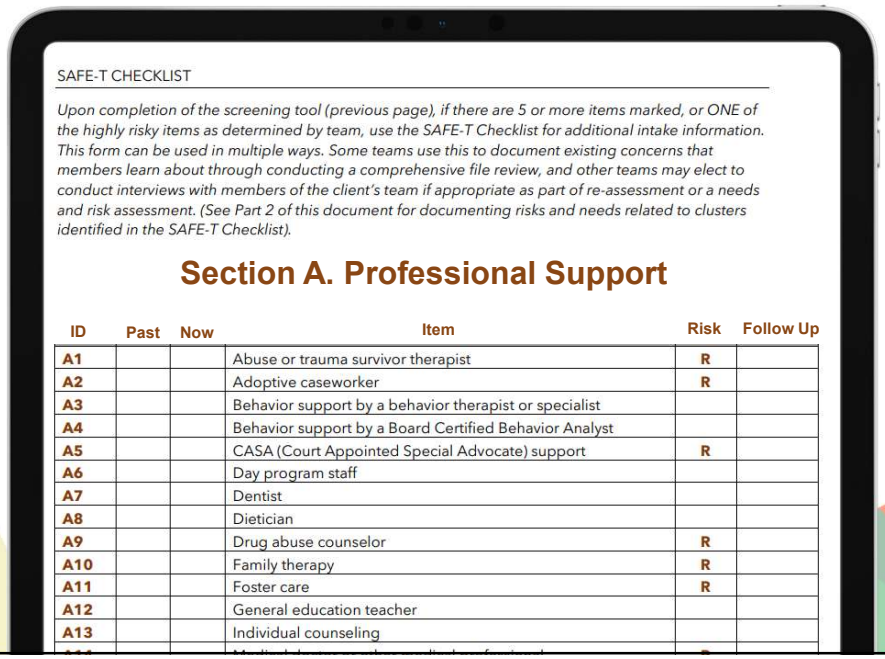
SAFE Staff: Screening tool for possible trauma indicators in staff or team members. NONE of these items is meant to judge a behavior as wrong, detect or diagnose trauma or any other concern on the part of staff or clients, but to assist teams with supporting their members and clients (could include areas such as training, emotional support, mental health support, or additional expertise, etc).

Y/N	Concern experienced by staff
	Client harm: Has witnessed clients harming themselves
	Client harm: Has witnessed clients harming other clients
	Client harm: Has witnessed clients harming staff or team members
	Client harm: Has been harmed by a client's physical actions
	Restraint: Has been involved in administering physical restraint
	Restraint: Has been involved in administering physical restraint in which someone else was injured
	Sexual trauma: Works with client who has experienced sexual trauma was experienced
	Property Destruction: Has had personal

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

Y/N	Situation experienced by staff
	Has experienced trauma in their own childhood – between 1 and 4 events
	Has experienced trauma in their own childhood – 5 or more events
	Has experienced housing or food insecurity as an adult
	Has experienced job, transportation, or financial insecurity as an adult
	Has family members with medical concerns at present

WHAT ABOUT WHEN SCREENING'S NOT ENOUGH?



SAFE-T CHECKLIST

Upon completion of the screening tool (previous page), if there are 5 or more items marked, or ONE of the highly risky items as determined by team, use the SAFE-T Checklist for additional intake information. This form can be used in multiple ways. Some teams use this to document existing concerns that members learn about through conducting a comprehensive file review, and other teams may elect to conduct interviews with members of the client's team if appropriate as part of re-assessment or a needs and risk assessment. (See Part 2 of this document for documenting risks and needs related to clusters identified in the SAFE-T Checklist).

Section A. Professional Support

ID	Past	Now	Item	Risk	Follow Up
A1			Abuse or trauma survivor therapist	R	
A2			Adoptive caseworker	R	
A3			Behavior support by a behavior therapist or specialist		
A4			Behavior support by a Board Certified Behavior Analyst		
A5			CASA (Court Appointed Special Advocate) support	R	
A6			Day program staff		
A7			Dentist		
A8			Dietician		
A9			Drug abuse counselor	R	
A10			Family therapy	R	
A11			Foster care	R	
A12			General education teacher		
A13			Individual counseling		

PART 1
SAFE-T Checklist with ACES

- Complete if needed
- 200 items
- 6 Domains

See Code item 2.15: "continually evaluate and document the effectiveness of restrictive or punishment-based procedures"

COMMUNICATING ABOUT RISKS

10-Step RVB
(Sample Items in Risk Versus Benefit Analysis Template)

Introduction

1. Overview of the document
2. Primary question the team is asking **(or decisions, procedures, or targets being considered)**
3. List of options being considered or potentially available, or list of risks and concerns being addressed, and options you have in addressing them

Option analysis

4. Describe Option A
5. List all potential risks given Option A (long-term risks, short-term risks; include section for each RISK TARGET
6. List of potential benefits given Option A
7. Summary statement of risks for Option A

(Repeat option analysis (Steps 4-7) for options B, C, D, etc)

Conclusions

9. Additional concerns or notes
10. Overall recommendations for Risk Versus Benefit Analysis (e.g., if person(s) preparing the analysis recommends one path over another)
11. Team input and signatures

Basic Risk Mitigation Report Template

Info

- Client:
- Team members:
- Problem this plan is addressing:
- Date the RVB was reviewed with team:
- Option the team selected:

Plan

- Risk(s) addressed by this option:
- Actions required to mitigate this risk:
- Person(s) responsible for actions:
- Additional resources required:
- Date to be completed:

Team communication

- Team initials for Risk Mitigation Plan (includes statement of agreement or nonagreement with plan, and place for each member to add input)

Some Features of a Trauma-Informed FBA

Examples of supportive timing for delivering key stimuli on preventive schedules (NCR, FT schedules)

Behavioral descriptions of adverse conditioning experiences and trauma related stimuli

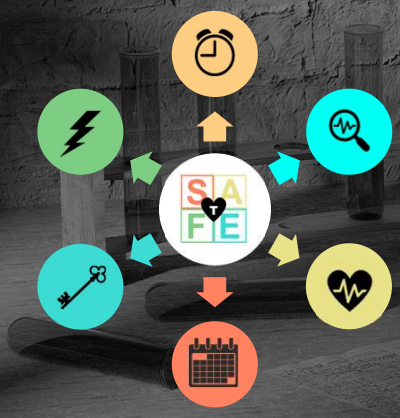
Past and historical functions of the person's challenging behaviors

List examples of triggering environmental events and how person responds

Document medical or physiological contributions to trauma-related events

Describe important past or present schedules and how person was affected
(e.g., what time of year a tragedy occurred, or what holidays or times of day, month or year are most difficult and why)

Some Features of a Trauma-Informed FBA



Possible Appendices

Referral documentation; description of social network of client and team; letters to police, administrators or medical staff describing important preventive interactions (NCR, FT schedules)

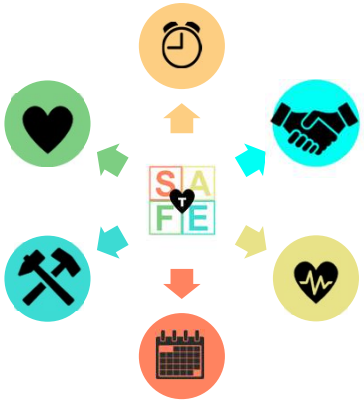
Risk versus benefit analysis for options being considered; risk mitigation plan addressing option(s)

Possible Features of a Trauma-Informed Behavior Plan

Time-In is scheduled as an antecedent strategy with preferred people. High-level attention is not contingent on acting out but regularly scheduled. Preventive check-ins are used and scheduled based on data.

There is a **designated safe person** who will start and regularly practice check ins at a safe place. Descriptions are in plan, to help safe person continue to foster the relationship.

Procedures and activity schedules are included that **target appropriate repertoire development**. May include AIM, PEERS, TAPS, ACT skills, behavioral activation, IISCA, etc; add **buffering items*** to plan if not already present

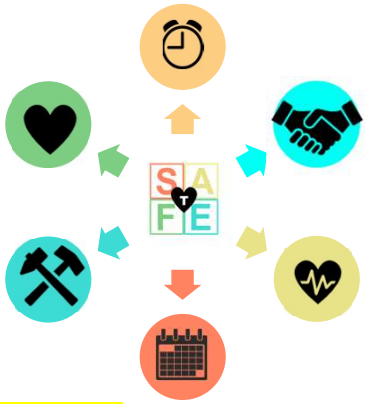


Relationship building procedures present for regular people in student's life. Primary caregivers/educators receive training (strengthen approach, neutralize aversive interactions, address needs). Adult attention preferences are assessed/ described.

If **medical factors** were part of FBA results, provide behavior plan recommendations in 3 areas: Communication, behavior, and training.

Preventive procedures for times of day, month, year, etc that team will be addressing historically difficult times. Team practices these in advance. If there is going to be a substitute, there are clear visual aids and videos or brief trainings.

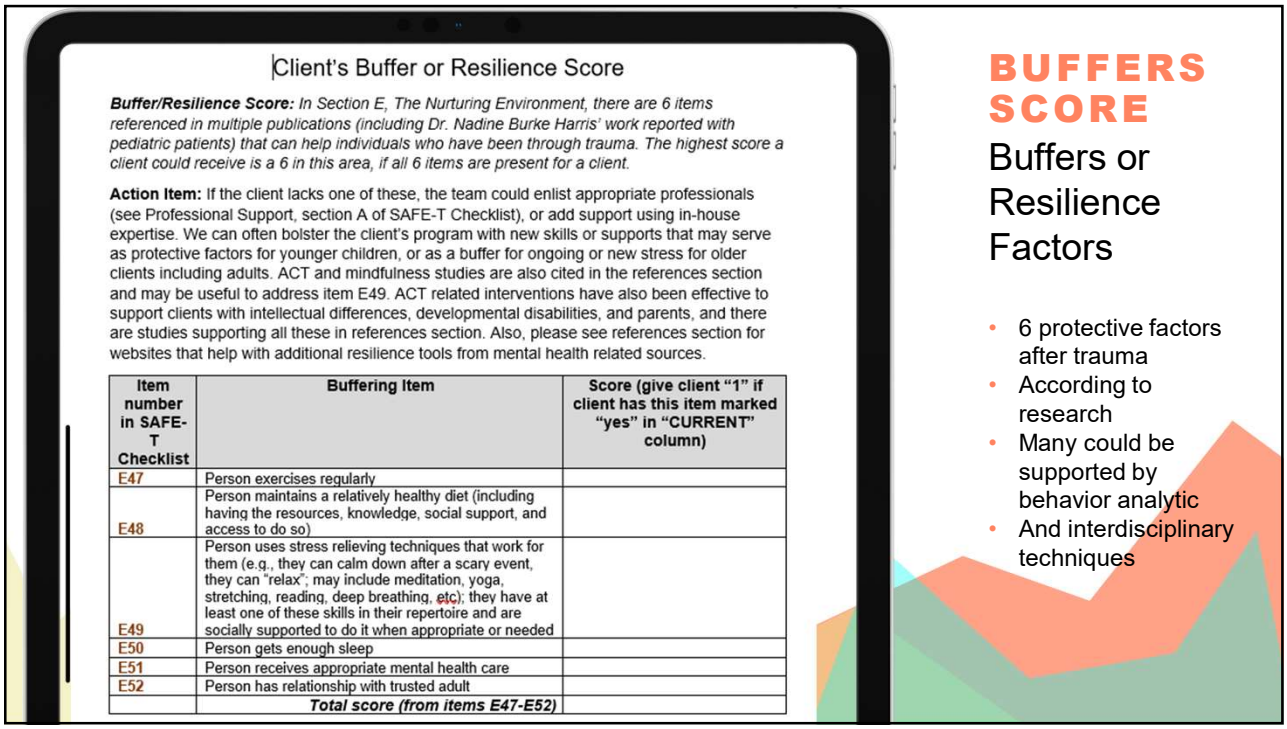
Possible Features of a Trauma-Informed Behavior Plan



**Buffering items are the 6 components that Nadine Burke Harris (2017) and others suggest can protect AFTER trauma; include adequate exercise, sleep, nutrition; good relationship; stress relieving skills; and mental health support*

Notes on procedures that target appropriate repertoire development:

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



Client's Buffer or Resilience Score

Buffer/Resilience Score: *In Section E, The Nurturing Environment, there are 6 items referenced in multiple publications (including Dr. Nadine Burke Harris' work reported with pediatric patients) that can help individuals who have been through trauma. The highest score a client could receive is a 6 in this area, if all 6 items are present for a client.*

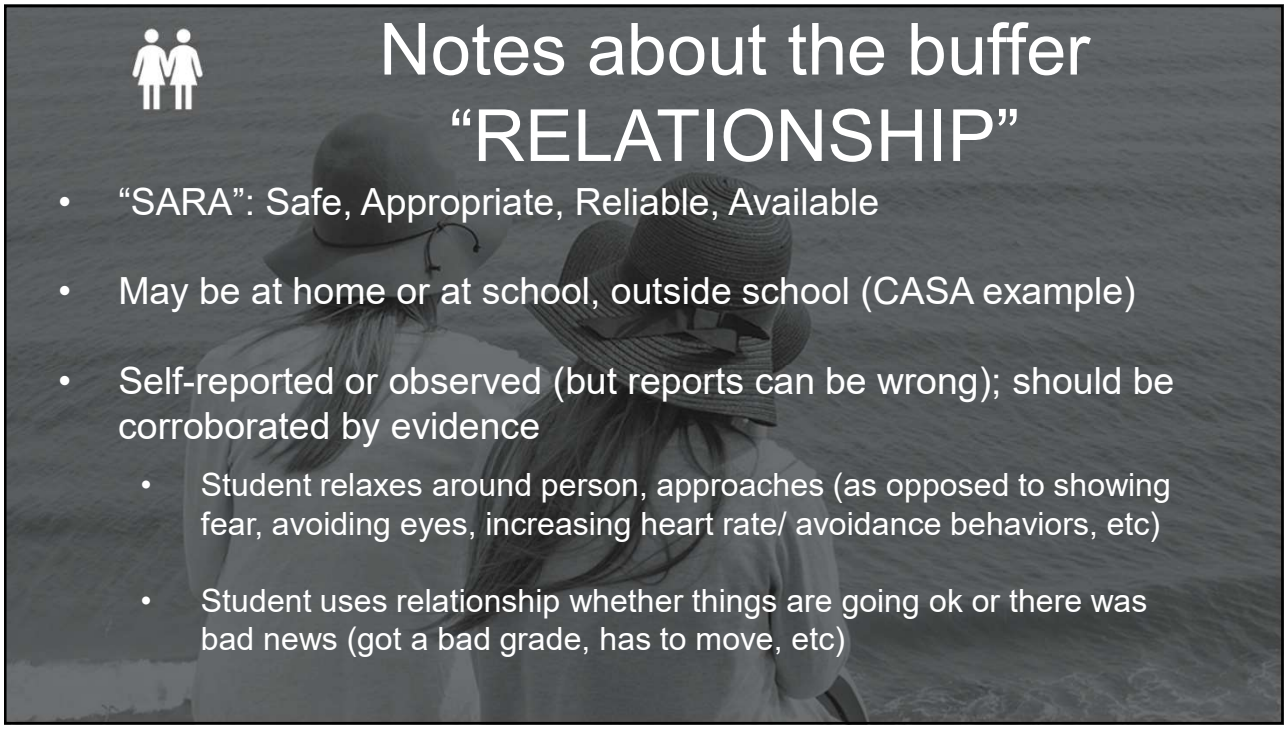
Action Item: If the client lacks one of these, the team could enlist appropriate professionals (see Professional Support, section A of SAFE-T Checklist), or add support using in-house expertise. We can often bolster the client's program with new skills or supports that may serve as protective factors for younger children, or as a buffer for ongoing or new stress for older clients including adults. ACT and mindfulness studies are also cited in the references section and may be useful to address item E49. ACT related interventions have also been effective to support clients with intellectual differences, developmental disabilities, and parents, and there are studies supporting all these in references section. Also, please see references section for websites that help with additional resilience tools from mental health related sources.

Item number in SAFE-T Checklist	Buffering Item	Score (give client "1" if client has this item marked "yes" in "CURRENT" column)
E47	Person exercises regularly	
E48	Person maintains a relatively healthy diet (including having the resources, knowledge, social support, and access to do so)	
E49	Person uses stress relieving techniques that work for them (e.g., they can calm down after a scary event, they can "relax"; may include meditation, yoga, stretching, reading, deep breathing, etc); they have at least one of these skills in their repertoire and are socially supported to do it when appropriate or needed	
E50	Person gets enough sleep	
E51	Person receives appropriate mental health care	
E52	Person has relationship with trusted adult	
	Total score (from items E47-E52)	

BUFFERS SCORE

Buffers or Resilience Factors

- 6 protective factors after trauma
- According to research
- Many could be supported by behavior analytic
- And interdisciplinary techniques



Notes about the buffer "RELATIONSHIP"

- "SARA": Safe, Appropriate, Reliable, Available
- May be at home or at school, outside school (CASA example)
- Self-reported or observed (but reports can be wrong); should be corroborated by evidence
  - Student relaxes around person, approaches (as opposed to showing fear, avoiding eyes, increasing heart rate/ avoidance behaviors, etc)
  - Student uses relationship whether things are going ok or there was bad news (got a bad grade, has to move, etc)

LIST OF TOOLS

(ARRANGED FROM TOP TO BOTTOM, LOOSELY IN ORDER OF GREATER INTRUSIVENESS AND ORDER I USE THEM)

Client-focused

- Client-At-A-Glance
- Role Map
- Adult Attention Preference Assessment
- I-PASS
- SAFE-T Assessment

Staff-focused

- 10-step Risk versus benefit
- Risk mitigation plan (see template)
- Trauma-informed FBA, BIP templates

Great for both

- TIPS and BIPS (trauma indicator possibilities screening/ buffer possibilities)

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3

3. State at least three features of multidisciplinary case studies in which behavior analytic procedures are supportive components after trauma.

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LEARNING OBJECTIVES

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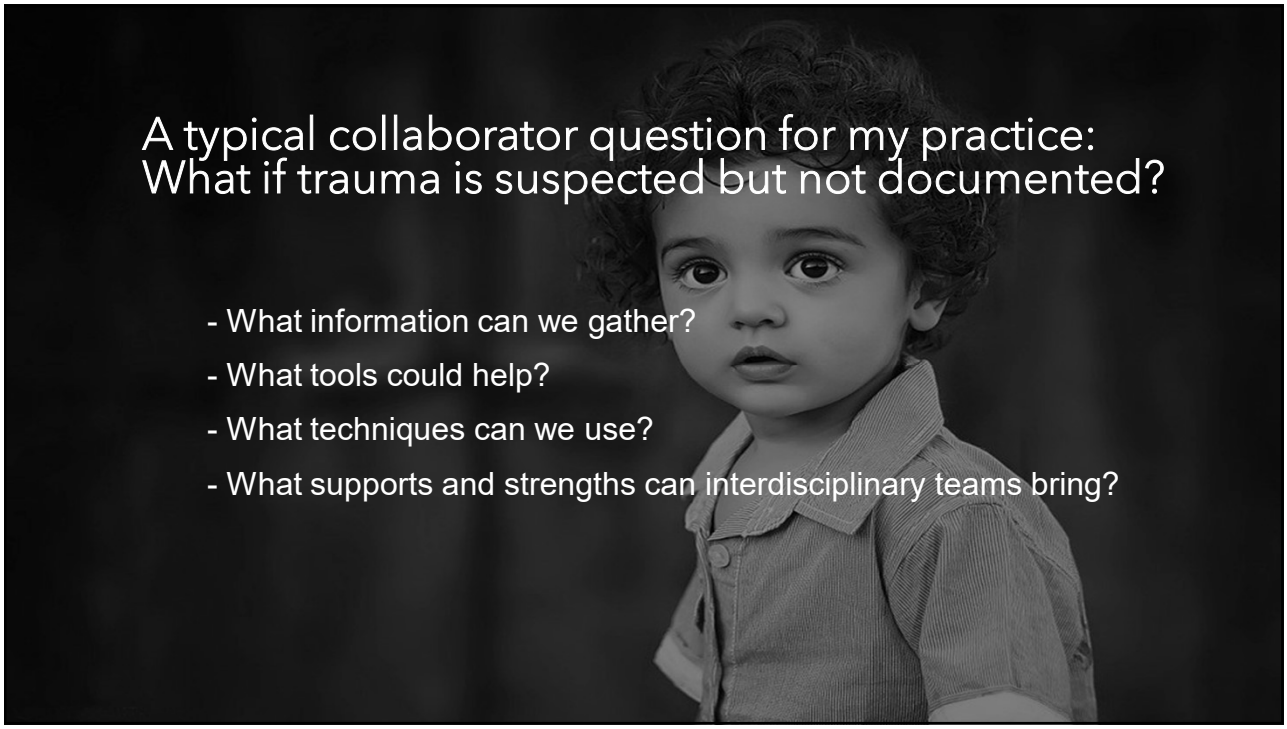

3

- Administrative (and systems) support is present
- Each person participates regularly, not reactively
- Expertise, and also clinical oversight, is valued
- Input is requested and shared regularly
  - This helps risks to be shared, documented and discussed preventively
- Tools are used to facilitate collaboration and cohesion (pulling all the information about the client's background into the forefront, if and when appropriate, to be integrated in FBAs, then plans, and then in support plans)

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Features of cases in which behavior analytic procedures are supportive components of support after trauma

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HELPFUL INFORMATION TO GATHER

- What does the person avoid or find difficult? (consider **IPASS** for sensory stimuli; **attention preference survey** for attention)
- Which times of day/week/year/month are difficult?
- Information about behavior (if lots of potentially trauma related behavior, consider **screening tool**)
- Information about buffers/ preventive factors (**consider BIPS to screen for protective factors**)
- Information about what is not working (some cues might be: parenting/caregiving techniques not working; praise causing adverse reaction; prompting results in emotional responding
- Information about the response itself (signs of conditioned responses to stimuli, non-operant behavior)
- Clues about situations without knowing the details (e.g., we know a child went through several foster placements, or was adopted and given back, or has a parent with multiple challenges)
- How are the team interactions affecting the person? **Are we contributing to problems without knowing it? Can we turn those into prevention opportunities instead?**

What supports and strengths can interdisciplinary teams bring?

- Information about goals we need to target, but could miss because of our lack of expertise/ experience
- Supports from a systems perspective
- Listening and valuing all perspectives / a different perspective
- Naysayers often bring a very important group of risks to consider in the risk versus benefit analysis, but these may be dismissed as “worries or concerns that don’t apply to us” if we don’t
  - Make a time to ask for them
  - Show we value them
  - Hear from everyone
  - Document them
  - And act on them

What supports and strengths can interdisciplinary teams bring? A few examples from my practice:

- **OT**: sensory differences; ways to design supportive sensory environments, assess sensory needs and challenges, look at pain threshold
- **Mental health and social workers**: safe place to hold the trauma- practice safe routines when it's not a challenging time; teach all team members how to support client in a crisis without re-presenting triggers; help differentiate whether a difficulty with mental health is part of a learning difference; help us learn about the client's past
- **SLP**: teach us to design communication and speech/ language goals related to self advocacy needs the student may have after trauma- honor the person's communication attempts, meet them where they are- bring in technology to help minimize the effort a student has to exert during a difficult situation – buttons, sentence strips, visuals, etc
- This works when we view each other as complementary pieces of the concerted effort to help the person after trauma.

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How can behavior analysis and trauma-informed approaches complement one another?

When we collaborate, we….

- ❑ Take into account more history (more contextual variables) that affect our client's behavior
- ❑ Provide better systems support
  - ❑ Arrange supportive environments and schedules for meetings
  - ❑ Get more input from caregivers and team members
  - ❑ Collaborate (e.g., police officers, social workers, CASA, guardians ad litem)

How can behavior analysis and trauma-informed approaches complement one another?

When we collaborate, we…

- ❑ Document and communicate about risks more robustly
- ❑ Consider respondent, medical, biological contributions more
- ❑ Reveal and address more sources of distress for our clients

Before:

- - Aniyah's principal only came in when things were pretty out of hand.
- - He calmed her down, but disrupted the class.
- - He only came to meetings when the advocate and lawyer were planning to show.
- - His "reactive approach" contributed to escalating behavior over time although suppressing it for a few weeks.
- - This was particularly true for Aniyah with rare interactions with higher level attention providers (police, principal, security guards) that were contingent on unsafe behaviors used after neglect history

After: Preventive meeting scheduling

Hint: Even if a particular team member's participation is much lower-frequency,

- We can implement this strategy
- By scheduling their involvement IN ADVANCE
- Even if it's once a year, it's still
  - Planned,
  - paired with planning,
  - and supportive

At this kind of meetings we might:

- Talk about "plans to restore" for any restricted environment, or procedure
- Talk about roles and supports, assigning duties for next months
- Discuss appropriate behaviors and skills/needs, not just solve problems
- Document our conversation, distribute notes to all, thank everyone, and follow up

2.10 Collaborating with Colleagues Behavior analysts collaborate with colleagues from their own and other professions in the best interest of clients and stakeholders. Behavior analysts address conflicts by compromising when possible and always prioritizing the best interest of the client. Behavior analysts document all actions taken in these circumstances and their eventual outcomes

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After:

- - NCR visits scheduled with principal/ client
- - FT visits from principal to meetings
- - Client planned with principal on calendar
- - Staff used less reactive/ emotional behaviors in meetings in front of their principal
- - Principal participated in learning list of "topics to bring up/ avoid in front of student"
- - Said he felt like part of the team and brought in additional training without us begging!

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After:

WE recognize it's our job to *teach administrators how*

- *- and why*
- *- THEY can*
- *- and need to support us*
- *- in ways they may not have realized*
- *- or been empowered to do*

Special thoughts for administrative team members:

- **Support the team**! Back up team members who need to insure our ethics are followed and team's needs are met:
- **Protect time and space** (and pay team members) for meetings
- **Follow guidelines** set to protect the client (e.g., if there's a program that asks that attention not be provided after certain events, or insure that attention IS provided regularly, try to be a part of it, be the change you want to see, not the one disruptive team member)
- **Follow guidance or team leadership** that gives pointers on how to speak to and about a client, or a parent/guardian, in their presence; know what behaviors to bring up (mention) in their presence, and topics to avoid (if the team doesn't give you guidelines on this, ask- and team members, ask a leading member to MAKE guidelines to distribute)

Special thoughts for administrative team members: *More on following clinical guidance*

- **Honoring** everyone's need to provide input
- **Making medical recommendations** even when those are not followed
- **Establishing and honoring boundaries:** Sometimes we need to draw a line in the sand (pause a certain treatment or something that is not safe to continue without knowing more, or getting someone training, or getting someone resources)
- **Connecting** us to other resources: If you can't facilitate training, but team desperately needs it to treat this new unsafe behavior or to understand this student, please honor expertise that is requesting that, and connect us to someone else who can help
- **Working with the community:** Grow and work relationships (you won't always have everything in house, but you may be able to facilitate a connection)

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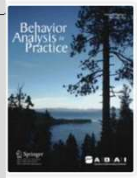
Ethics and Supervision topic: Collaboration

2.10 Collaborating with Colleagues
Behavior analysts collaborate with colleagues from their own and other professions in the best interest of clients and stakeholders. Behavior analysts address conflicts by compromising when possible and always prioritizing the best interest of the client. Behavior analysts document all actions taken in these circumstances and their eventual outcomes

How do we supervise team members toward effective collaboration?



Volume 9, issue 4, December 2016

15 articles in this issue

Refining Supervisory Practices in the Field of Behavior Analysis: Introduction to the Special Section on Supervision

Linda A. LeBlanc & James K. Luiselli

Special Section: Supervision Practices | Published: 28 October 2016 | Pages: 271 - 273

Recommended Practices for Individual Supervision of Aspiring Behavior Analysts

› Behav Anal Pract. 2018 Sep 20;12(3):654-666. doi: 10.1007/s40617-018-00289-3. eCollection 2019 Sep.

Compassionate Care in Behavior Analytic Treatment: Can Outcomes be Enhanced by Attending to Relationships with Caregivers?

Bridget A Taylor [1], Linda A LeBlanc [2], Melissa R Nosik [3]

Affiliations + expand

Some critical multidisciplinary team members for Aniyah

Do you have these counterparts in your schools? Who else should be here?

Educational occupational therapist: Functioned as "safe person" on team

School psychologist: Assisted team to understand "triggers" and relationships to trauma

Behavior Analyst: Helped teachers document "behaviors out of the blue", develop trauma-informed FBA (assessment) and implement TIBA strategies in the classroom

Principal: Followed preventive plan to visit Aniyah when things were going WELL, not just "reactively", following Behavior Plan

Social worker: Helped provide information on A's past so that the team could move beyond guessing what she had been through and actually use information in plans

Residential counselor: Performed "daily staff" duties while A. waited for a foster home, communicated with school daily and informed them when things were rough at home to help educators prepare for the day and be even more preventive

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When we consider ACES from a collaborative perspective…

We ask our teams:

- Do we all have the same definition for ACES?
- Do some team members disagree on whether ABA provides a helpful approach?
- How do we show them we care about and listen to their concerns… and still implement what we feel is responsible for our clients?

2.15 We truly start to minimize risk of Behavior-Change Interventions

Behavior analysts select, design, and implement behavior-change interventions (including the selection and use of consequences) with a focus on minimizing risk of harm to the client and stakeholders. They recommend and implement restrictive or punishment-based procedures only after demonstrating that desired results have not been obtained using less intrusive means, or when it is determined by an existing intervention team that the risk of harm to the client outweighs the risk associated with the behavior-change intervention. When recommending and implementing restrictive or punishment-based procedures, behavior analysts comply with any required review processes (e.g., a human rights review committee). Behavior analysts must continually evaluate and document the effectiveness of restrictive or punishment-based procedures and modify or discontinue the behavior-change intervention in a timely manner if it is ineffective

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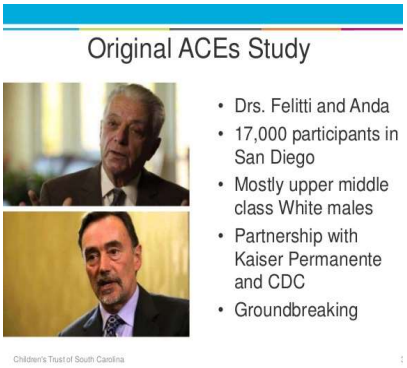
Typically,
A = Adverse
C = Childhood
E = Experiences

You probably recognize the acronym "ACEs"…

- ACEs study grew out of Felitti's obesity research
- The effect of ACEs on "negative health outcomes" was dose dependent
- Individuals with 4+ ACEs more likely to have chronic bronchitis or emphysema, strokes and/or heart disease, hepatitis or jaundice, and skeletal fractures, and much more
- Many identified "negative outcomes" of ACEs exposure were behavioral, not purely medical
  - lack of healthcare utilization
  - suicide attempts
  - alcoholism, use of illicit drugs, injection of illicit drugs, 50+ sexual partners, etc



https://www.slideshare.net/ChildrensTrustofSC/building-community-resilience-and-wellbeing-using-ace-data?qid=b1f4672d-2bf6-4508-8277-f03b7438d1b7&v=&b=&from_search=1

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Typically,
A = Adverse
C = Childhood
E = Experiences

But what if we assessed for "adverse and aversive conditioning experiences", As well as adverse "childhood experiences"?

Aversive, not just "adverse" experiences (because we care about experience with an adverse outcome, not just the "feeling" of whether something is good or bad, or whether an individual approaches or avoids related stimuli)

Conditioning, not just childhood, because adverse conditioning experiences can plague an adult too (think of PTSD after adult experiences)

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- It is often thought of as something done "on purpose" (and if we're not DOING it, we often IGNORE it)
- But we forget that a lot of what we THINK is positive, even "best practice", is actually aversive because of someone's history
- **So we're accidentally subjecting them to coercion and aversive control without realizing it**

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How do the non-behavior team members *feel* when a student does not behave as expected?

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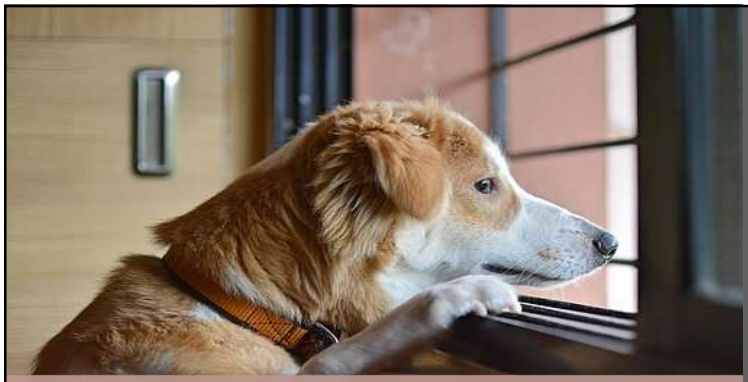
- Scared/ afraid?
- Anxious?
- At risk of "being traumatized" ourselves?
- Under-resourced?
- Worried for the student?
- Frustrated at loss of educational time when behavior problems occur
- Sympathetic for students around the individual
- Confused about why this is happening (especially in an ABA environment where the team tried really hard to identify the function)



After doing reunification work with families whose children had been removed after abuse or neglect, observed disruption in stimulus schedules (e.g., the child suddenly interacted with typical childhood stimuli differently)

Example: In response to adult praise, or a caregiver137 instruction, or a dog walking by, there were suddenly

- Explosive tantrums
- Aggression to pets
- Going into a bathroom and smearing feces everywhere
- Or taking food out of the trash and eating garbage

NOTE: These were children who were previously doing well (that is why the reunification process had begun)

Even if it's not medical and obvious, knowing trauma has occurred (or even knowing a child is behaving as if it has)…

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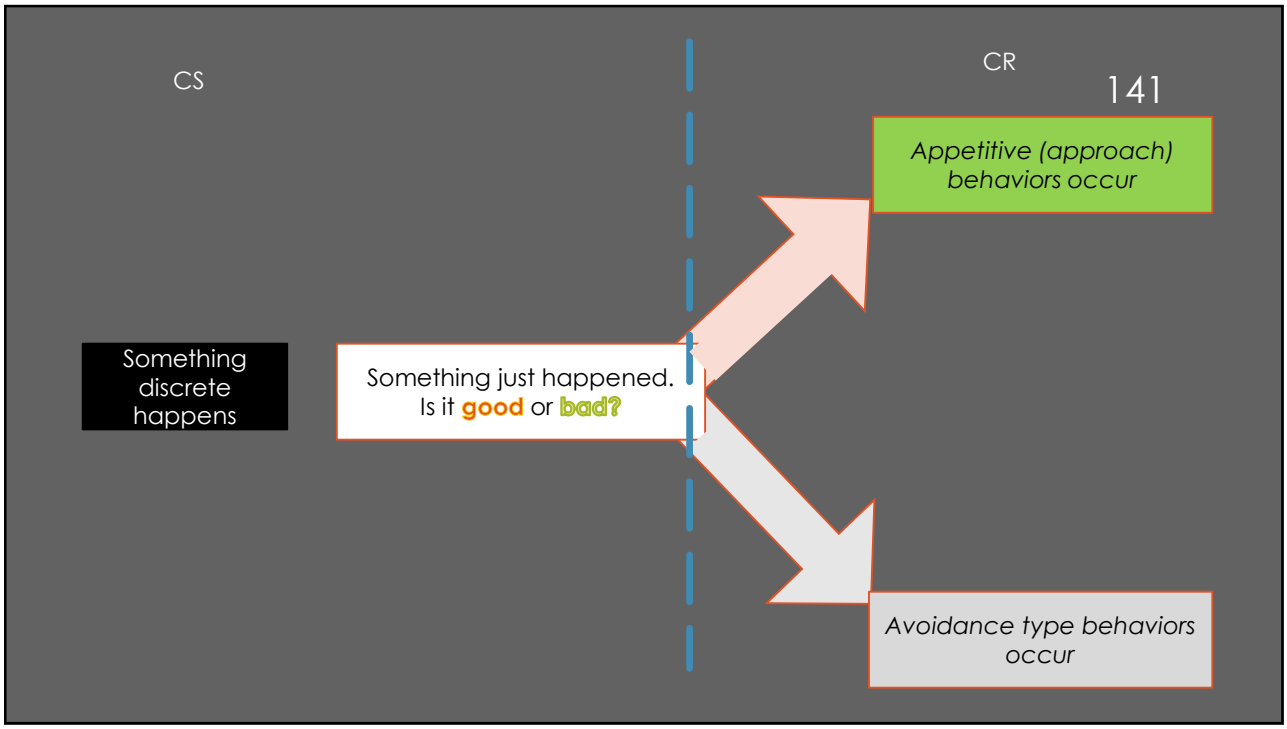
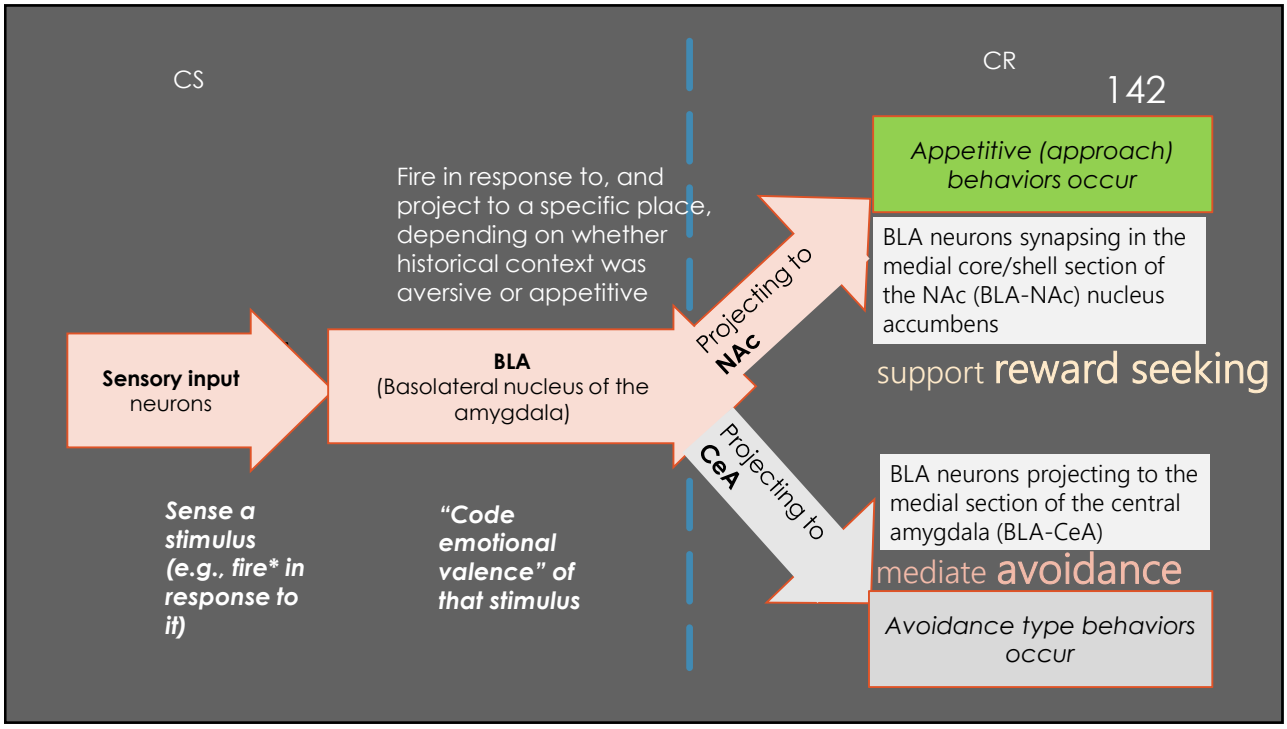
Can help us be preventive AND understand why in some moments they CANNOT approach stimuli or "unfreeze" just because a teacher thinks they should or it LOOKS like nothing is wrong

Is this context safe or unsafe?

Related Ethics Code Item 2.12: Medical contributions

Thought question for this information: How could trauma give Jonah's behavior **a possible medical contribution?**


CS
CR
141
Appetitive (approach) behaviors occur
Something discrete happens
Something just happened. Is it good or bad?
Avoidance type behaviors occur


CS
CR
142
Appetitive (approach) behaviors occur
Fire in response to, and project to a specific place, depending on whether historical context was aversive or appetitive
BLA neurons synapsing in the medial core/shell section of the NAc (BLA-NAc) nucleus accumbens
Projecting to NAc
support reward seeking
Sensory input neurons
BLA (Basolateral nucleus of the amygdala)
Projecting to CeA
BLA neurons projecting to the medial section of the central amygdala (BLA-CeA)
mediate avoidance
Sense a stimulus (e.g., fire* in response to it)
"Code emotional valence" of that stimulus
Avoidance type behaviors occur

In practice, knowing about the context, stimuli **and responses during the traumatic history** can give me ways to… 143

-Be predictive in my risk documentation

-**Reduce likelihood of harm** to others

-Be more likely to **select a treatment outcome that may be effective**

- **Support caregivers and teachers** in knowing what to expect

-**Prevent painful relapse, reinstatement, renewal**, etc

-Prevent **overmedicating** or medicating incorrectly (learned helplessness-related behavioral changes may be similar to presentations of ADHD and misdiagnosed)

-**Be kinder** during a tough episode/ situation

On the upside…

Examples of TIBA skills for providers and clients

We often focus on skills that are more likely to be **lacking *or valued*** in repertoires after trauma

- Becoming calm; mindfulness/"noticing" skills
- Asking for AND TAKING BREAKS
- Communication skills (including reporting or discussing scheduled, unpredictable, and regular "triggers")
- Accurate reporting (including pain)
- Playing (or using leisure skills) alone
- Asking for assistance
- Reporting misdeeds (& ethical concerns)
- Using self-advocacy skills
- Using healthy eating habits
- Using healthy sleeping habits… etc

- Singh, Singh, Lancioni, Singh, Winton, and Adkins (2010) on mindfulness training
- Article is about caregivers but applies to teachers and team members

4

4. State at least one example of a behavioral cusp and a skill that helps individuals (and team members) after trauma.

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LEARNING OBJECTIVES

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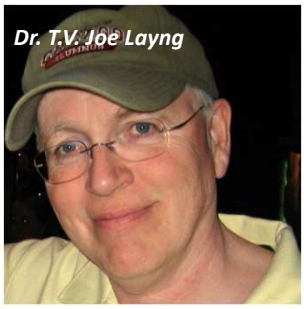
The behavioral cusp

The behavioral cusp:

Even more powerful when combined with a constructional, nonlinear contingency analysis, approach

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

Pictures courtesy of researchgate



Dr. T.V. Joe Layng

Dr. Israel Goldiamond

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

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

T. V. Joe Layng
Headsprout

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

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

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

How can you give more *freedom* to your client and yourself? It may help to ask…

- Are you looking at all the **contingencies**, not just the obvious ones?
- Are there **alternatives** to switch to?
- Do you need to be more fluent at **switching** to them?
- Are you **fluent** at the alternatives?
- Are these alternatives reinforcing, meaningful, and available…

- *Are you programming behavioral cusps?*

Examples of some individualized cusps for clients after trauma

- Describe a person
  - *(a cusp for Aniyah who had been victimized repeatedly in their foster homes)*
- Tact body parts
  - *(a cusp for Cindy, who had experienced trauma and then used severe behavior avoiding all medical appointments. She used significant pain-related SIB but no one knew)*
- Successfully request assistance
  - *(identifying a person to ask; getting someone's attention; sounding assertive; asking with repetition; waiting until there is a response)*
- Using skills that help them remain in the present
  - *(noticing; cognitive flexibility)*

Examples of cusps for trauma-healing teams

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

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5. Identify at least two examples of ACT (acceptance and commitment training) being used to support teams and individuals after trauma.

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LEARNING OBJECTIVES

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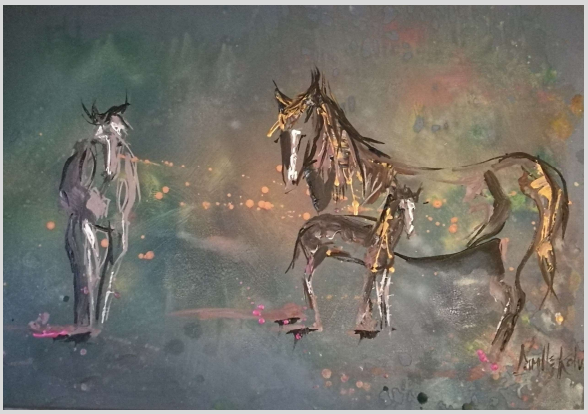
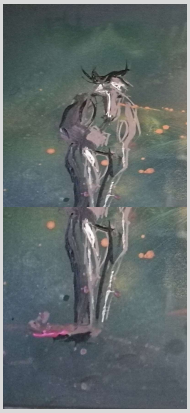
Again, why "TIBA"?

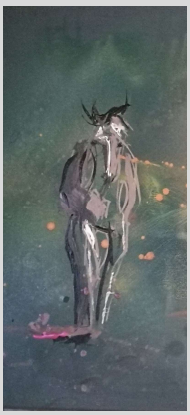


Trauma-Informed Behavior Analysis: *Redundant Term or Useful Phrase?*



- Yes, "TIBA" is redundant! In fact, the ***ethical practice of behavior analysis already moves toward being "trauma-informed" when we***
  - Collaborate and refer out when needed (2.10, 3.06);
  - individualize treatment to insure it is effective (2.01);
  - practice within our expertise (3.03);
  - use a functional contextual approach (page 5);
  - and consider medical needs and biological variables (2.12).

Trauma-Informed Behavior Analysis: *Redundant Term or Useful Phrase?*



Both application and science of behavior analysis potentially cover behavior after trauma:

- ABA tackles behavior of meaningful social significance (e.g., Baer, Wolf, and Risley 1968) and treatment of behavior after trauma may be conducted in ways that are conceptually systematic with our science
- Existing behavioral interventions may be applicable and effective with populations affected by trauma
  - Including treatments for behaviors of concern that are modified using interventions based on functional analysis, schedules of reinforcement, ACT principles, etc
- Researching extinction effects (resurgence, renewal, reinstatement, etc) can help us understand challenging behavior and conditioned responses long after trauma

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The first way: Connecting

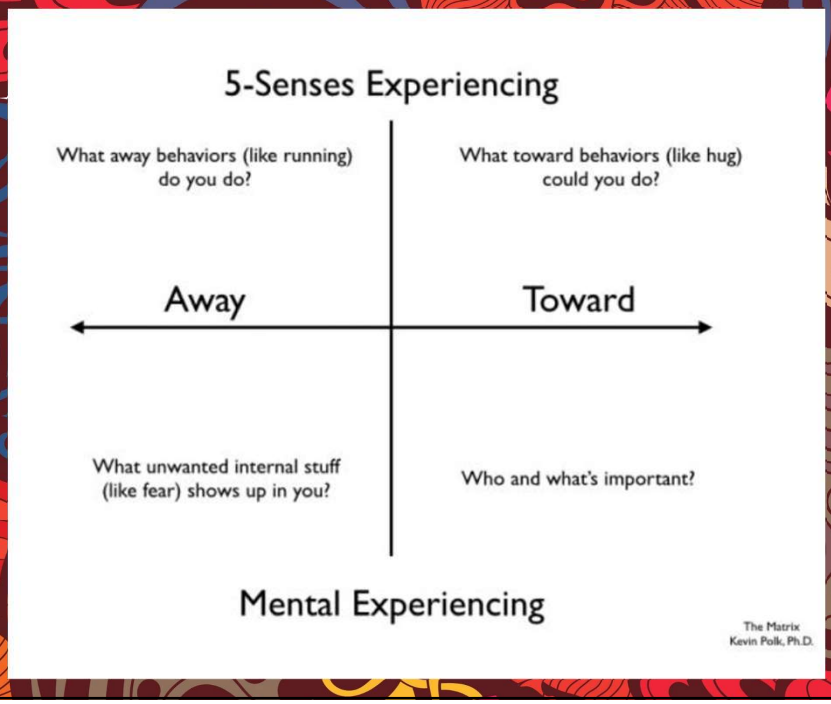
We're all here to help

So we avoid working together and we fight and stay stuck

We are AFRAID of hurting or doing worse harm

While we COULD be doing ….. X, y, z

We WANT to help



Tool: The ACT Matrix

Outcomes:

- Aniyah's team finally identified shared values
- Team embraced new goals
- Team tried new value-centered tactics

ACT Tools for connecting:

Matrix; values work

Outcomes:

Build understanding of WHY and HOW…

- Trauma-related factors still influence behavior
- "Triggers" aren't going away by themselves
- "Trauma" stimuli can be behaviorally understood

The second way: Understanding

ACT helps us understand WHY there is so much hurt

Trauma-related triggers can persist a lifetime

Things that were not originally part of the picture get "sucked in", paired, conditioned (but not JUST conditioned… also enter ***relational frames) with historical variables)***

Trauma changes medical trajectory, the brain, thinking, the stress response in the body… etc

ACT Tools for understanding:

RFT, Derived relations, transformation of stimulus function

Outcomes:

Build understanding of WHY and HOW…

- Trauma-related factors still influence behavior
- "Triggers" aren't going away by themselves
- "Trauma" stimuli can be behaviorally understood

The third way: Healing

ACT shares tools that really heal

- Mental health care
- Mindfulness and healthy response to stress
- Good relationships

ACES impact medical health, but there is much we can do about it

Oh *et al. BMC Pediatrics* (2018) 18:83
https://doi.org/10.1186/s12887-018-1037-7

BMC Pediatrics

RESEARCH ARTICLE Open Access

Systematic review of pediatric health outcomes associated with childhood adversity

Debora Lee Oh[1*], Petra Jerman[1], Sara Silvério Marques[1], Kadiatou Koita[1], Sukhdip Kaur Purewal Boparai[1,2], Nadine Burke Harris[1] and Monica Bucci[1]

ACT Tools for healing:

Noticing/ being present; mindfulness; flexibility; acceptance

Outcomes:

- Build healing relationships
- Establish good mental health care
- Establish mindfulness, healthy stress response

ACT Tools for healing:

Noticing/ being present; mindfulness; flexibility; acceptance

Outcomes:

- Aniyah learned noticing skills during her yoga practice
- She taught the skills to her CASA volunteer (a long-term relationship)
- Gradually she worked on flexibility

6

6. State at least three examples of resources to support individuals and teams after trauma.

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LEARNING OBJECTIVES

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6

6. State at least three examples of resources to support individuals and teams after trauma.

- Your behavior analytic repertoire
- Your knowledge
  - about trauma and YOUR POPULATION
  - of behavior analytic concepts
- Your collaboration with other professionals

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LEARNING OBJECTIVES

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Examples of repertoire components (and people from whom I've learned some of them)

169

Dr. Shahla Ala'i

- Value and insure cultural responsiveness in interventions
- Conduct preventive behavior analysis

Shahla Ala'i PhD, BCBA-D, LBA | College of Health and Public Service (unt.edu)

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You might have seen me mention screening.

- Is it really within our scope of practice as behavioral providers to screen?
- Screen for what?
- Don't you want to know with whom you're working,
- and more about the conditions under which the techniques you're choosing, might be successful?

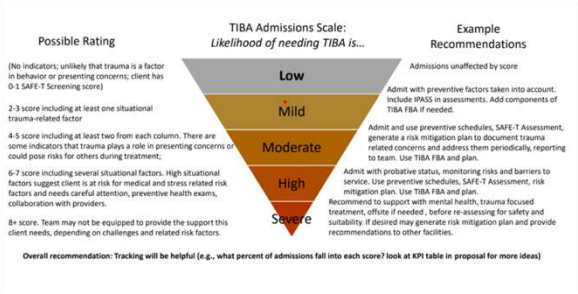
Why we screen for trauma in my practice and those with whom I consult

Possible Rating	TIBA Admissions Scale: *Likelihood of needing TIBA is…*	Example Recommendations
(No indicators; unlikely that trauma is a factor in behavior or presenting concerns; client has 0-1 SAFE-T Screening score)	Low	Admissions unaffected by score
2-3 score including at least one situational trauma-related factor	Mild	Admit with preventive factors taken into account. Include IPASS in assessments. Add components of TIBA FBA if needed.
4-5 score including at least two from each column. There are some indicators that trauma plays a role in presenting concerns or could pose risks for others during treatment;	Moderate	Admit and use preventive schedules, SAFE-T Assessment, generate a risk mitigation plan to document trauma related concerns and address them periodically, reporting to team. Use TIBA FBA and plan.
6-7 score including several situational factors. High situational factors suggest client is at risk for medical and stress related risk factors and needs careful attention, preventive health exams, collaboration with providers.	High	Admit with probative status, monitoring risks and barriers to service. Use preventive schedules, SAFE-T Assessment, risk mitigation plan. Use TIBA FBA and plan.
8+ score. Team may not be equipped to provide the support this client needs, depending on challenges and related risk factors.	Severe	Recommend to support with mental health, trauma focused treatment, offsite if needed , before re-assessing for safety and suitability. If desired may generate risk mitigation plan and provide recommendations to other facilities.

Overall recommendation: Tracking will be helpful (e.g., what percent of admissions fall into each score? look at KPI table in proposal for more ideas)

Why we screen for trauma in my practice and those with whom I consult

- Get to know your population
- Make more appropriate referrals
- Make better predictions about outcomes
- Identify needs for resources, skills
- Do less harm
- Use your training dollars more strategically
- Screening helps us prevent harm by adopting proactive strategies!



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Possible examples of prevention:

- **Screening for diagnosis:** Identify person at risk for using challenging behavior, use preventive teaching of ways to meet someone's needs (see Ala'i-Rosales' paper on The Big Four)
- **Screening for inappropriate procedures:** Identify someone at risk for experiencing least to most punishment and restrictive settings, use preventive schedule arrangements (delivering NCR related to function normally accessed only contingent on the challenging; example with massage, police visits, principal meetings.)
- **Screening for experiences and settings:** Identify someone who has experienced sexual trauma and is in vulnerable settings; use preventive teaching of skills related to someone's needs to protect, empower them in those settings
- **Screening for risk of abusive interactions:** Identify parents at risk of struggling with behavior needs, teach parents preventive skills (Rajaraman's, Hanley's work on teaching parents; Singh's work on teaching mindfulness to staff/ caregivers)

Dr. Shahla Ala'i

- ❑ Value and insure cultural responsiveness in interventions
- ❑ Conduct preventive behavior analysis

Shahla.Ala'i.PhD, BCBA-D, LBA | College of Health and Public Service (unt.edu)

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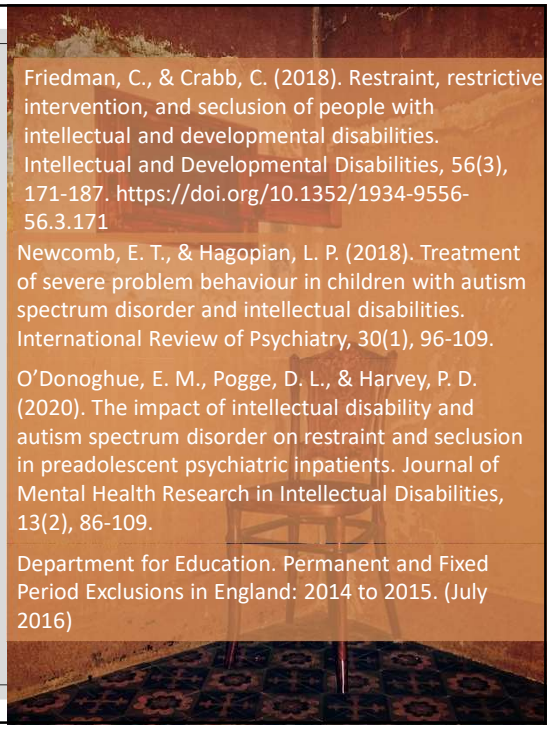
Review of Section O:

Overlap between autism and trauma

- ❑ Consider YOUR target population: What special risks might they face?
- ❑ Remember that autism confers a risk of trauma.
- ❑ Researchers have found that after trauma, people with autism may use different behaviors. These might be misinterpreted as "just their autism" and the person might be mistreated as a result.
- ❑ Researchers urge us to screen for trauma, including if the person has "a behavioral" difference or diagnosis.

People with autism are often exposed to restricted* environments and reduced quality of life

- Physical restraint (7x more)
- Seclusion (4x more)
- Kicked out of school (7x more)



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Department for Education. Permanent and Fixed Period Exclusions in England: 2014 to 2015. (July 2016)

6

6. State at least three examples of resources to support individuals and teams after trauma.

- Your behavior analytic repertoire
- Your knowledge
  - about trauma and YOUR POPULATION
  - of behavior analytic concepts
- Your collaboration with other professionals

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LEARNING OBJECTIVES

cuspemergence.com

Dr. Kim Crosland

- ❑ Consider drug side effects
- ❑ Take into account the trauma-related history of the behavior
- ❑ See her FA of runaway behavior; many articles with trauma population; see articles in Social Work journals

ASDnet - University of South Florida (usf.edu)

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Pat Friman

- ❑ Study emotion
- ❑ Consider the circumstances of the behavior

I Didn't Know Her Circumstances | Pat Friman (BCBA, RBT, BACB) - YouTube

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- ❑ Practice "microshaping"
- ❑ (re)build attachment
- ❑ Learn to operationalize and provide safety, empathy

GoldenJeannieBW.jpg (202×202) (abainternational.org)

Dr. Jeannie Golden

Dr. Greg Hanley

- Consider synthesized contingency analyses;
- See PFA/ SCA approach; HRE (value working towards a happy, relaxed, engaged learner)
- Examine "routine" components of plan and procedures for aversive qualities (e.g., Heal and Hanley 2011)
- Incorporate choice, preferences (Hanley et al. 2005)

https://practicalfunctionalassessment.files.wordpress.com/2020/06/2018-12-10_2111.png

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T. V. Joe Layng

- ❑ Consider the alternatives the person has. What were and are the contingencies for THOSE?
- ❑ Use nonlinear contingency analysis

https://www.researchgate.net/profile/T-V-Layng

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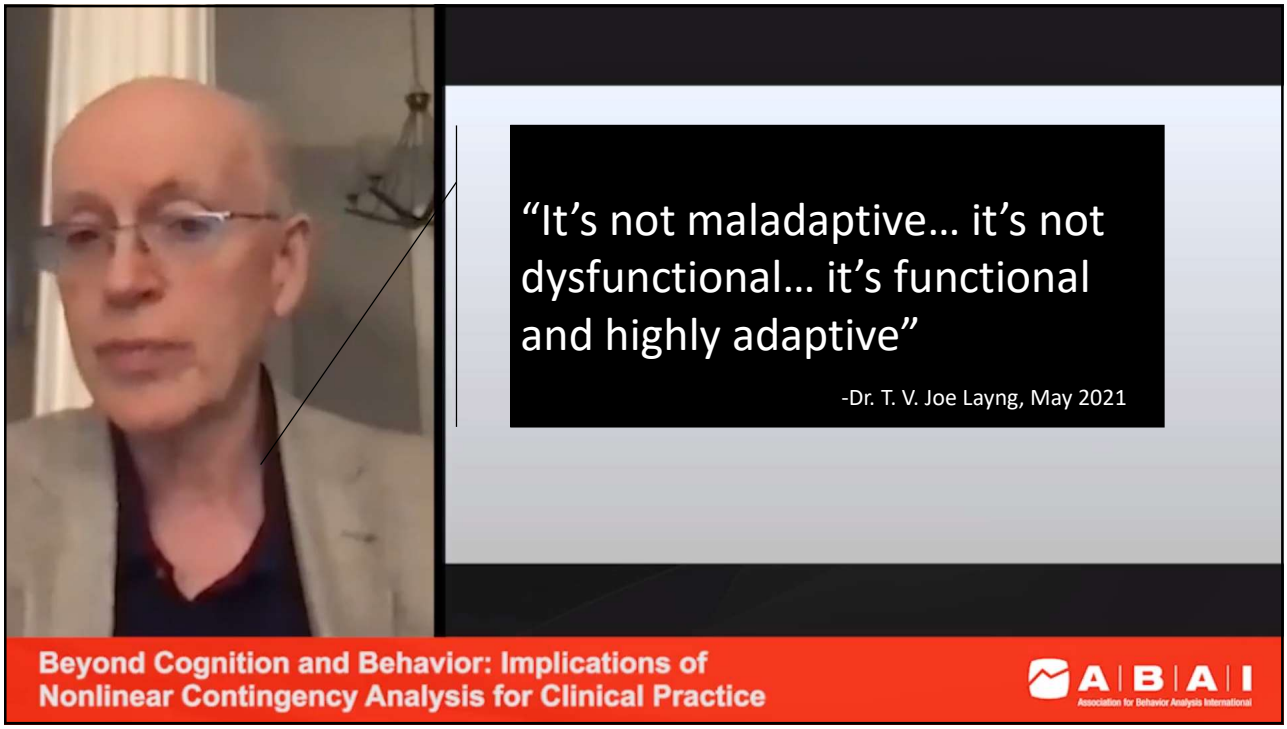
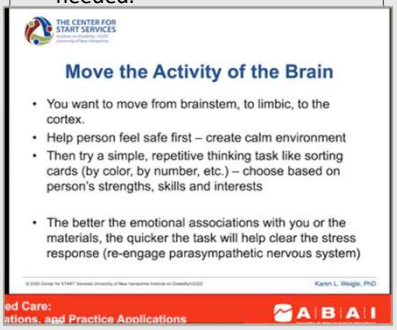


Dr. Karen Weigle

- Define demands for YOUR client so you can present truly NEUTRAL stimuli when needed.



Important repertoire components

DR. NADINE BURKE HARRIS

Understand that
- Trauma = stress
- Stress changes the body
- Stress = a medical function of behavior
- Trauma = medical function of behavior
- Trauma changes the body and behavior!

So you and I need to…
- Document medical impact of trauma
  - In our FBAs and BIPs
- And collaborate with others who care about this intersection

Gain fluency in…

- NCR (noncontingent reinforcement) schedules
- Shaping
  - While avoiding extinction when needed
- Analyzing risks
  - **and benefits**
  - of possible **options**
  - and their **short- and long-term** outcomes

"preventive schedules"; check-ins

PAPERS RELEVANT TO PRACTICE AFTER TRAUMA
- RICCIARDI ET AL. 2006 ON SHAPING WITHOUT EXTINCTION
- RICHMAN ET AL. 2015 ON NCR FOR CHALLENGING BEHAVIOR
- FRITZ ET AL. 2017 ON NCR WITHOUT EXTINCTION

- We looked at a case study and then discussed several tools to help us understand relationships between challenging behaviors and trauma related events
- We saw some examples of how interdisciplinary team members could support a complex trauma related case
- We can use the tools (all free except SAFE-T Assessment) in our own cases to guide development of more trauma informed FBAs, behavior plans, and support programs for students after trauma.
- We have so many resources already. We are needed, and we need to show up.

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BRIEF REVIEW

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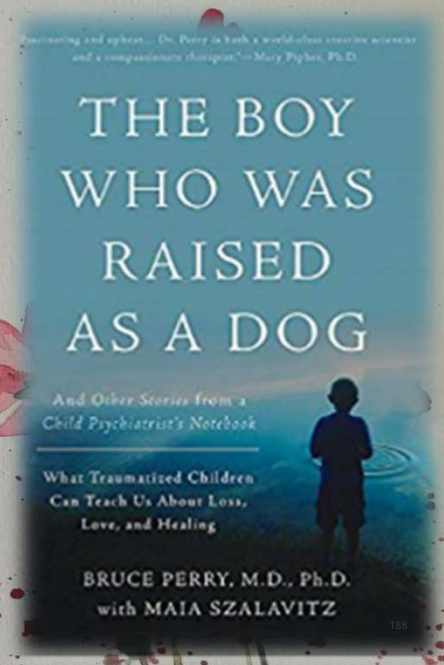
We need to understand "the persistence of fear-related emotional, behavioral, cognitive and physiological patterns"

- **Bruce D. Perry**



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"Trauma-informed behavior analysis: the application of behavior analysis to treating behaviors affected by histories involving trauma, including the documentation of those histories, their significance, and related risks, in a context of rich team collaboration."

-Dr. Camille Kolu

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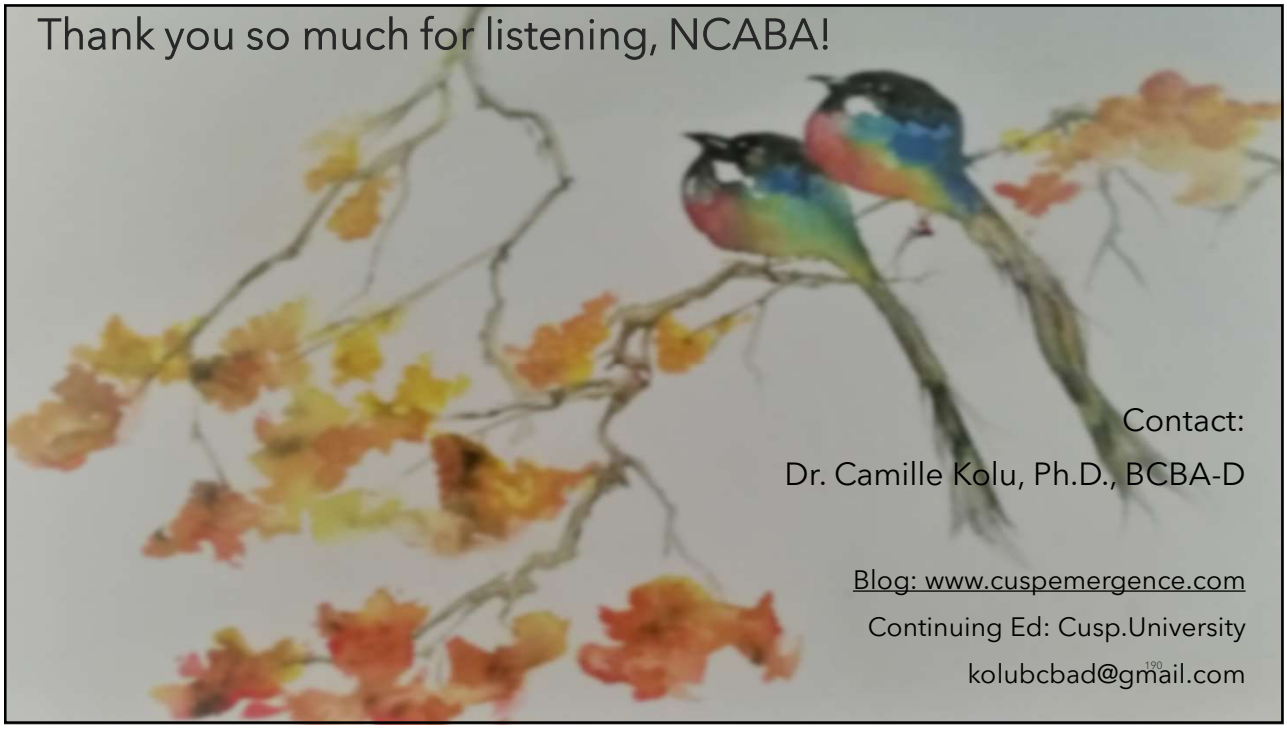
Thank you so much for listening, NCABA!



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kolubcbad@gmail.com

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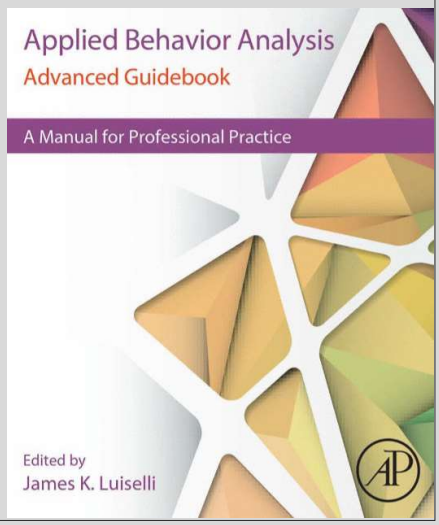
Some selected references and further reading (see next pages for articles)

Books mentioned:

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



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