CHAPTER 14

Dealing With Behavior Problems

Behavioral difficulties in autism and related conditions can take many forms and can be uncommon or very frequent. Common behavior can include repetitive movements such as hand mannerisms, finger/hand flapping, or complicated whole-body movements such as rocking. Sometimes challenging behaviors may take other forms such as major tantrums or self-injurious behaviors like head banging. The child may pursue very unusual interests; for example, she may line up toys or dolls rather than play with them. Behavioral problems also tend to change over time, often becoming most problematic in the early and middle teenage years. Sometimes behaviors persist over time, but what was slightly problematic behavior in a 3-year-old can become much more so in a larger 13-year-old!

In this chapter, we discuss some of the behavioral problems and emotional difficulties seen in autism spectrum disorders (ASDs). Keep in mind that, when the problem is affecting a particular child, you'll need to work with people who know the child very well. Also keep in mind that we're discussing the entire range of difficulties that can be seen, but an individual may not have many or even any of these problems! When considering any treatment, you must always weigh the potential benefits against the risks of treatment. Several excellent resources for parents are now available on behavioral treatments and are listed in the reading list at the end of this chapter.

For purposes of this chapter, we group problem behaviors and emotional problems into several broad categories that include the most common kinds of behaviors you might see within each category. Then we discuss some general aspects of interventions. Near the end of the chapter, we also talk about behavior problems related to mental health conditions—an issue usually most relevant to more cognitively able individuals on the autism spectrum. Specific medications and aspects of drug treatment are discussed in the next chapter.

In an ideal world, there would be a simple one-to-one correspondence between a behavioral or emotional difficulty and a treatment. Unfortunately,

things are a lot more complicated than this in the real world. First, it may be difficult to apply the usual diagnostic categories, particularly in a more impaired child with an ASD. (This is a general problem for all children with significant disabilities.) Second, people sometimes do not recognize the other difficulties/disorders that are present, or mistakenly assume that having autism somehow protects you from other problems. That is, the diagnosis of autism or Asperger's disorder overshadows an awareness of other difficulties like anxiety or depression. As we talk about later in this chapter, these issues complicate decisions about how best to treat behavioral difficulties—particularly in children who have significant communication problems. Even the most cognitively able children can have "meltdowns" and other difficulties, and sometimes it is hard for people to get a handle on these as well.

COMMON BEHAVIORAL/MOOD PROBLEMS IN AUTISM SPECTRUM CONDITIONS

Type of Behaviors	Specific Examples
Stereotyped behaviors	Body rocking Hand/finger flicking Other repetitive behaviors
Self-injury and aggression	Injury to self or others; property destruction
Problems with rigidity and perseveration	Resistance to change Perseveration, compulsiveness Unusual interests
Overactivity and problems with attention	High activity levels Difficulties with attention Impulsivity Running/Bolting
Mood problems	Depression Anxiety Bipolar disorders

As mentioned, children with ASDs often have many different problems. For example, problems with attention may go along with problems with stereotyped (apparently purposeless and repetitive) behaviors. It is important to decide which problems are the ones to focus on, as well as what the benefits and potential risks of the treatment are. Sometimes the same problem behavior is the product of several different factors. However, sometimes the fact that the child has several different problems will be very important in selecting a treatment. As a practical matter, problem behaviors often seem to travel in groups! For simplicity's sake, we usually refer to "the child," but what we have to say is relevant to adolescents and adults as well.

Behavioral Interventions—A Brief Introduction

Behavioral and educational interventions are usually the first line of treatment for behavioral difficulties. A whole body of work on understanding and treating behavioral difficulties using assessment and intervention principles from **applied behavior analysis (ABA)** provides a very helpful framework for dealing with behavioral difficulties. The assumptions of ABA are that, like other children, those with an ASD learn through experience. Accordingly, the events that precede behavioral difficulties (the antecedents) and those that follow them (the consequences) are important. The antecedents are the things that set off the behavior in the first place. For example, if you ask the child to stop body rocking and put away her toys and this leads to a tantrum, you have a pretty good idea that the child does not want to stop her body rocking or put away her toys. If the response to the tantrum is to let the child continue to body rock, you've given a pretty strong message (the consequence) that the child doesn't need to listen to you!

There are many different approaches to dealing with behavior problems; the reading list at the end of this chapter and the additional readings at the end of the book provide some basic information. Because parents (and sometimes teachers) find themselves coping with a lot of things at the same time, it is not always easy to step back and get the "big picture" on behavior problems. There are some general principles to keep in mind. First don't pay attention to the child only when he is behaving badly. If you want to encourage positive behavior, then be sure to acknowledge and praise it specifically! Put another way, one of the "tricks" of dealing with problem behaviors is also to have a vision of the kinds of positive behavior you want to have replace them.

Generally, one of the most important steps is to see if you can observe regularities in the problem behaviors—for example, does the behavior happen only at a certain time or place or following a certain activity? Look at what goes before and what follows the behavior—is the behavior being (unintentionally) rewarded (reinforced)? This assessment approach is sometimes referred to as doing an ABC analysis—that is, analysis of Antecedent–Behavior–Consequence.

Keep in mind that you want to reinforce good behavior. To do this, be sure to praise such behavior quickly and specifically when it happens. In many ways, the solution to the problem of bad behavior is to get the child to increase good behaviors that will replace the problem behaviors. Planning ahead is helpful; if you know a situation will be stressful or a problem for the child, have a plan in advance. It is always easier to prevent problems than to have to react to them during a crisis. Keep in mind that when you are trying

to eliminate or reduce a problem behavior, you ought to have something you want to happen instead.

Be a careful observer of your child. Often, you'll be able to notice subtle behaviors that may be clues that she is going to have difficulties. Use these warning signs to head off problem behaviors, for example, by giving the child something else to do or giving the child a better strategy to use for communicating his needs (e.g., picture exchange; see chapter 6). When you do need to set limits or have consequences, be clear, be specific, and then follow through. Again, being prepared is a big part of the battle! If you have a plan in place, you can implement it rather than feeling confused and overwhelmed. If, for example, the child has trouble at the grocery store, you should make a specific plan before you go. First, you probably should do everything possible to make initial visits a success such as making initial visits very brief and going in to get the child's favorite food. The idea, for children who have problems with change, is to introduce change gradually and to build on success. As time goes on, you can use a shopping list (if need be with photographs, visual cues, or actual labels from cans/cartons) that the child can help you complete. If the child has behavioral difficulties, tell her in advance what will happen if she engages in the problem behavior: "Jenny, there is no screaming in the grocery store; if you scream, we'll have to leave and can't get ice cream."

It may help to take notes and/or develop a chart where you can list the ABC's of problem behaviors: antecedents, the behavior itself, and the consequences. Often, as you pay more attention, you'll start to notice important clues and patterns—for example, that the behavior happens only in one place or at one time of the day.

Also take a careful look at the environment. Sometimes what seem to be simple adjustments in the child's environment (e.g., moving from a more disorganized and disorganizing environment to a simpler, structured one) can make for a major change in her behavior. Children with ASDs respond well to structure, predictability, and consistency, and it is important to be sure that the environment is not contributing to the child's problems. We'll give an example of a situation where the environment was contributing to a problem behavior at the end of this chapter.

In addition, pay attention to the functions of the behavior. If the child is using some behavior to get attention, then try planned ignoring. That is, don't acknowledge what the child is doing inappropriately but *do* pay attention when she starts doing something you want her to do. You might even try time-outs. Be sure to pair this with lavish and appropriate praise when the child is behaving well. If the child has trouble with the word *no* (as most children do), be careful not to reinforce tantrums or other inappropriate behaviors.

Sometimes parents unintentionally encourage this behavior by doing exactly what the child wants. It is important to become adept at "catching" the child doing the right thing—if only for a moment—so you can praise that rather than punish "bad" behavior.

Sometimes problems will arise because the child is trying to avoid work or other activities. Unfortunately, if you give in, this sends a strong message to the child about how to get out of work! Try, instead, to get her to engage for a short time in the activity, then praise her and let her do something else for a while. Also try to model and encourage good, straightforward communication.

Some sensory behaviors (see chapter 16) can be addressed by helping the child find more appropriate ways to engage in the behavior. The child's occupational therapist (OT) may be helpful to you here. For example, if the child has trouble with prolonged body rocking, you might start by trying to contain the behavior to a certain place (e.g., a rocking chair) with set amounts of time for rocking alternated with periods of time for work. (These periods of time can be made progressively longer!)

Many times, children who have major communication difficulties use problem behaviors as an inappropriate way of communicating. To try to minimize communication difficulties in dealing with problem behaviors, you're your communications clear and simple. Be sure the child is paying attention when you communicate with her. Be exact and specific about what you want. Try to give her appropriate ways for communicating her needs and wants, for example, using a "Help" card to ask for help rather than screaming. Helping children learn to communicate—at whetever level they can—feelings of frustration, anxiety, and so forth is important. The child's speech–language pathologist should be able to suggest strategies or communication methods to help with this and may be able to collaborate with the school psychologist or a behavior specialist on ways to do this.

COMMON MISTAKES IN DEALING WITH BEHAVIOR PROBLEMS

Making Language Too Complicated

When children or adolescents seem upset, there is often an understandable desire on the part of teachers and parents to be sympathetic, polite, and caring. This is indeed understandable but often results in the language used with the child being overly complicated. It is more helpful to be short, simple, and directive. More complex language is difficult to follow and may only make the child feel more frustrating.

Focusing Only on the Negative

If you want the child to stop doing something, then be prepared to give some alternatives.

Time Pressure

Sometimes there is a sense of wanting a difficult activity to be over and, as a result, teacher and parents (and sometimes student) try to move things along very quickly. For individuals on the autism spectrum, giving sufficient time lets them "take it easy" and helps the individual plan and respond more effectively.

Sarcasm, Irony, or Complex Humor

Individuals on the autism spectrum can have wonderful senses of humor. That being said, it is common for them to truly be made fun of, to misunderstand attempts at humor as criticism, and be confused by multiple conflicting cues. Keep jokes and humor to a minimum. Be on the alert for more able children and adolescents to be confused by humor and explicitly target working on humor as a goal in their program.

Ambiguity

Lack of clarity often leads to trouble. Keep in mind that imprecision may lead to confusion. This is particularly common when tasks don't have obvious start/stop points. For example, when asked to clean a rectangular table with a dusting cloth, the person with autism may keep cleaning and cleaning and cleaning—there is no obvious start and stop. In a situation of this kind, build in a start and stop; this is totally artificial but can be very helpful. For example, teach that in cleaning a table you start from the top left-hand corner and work until you are at the bottom right corner—and then you're done!

Inconsistency

Introduce change in a planful and sensible way when it is needed. Children on the autism spectrum often have trouble in dealing with the unexpected. Inconsistency leads to anxiety and disorganization. Try, as much as possible, to use the child's interest in consistency to help him organize himself at home and in the classroom.

Unintentionally Rewarding Undesired Behavior

Often, minimally problematic behaviors can be made much worse by excessive attention from parents and teachers.

As always, keep the big picture in mind. It is often easy to say what you don't want the child to do, but it is essential that you teach the child what you want her to do. The child's classroom teacher, school psychologist, speech–language pathologist, and OT or physical therapist (PT) all have valuable perspective and may be able to give good advice to parents and each other. Sometimes the assistance of a behavior specialist is needed. Unfortunately, children with ASDs are all sufficiently different from each other that one really needs to tailor the intervention to the child. Having an outside specialist can be a great help in this process, particularly if the behavior is challenging. A large body of work on behavioral approaches now exists and can ehlp parents and teachers in their efforts to encourage positive behavioral change.

Drug Interventions—A Brief Discussion

Although behavioral and educational interventions are typically tried first, medications also play an important role in helping children with behavioral difficulties. Sometimes behavioral interventions alone don't do the trick. Other times there may be a real emergency (such as when a child is seriously injuring herself by head banging). For still other situations—for example, depression—medicines may be the first line of treatment. Medicines and behavioral procedures can be used together—often very effectively. We discuss this issue in much more detail in the next chapter.

There are several times in the life of a child with autism when medications are more likely to be considered. Generally, very young children are least likely to receive medications. Usually, their behavioral difficulties are pretty minimal, and it is much easier to physically manage an out-of-control 2-year-old than a 12-year-old. The year or so before children enter puberty is often a time when behavioral difficulties arise. We are not sure why this is, although the various changes they experience in their bodies and changes in hormone levels probably are part of the picture.

For some children, particularly higher functioning children, the advent of adolescence also means that the child is more aware of being different, in some important ways, from other children. They may be able to talk about feeling anxious and may also talk about feelings of depression and sometimes serious symptoms of depression. Fortunately, we have fairly effective treatments for depression—both drug and behavioral treatments. Even more important, the desire to fit in really spurs remarkable growth in some children.

Types of Behavioral and Emotional Difficulties

Behavioral and emotional difficulties in autism and related conditions can take many different forms, but these generally fall into several, sometimes overlapping, categories.

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Occasionally, the individual exhibits so many difficulties that it is hard to sort out exactly what is going on. This is particularly true if—as is understandable for a parent or teacher—you are so closely involved that it is hard to get a sense of the "big picture." This is one of the reasons that an outside consultant (a behavioral psychologist or behavior specialist) can be helpful. These individuals have the great advantage of being able to "step back a bit" and look at the entire picture.

Stereotyped Behaviors and Agitation

These apparently purposeless, repetitive movements are common in young children with autism and related conditions (although not as common in Asperger's disorder). They often seem to emerge around ages 2 to 3 (see chapter 7). These can include body rocking, finger flicking, toe walking, body rocking, and other complex, whole-body movements. As discussed in chapter 13, other kinds of unusual movements are seen in Rett's disorder—for example, hand washing or hand wringing, as well as some other very odd behaviors such as pulling at the tongue. Stereotyped movements may also be referred to as self-stimulatory movements (although this sometimes leads to confusion with masturbation, which is a somewhat different problem; see chapter 9).

Stereotyped movements are often associated with other behavior problems such as self-injury or sometimes with aggression (particularly if you attempt to interrupt the movements). They also are often associated with behavioral rigidity and difficulties with change. Some degree of agitation or general tendency toward being upset and "on edge" is also often seen; you can feel as if the child is about to explode at any second.

Sometimes infants and very young children who go on to have typical development engage in some body rocking, occasionally even head banging, sometimes while asleep. For these children, the problem usually goes away on its own in the first couple of years of life. Many of us know typical children and adolescents who engage in self-stimulatory movements such as moving their leg rapidly while taking a test. These seem to have an anxiety-reducing function, but are not as all-encompassing as those seen in autism, and they go away once the stressful situation is over.

In contrast to the stereotyped movements seen in ASDs, the unusual movements or tics of Tourette's disorder are different in several ways. Tics tend to occur in bouts, tend to involve the head and neck—particularly early on—and the child doesn't seem to enjoy engaging in them. Thus, they tend not to involve the hands or finger flicking or the whirling/twirling more frequent in ASDs. Movement problems may also be seen in other disorders (e.g., sometimes following infections), and occasionally it can be difficult to disentangle the

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nature of the movements. This is one of the reasons it is good to have a specialist such as an experienced psychiatrist or neurologist involved if the child is making seemingly purposeless movements.

For children with autism and related disorders, some unusual interests and fascinations often come before the more typical stereotyped behaviors. These interests can include lights (and light switches), twirling and spinning objects (such as fans and tops), and fascination with the smell, taste, or feel of things. The child may begin to engage in some form of visual self-stimulation—for example, looking at things out of the corner of her eye or bringing materials up to the corner of her eye. Sometimes the development of an unusual attachment—such as to a ball of string or unusual objects—may come before the more typical stereotyped movements.

Repetitive, stereotyped movements vary over both the short and long term. Often, they seem to increase after about age 3 and then may increase in frequency or intensity (or both) again around 5 or 6 years of age. For some children, they may then subside only to return in force around the onset of puberty—often some months before. These behaviors can show up at times when the child is bored or stressed, as well as overstimulated or anxious. They may also seem to serve as a preferred mode of activity for the child, almost like relaxation. Sometimes these behaviors shade off into more compulsive and ritualistic behaviors (which we discuss shortly).

Parents and teachers often ask us when we would intervene with these behaviors and often are eager to try medications. These behaviors are often more difficult for parents to manage effectively when the child is in more public settings, and parents—and particularly siblings—are often quite distressed by these behaviors. Teachers may find that the behaviors interfere with engaging the child in the educational program. Fortunately, although these behaviors are difficult to entirely eliminate, many children can be helped to decrease them. The decision to pursue treatment should include consideration of whether the behavior really interferes with the child's or the family's life or the classroom in some important way. Low levels of such behavior are often easier to live with, and parents and others can work to confine the behaviors to certain places or contexts. Occasionally, giving the child the opportunity to engage in these behaviors can itself even be used as a reward for appropriate behavior. With occasional exceptions (e.g., when the behavior is putting the child in some danger), we would not generally recommend medications as a first step.

There are many different behaviorally based approaches for dealing with these behaviors. A whole body of work in behavioral psychology has focused on reducing levels of such behaviors by viewing them as learned behaviors. That is, they are not necessarily so much part and parcel of autism but, rather, responses that the child learns to help her deal with her environment. Many of the

effective treatments developed have used this perspective—for example, to see when the behaviors occur, what sets them off, what keeps them going, and so forth. Having understood something about the functions of these behaviors, steps can then be taken to reduce them. For example, if a child has problems with finger flicking or spinning objects, giving her something else to do with her hands may reduce the behavior. Analysis of the environment may reveal that it is too stimulating and that the child is overloaded with information. By giving the child a less stimulating environment, levels of these behaviors may be reduced.

It is also clear that movement and vigorous physical activity can help reduce stereotyped behaviors. Children who engage in high levels of spinning or twirling can benefit from regular exercise. Even getting the child up for short periods in the classroom engaging in vigorous movement such as stretching, jumping, or bouncing can help. Sometimes one of the problems with more inclusive classroom settings is that opportunities for physical movement and vigorous activity are limited to gym and recess (places where children with autism often need the most supervision and where they may not get as much exercise as other children). In addition, children are generally encouraged to stay seated in the regular classroom setting. If movement seems to help, some modification in the program to allow for breaks for movement and other physical activity can be useful. Often, the OT can be very useful in consulting with parents and the classroom teacher about possible activities to try.

Occasionally, children engage in auditory self-stimulation, for example, by spending long periods of time humming or making noises. Again, this sometimes happens when the child is overly stimulated (particularly by noises and sounds), and a look at the environment may help clarify what is going on. For children who are overly responsive to sounds, various devices are available, ranging from simple earplugs to music devices (a portable CD player or MP3 player) and those that produce "white noise" or certain sounds (such as the sound of the ocean or of rain falling).

Some drug treatments are also effective in helping reduce levels of these behaviors. These are discussed in detail in the next chapter and include the major tranquilizers and some other agents. When a major change occurs in the child's behavior, you should also ask the pediatrician to rule out medical reasons. Sometimes behavior problems increase as a child is becoming sick or when she is unable to communicate that she is ill or in pain.

Aggression and Self-Injury

These behaviors involve either self-inflicted injury or injury to others and are among the most difficult and problematic behaviors for parents, teachers, and

professionals to deal with. Fortunately, this problem is not that common, and, even when it occurs, there are a number of potential interventions. **Aggression** and/or **self-injury** tend to occur along with other problems (such as stereotyped movements, rigidity, or perseveration).

Self-injury can take many different forms, including head banging, pinching oneself, pulling out hair, poking the eye, biting the hand, and so forth. Aggression against others may include biting, scratching, or hitting. Behavior that is destructive to property is also often associates with this category of difficulties. Self-injurious behavior can be extremely distressing for parents to see. It not common until school age but although occasionally it occurs in younger children with autism.

The sudden onset of self-injurious behavior, particularly head banging, should prompt a trip to the pediatrician, since such behavior may be a way for a child who does not have words to communicate about her physical pain. Infected ears are particularly likely culprits in younger children; in adolescents who are nonverbal and who start head banging for the first time, dental problems such as impacted wisdom teeth are sometimes to blame. (This is another important reason for the child to have regular dental care!) Children who start to poke their eye may have some physical problem or occasionally even a visual difficulty that they can't complain about in words.

Aggression toward others is often (but not always) "provoked" in some way. For example, the child is interrupted or asked to do something more challenging. Because of the unusual interests and preoccupations, it may be hard to know what sets off these behaviors. Similarly, the unusual ways that the person who is verbal talks may sometimes make it difficult to understand what gets the behavior going. Like self-injury, aggression can be a major problem for parents as well as teachers and school staff. It may take the form of biting, hitting, kicking, scratching, or head butting.

Again a careful analysis of what seems to set off the behavior is very important. For example, is it a response to frustration or an escape behavior or the child's way of saying, "No, I don't want to do this"? In analyzing the behavior, it is also important to look at the context in which the behavior occurs. For example, is it only at school? Only with some care providers? Only during some activities or situations? Only at certain times of the day? Often, this information gives important clues as to why the behavior may be happening and what you can do about it. Turn yourself into a reporter or a detective and ask the basic "wh" questions—who, what, where, when, and why. The parents of one 8-year-old boy with autism called one of us complaining that their child needed medication to decrease his aggression. Discussion with the parents made it clear that this was a new behavior for the boy. The aggression had started when the child's bus route and driver had been changed. The new route (itself a potential

problem) was much longer, there was no longer a bus monitor, and there was a new student on board who screamed during the bus ride. The child, who was very sensitive to loud sounds and greatly annoyed by the screaming student, reacted by trying to bite him. In this case, some modifications in the bus arrangements and giving the boy an MP3 player to listen to resulted in a quick change in the behavior.

As our example illustrates and as with other behavioral difficulties, a good analysis of potential causes and consequences of the behavior is very important. Did the head banging or self-injury start after the child entered a new classroom or after some aspect of her program was changed? Does the self-injury occur only during "downtimes"? Is it related to levels of environmental stimulation (either too much or too little)? Some children head bang only at night, while others will engage in this behavior only in very specific situations. For other children it may be a more general problem seen in many different situations and contexts.

For situations where the behavior is potentially very dangerous, medications may be used much more quickly. For example, occasionally children with autism will bite themselves to the point of causing significant injury and may need medications. Even when medications are used, it is important to try to understand what sets off, and keeps up, the behavior. In such cases, a comprehensive functional assessment is essential in part of the treatment planning process.

Aggression against others is usually seen in very specific situations. These include when the child is frustrated and unable to communicate, when favored routines are violated, or when someone attempts to interfere with the child's behavior. Transitions and times of change are often a time when children are very anxious and easily provoked. Many people have made the observation that such behaviors may represent a very basic (and sometimes difficult-to-understand) communication, that is, that the child is overwhelmed and unable to cope. What provokes the behavior may be hard to understand—something as seemingly simple as a small change in routine may lead to major troubles.

Communication difficulties may make it hard for children with autism to tell people how they feel or when they are being pushed too much. This can happen even with older children who can communicate. For example, a 10-year-old boy with Asperger's disorder went to his PE class in school without his usual paraprofessional (a stressful situation now made worse), where the children were running sprints and timing themselves using a stopwatch. The substitute was a regular gym teacher, totally new to the child, who gave him a stopwatch (which he did not know how to operate) and told him to run as fast as he could. The boy put in a great effort, but at the finish line discovered that the stopwatch hadn't worked because he hadn't realized you had to start it. The coach said something like, "Hey, dummy, why'd you stop?" and then refused to let him

run again. The boy threw the stopwatch on the ground, breaking it, and the coach came up to restrain the boy, only to get smacked in the face. The school threatened to expel the youngster for aggression since he should have "used his words" and not hit the teacher. In this case, the multiple difficulties included the stressful situation, the lack of his usual supporter, a lack of any instruction on how to operate the stopwatch, an unsympathetic coach who was anxiety provoking, and a boy who was really trying his hardest to cope. In fact, the aggression toward the coach would not have happened at all had the coach "used his words" at any of a number of points with the boy!

Some children with autism also have problems with destroying property. Again, many different solutions are available, depending on the circumstance and function of the behavior. You should *not* feel as if you have to turn the home or classroom into Stalag 17! Rather, explore different options, talk with other parents and teachers, and, if need be, talk to professionals who can provide suggestions. Again, the help of someone who can stand back a bit and see the big picture may be helpful. One child we know loved tearing up clothes, books, and furniture. His parents coped with this in several ways, but most importantly realized that by giving him his own (more-or-less indestructible) room, as well as plenty of physical exercise, they could greatly reduce his destructive behavior.

Some of the same medicines used for treating stereotyped behaviors can be used for treating aggression. Again, behavioral methods are, generally, the first things to try, and again, the exception has to do with dangerous behaviors. As with other behaviors, it is important to do an analysis of the behavior to understand when it occurs, what makes it better or worse, how it changes over time, and so forth.

Rigidity and Perseverative Behaviors

Unusual interests, ritualistic and compulsive behaviors, and problems with transitions are frequent in children with ASDs. These behaviors can take many forms. For example, a child may be preoccupied with turning lights on and off, or opening and closing doors, or feeling water run out of faucets. Some children may hoard objects or place them in very specific ways/places (and become upset if anyone changes them).

Although sometimes hard to measure, these behaviors can be particular sources of difficulty for higher functioning children. For example, children with Asperger's syndrome can spend inordinate amounts of time pursuing more facts in relation to their topic of interest. Typical kinds of interests in Asperger's include time, geology, astronomy, dinosaurs, and snakes. Some of the more unusual interests we've seen have included deep fat fryers, telegraph pole line

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insulators, disasters, and the names (of spouses and children) and dates of birth and home addresses of every member of Congress!

Sometimes lower functioning children with autism who otherwise seem to have very short attention spans can spend seemingly endless time on their particular fixation. Regardless of the child's level of functioning, these special interests are a problem if the child spends so much time on them that they actually interfere with her functioning in other areas.

Related problems are the "resistance to change" and "insistence on sameness" first described by Leo Kanner back in 1943. These problems often are combined with the restricted interests, since, in some ways, they are two sides of the same coin. That is, by being so fixated on a particular object or topic, the child also avoids being exposed to new situations and learning new things. Teaching staff and parents may find themselves going to great lengths not to provoke the child by keeping her from pursuing her interests, and, as a result, the child's learning may suffer

In younger and lower functioning children, insistence on sameness can take various forms. For example, the child may insist that you always take the same route to school, or that you always wear the same clothes to church, or that on Monday night you always have pizza. Sometimes it seems almost as if the child learns a thing once—the first time—and then cannot tolerate any change. Older and higher functioning children may rely on a set of very specific social routines. For example, one young man one of us knows always opens any conversation with a question from the quiz show *Jeopardy!* This is (kind of) okay for someone who knows him, but does cause trouble for those who don't when he opens a conversation with, "Monica Lewinsky and the category is politics"!

The difficulties that children with autism have in dealing with change really speak to their problems with information processing as well as their tendency to learn things in whole chunks (what psychologists call "gestalt learning") rather than breaking things down into bits (see chapter 5). As long as things stay exactly the same, the child doesn't have to deal with the complexity posed by change. This problem also speaks to the difficulties children with autism have in getting the big picture of social interaction. That is, social interaction presents many significant obstacles if you have trouble dealing with any change, since meaning is always changing, depending on who is talking and what he is talking about. Furthermore, the multiple competing cues in interaction (tone of voice, facial expression, gesture, and content of words), which provide important meaning for the rest of us, are potential sources of confusion and disorganization for children with ASD.

Sometimes, particularly for higher functioning children, special interests and preoccupations can be put to good use. For example, a child with Asperger's disorder who was interested in astronomy led the discussion of space and planets

in his fifth-grade class. Similarly, another child who was interested in chess was able to work as a chess teacher for his peers. Unfortunately, finding a good use for special interests is not usually so easily done.

Various strategies can be used to help deal with resistance to change. For children who do not have much spoken language, visual schedules can be quite helpful. As we mentioned previously, a small camera and notebook or cards can be used to help the child see what came before, what is happening now, and what is happening in the future. These visual schedules can be placed on refrigerators at home or on bulletin boards in the classroom, and the student's attention can periodically be drawn to them. A growing e literature on the use of these visual schedules now exists (see the reading list). A second strategy entails helping the child tolerate change through a more gradual process. Again, an entire body of work based on learning theory can be used to introduce change gradually. You can try ''planned change'' or ''planned surprises''—have times when you give the child the choice among three secret surprises—these can be put on the back of an index card. The child gets to pick one, not knowing what it is—of course, in the beginning make all the choices ones the child will like. Help the child work with time and organization skills (see also chapter 6). Depending on the child's level of ability, these can range from use of simple visual supports to lists (for children who can read) and organizers and more sophisticated computer/software devices. Another approach is to make the behavior more functional—that is, by helping the child use her interest in a more normal or typical way. The idea is that by helping the child learn to use her behavior in more productive ways, she can be helped to be more functional in daily life.

Other strategies are available for verbal individuals and are especially effective for children with Asperger's syndrome. These can include use of:

- Scripts and verbal routines (basically a ''canned'' set of verbalized guidelines a child can use to talk herself through specific situations)
- Social Stories™ (prewritten stories a child can review to help her practice and rehearse strategies for dealing with potentially problematic situations (see Chapter 6)
- Provided ''rules'' (e.g., you must always ask before you take something) that are simple, functional, and can be written down for children who read

Behavioral approaches can be helpful with more able children as well. For example, many higher functioning individuals have difficulty dealing with novelty—which makes them anxious—. In addition they may have trouble both in recognizing that something is new and in realizing that they are anxious. Explicit teaching and counseling can be quite helpful for these children.

A related issue has to do with compulsive and ritualistic behaviors. The child may have to go through a set series of actions or behaviors when engaging in some activity. One high-functioning man with autism we know will, for example, walk 3 miles out of his way every day as he walks to work to pick up his (same) lunch at a corner market because that market is the one he happened to go to on his first day on the job. A young adult woman with autism we know is very preoccupied with keeping all her clothes neat—every single item has a place in her room and heaven help anyone who tries to interfere with this!

Some ritualistic or compulsive behaviors have some similarity to those seen in **obsessive–compulsive disorder (OCD)**, a condition where people are troubled by obsessions (things they can't stop thinking about, such as the thought that they are bad, or the need to do something) and compulsions (the need to do an activity over and over, such as washing the hands because you are afraid they are dirty). Some degree of obsessiveness and compulsiveness is perfectly normal. It is not normal, however, if the child is washing her hands for 50 minutes at a time (often to the point where they are bleeding) or is so troubled by doing something bad that she is essentially immobilized.

The similarities of more typical OCD-type behaviors to some of these seen in autism (the rigidity and tendency to repeat things) are very interesting, and some of the drug treatments for these behaviors are similar for OCD and autism. A major point of difference is that often children (or adolescents and adults) with OCD will tell you that they *don't like* having to engage in the behaviors. In contrast, individuals with ASDs often find their compulsive behaviors are not distressing—if anything, they are things the child *likes* to do.

Various medications may be helpful with this set of problems (see chapter 15). The most frequently used medications are the selective serotonin reuptake inhibitors (SSRIs). The particular advantage of these medications is that they target both the rigidity and compulsiveness as well as the anxiety involved in dealing with change. Sometimes these behaviors respond to other medicationsas well.

Attention and Overactivity

Problems with attention and overactivity **(hyperactivity)** are fairly common in children with ASDs. These problems may include difficulties with listening, disorganization, high levels of activity, and impulsiveness. The child may be restless and on the go more or less all the time. Difficulties with not listening and impulsive behavior can be the source of much trouble, such as bolting into the street. For children with emerging language or no language, it is important to realize that at least some of the difficulties may relate to difficulties with language and communication. That is, if you have language, you can use it to help organize yourself, but if you don't, you will tend to be disorganized.

For higher functioning children with pervasive developmental disorder not otherwise specified (PDD-NOS), autism, and Asperger's syndrome who have language, the attentional problems (and to some extent hyperactivity) may suggest attention deficit hyperactivity disorder (AD HD), a commonly recognized syndrome in otherwise typically developing children of school age. The question as to whether to formally diagnose ADHD in children with ASDs remains somewhat controversial. One reason is that—at least for some children—language problems, learning issues, and difficulties with organization and lack of good judgment seem more part and parcel of the ASD. We know, for example, that children with language problems are also likely to have attentional problems. Particularly if attentional problems are confined to the school setting, it is important to look at the curriculum to be sure it is appropriately matched to the student's needs.

One of the first questions to ask is whether the child's difficulties with activity and attention are seen in all situations or only at school. If they occur only at school, it is then worth asking if these difficulties are seen in every class or setting or only in some. If only in school and only in some settings, it would be worth paying careful attention to what is going on. Ask questions such as:

- Are the language (or social–communication) demands for the child too high?
- Is the academic material over his head?
- Can the classroom environment be modified to help the child be more organized?
- Can visual support or augmentative communication systems or other strategies be used to help the have a more predictable learning environment? For example can a review of a schedule or preteaching be helpful?
- Does the child start the day doing well and then seem to "lose it" as time goes on? (If so, fatigue may be a factor.)
- Do different approaches seem to be helpful (giving the child periods for activity interspersed with school work)?
- What rewards motivate the child? What will the child work for?

If the problems with attention and/or overactivity seem to be happening in all parts of the child's life, some of the same considerations will apply. For instance, there should be a functional assessment and consideration of measures (such as visual cues) to help the child be more organized. For the more able child with Asperger's or high functioning autism/PDD, other organizational aids may be helpful. A behavioral program may be helpful in both school and home settings, with consistent record keeping and attention to the child's behavior coupled

with a system of rewards and positive supports. This effort should involve both parents and teachers so that the system can be applied consistently across the child's day.

A number of different treatments have been used over the years to help children with attentional problems. The most commonly used medicines (in all children) are the stimulants (amphetamines, methylphenidate). Some children, particularly more "classically autistic" children, may respond to these medicines by becoming *more* disorganized and active. (This does not always happen, and even when it does, the medicine is out of the system fairly quickly!). Other medicines are sometimes used as well and are discussed in the next chapter.

Mental Health Issues and Behavior Problems

Sometimes, particularly for more verbal and cognitively able individuals, behavior problems are seen but in the context of what appear to be additional mental health problems. The behaviors of the child with Asperger's who is highly anxious or depressed, or the more able student with autism who is rigid and compulseive can be suggestive of OCD. The phenomenon of having more than one disorder at a time is called *comorbidity*—a fancy term to basically say you have two problems, not just one. This issue comes up with reference to thinking about both behavioral problems and medications (and we talk about this again in the next chapter with special reference to drug treatments). In thinking about behavior problems, this issue of comorbidity has special importance when we think that behavior problems are coming about because of some other difficulties with anxiety or attention or depression. There can be issues of assessment and diagnosis with more cognitively able individuals with autism; these are magnified even further when the person doesn't talk much or at all. For example, how would you know the person is feeling depressed or that their blowups come when they feel the most anxious? Even when the child does talk, when do you decide when he is feeling depressed about school crosses the boundary from an understandable response to a clinical disorder? And finally, some problems come more frequently at some times; for example, clinical depression tends to be seen more in adolescents and adults, while anxiety and attention problems are usually first seen in younger children.

Several books have now appeared that focus on issues of dual diagnosis. One book attempts to modify the traditional diagnostic guidebook (the *Diagnostic and Statistical Manual of Mental Disorders* [DSM]) to make it more appropriate to individuals with cognitive challenge/intellectual disability (Fletcher, Loschen, Stavrakaki, & First, 2007). In contrast other works (e.g., Ghaziuddin 2005) focus more specifically on mental health issues in individuals on the autism spectrum.

It makes sense that many of the same treatments (behavioral, counseling, and drug treatments) might work for emotional problems in individuals with ASDs at least as well as they work for other problems. Unfortunately, until recently, this area has been a relatively neglected topic for research. Several different issues probably worked to delay work in this area, an important historical one being the tendency, in the 1950s, to (1) blame parents for causing their child's autism and (2) then recommending long-term intensive psychotherapy for the child (and parents) to "fix" the underlying parent-caused problem (Riddle, 1987). This approach was discredited in the 1970s, and, partly as a result, the entire issue of psychotherapy for individuals on the autism spectrum was relatively neglected.

Fortunately, this situation is beginning to change. Within the field of autism, particularly as individuals have become older, it is clear that many people can profit from very focused, counseling-type psychotherapies (Volkmar et al. 1999). Often, the explicit verbal teaching and focused problem solving so helpful to students with Asperger's (Myles, 2003) verges into psychotherapy. The boundaries of teaching, counseling, and psychotherapy can be blurry, but these approaches can sometimes be very, very helpful to students with behavior problems. There are some excellent papers that address some of these issues (Atwood, 2003; Bauminger, 2002). These address the behavioral difficulties, social problems, and difficulties with mood and anxiety so often found, particularly in older children and adolescents.

Within the psychotherapy field itself there have been some important advances. One approach, called *cognitive behavior therapy* (CBT), is grounded in findings from research in both cognitive and behavioral psychology. CBT refers to a range of different treatments used for a number of different problems, including mood and anxiety disorders. Some of these approaches focus more on the cognitive side, while others focus more on the behavioral side of things. These approaches have a number of advantages over older psychotherapies in that they tend to be brief and time limited. They may be done on an individual or group basis, and some have been adapted for people to do on their own. For example, the objective may be to help the individual understand why he or she becomes anxious and how anxiety can be identified and dealt with in more appropriate ways. In some ways, as you might imagine, the more teaching aspects (the cognitive part) of CBT can be very helpful for people on the autism spectrum, and, at the same time, the focus on behavior is also very helpful.

These approaches can be used to address various problems common in individuals on the autism spectrum, including mood and anxiety problems, recurrent thoughts, and obsessive features; and social problems, including coping with social relationships, making friends, and so forth (Atwood, 2003; Bauminger, 2007; Bauminger, Shulman, & Agam, 2004; Sze & Wood, 2007).

There now have been some scientifically well controlled studies showing that this method works well in helping children cope with and reduce levels of anxiety (e.g., Wood et al., in press).

What are the limitations of these methods? It is important to realize that one of the reasons why psychotherapy (and, by extension, many forms of counseling) got a "bad rep" in the autism world was the early focus on blaming parents and attempting to cure the child with autism. Even now, when our perspectives have changed dramatically, there is some potential for people to overly focus on some condition as causing/explaining/excusing bad behavior. The excusing part is a particular source of disagreement with schools. Sometimes there is, of course, truth in the observation that the child acted out because he was stressed or anxious or depressed. However, other children without ASDs also become anxious and depressed and stressed. So, as is often the case, the truth lies somewhere between the two extremes. For many children, an explicit focus on problem behavior will lead parents and teachers to a straightforward behavioral assessment and intervention. However, particularly for more able students, a broader view of the troubles may lead to other kinds of intervention. When CBT or other talking-type therapies are explored, it is important that teachers and parents (and the individual) *not* lose sight of the behavioral difficulties. Also, it is important for therapists to keep in mind that usual short-term intervention models—for example, the individual comes to a group for 6 to 10 weeks and then is finished—may be less applicable. In our experience (and one of us has seen a handful of folks, off and on, for several decades), a model where people on the autism spectrum tap into services when they need them may be most appropriate.

Case Examples

Here are two case examples of how behavioral techniques could be used effectively in dealing with "bolting" (see chapter 11 for a more general discussion of safety issues).

Case 1: Willy

Willy was a 9-year-old boy with autism. He had some words, but generally his expressive speech was rather limited. He understood language to a greater degree than he actually used it. Cognitive testing with him had consistently shown that he was functioning overall in the moderate range of intellectual disability, with a full-scale intelligence quotient (IQ) of about 50, although his nonverbal abilities were higher (close to 70). The problem with bolting/running out of the classroom had started in the fall as Willy was enrolled in a new classroom setting. He previously had not had many behavior problems. As part of the

understandable attempt to provide him with greater access to peers, he was being mainstreamed for the mornings (for the most part), spending most of his afternoon in special education and/or getting his various specials. Staffing in the morning included a regular education teacher along with a paraprofessional (mostly for Willy, but also for one other student with special needs). The special education teacher consulted to the regular ed teacher, but only periodically. The bolting was almost entirely confined to the morning setting. The regular ed teacher had tried several things, including trying to reason with Willy, and then, at the suggestion of the speech pathologist, giving him a written schedule and making some other accommodations for him. Despite these changes, by the middle of October, he was running/bolting about 15 times a day on average. A behaviorally trained psychologist was asked to consult and spent some time observing Willy at various points during his day and spent time in his various classroom settings. She also spoke to Willy's parents, who were as mystified as his regular ed teacher since Willy did not generally have a problem with bolting/running at home.

The psychologist noticed two different factors that seemed to contribute to the behavioral difficulties. She recommended two different interventions, but did this in stages. The first recommendation (see Figure 14.1) occurred on day 5. The psychologist in her previous 4 days of observation realized that the bolting/running business had turned into a fairly exciting and dramatic game for Willy. He would carefully wait for his moment, then bolt, precipitating yelling/screaming/general upset. He was smiling a good part of the time and seemed to enjoy the run-and-chase activities.

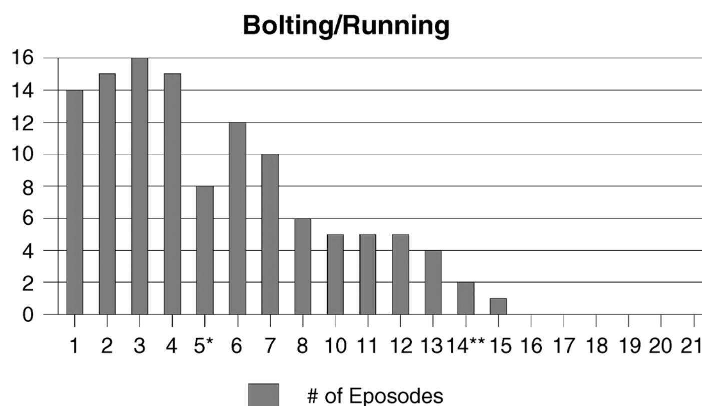

FIGURE 14.1 **Behavioral data from Willy, a boy with ''bolting.'' Data are presented for consecutive school days; * and ** indicate changes in behavior procedures. See text for explanation.**

The psychologist arranged for the school guard to be available in the immediate area (but outside the classroom on day 5) and had arranged with him to be on the alert for Willy and to calmly and matter-of-factly escort him back to class. The teacher and paraprofessional were instructed when Willy bolted to *not* engage in the run-and-chase game but to generally ignore this behavior. The system was in place for alerting the school guard, who indeed would meet Willy in the hall and redirect him back to the classroom.

On the first day this was instituted as a procedure, the bolting decreased. For the next 2 days, it appeared that Willy was testing the limits, but by day 8 it did appear that the behavior had been markedly reduced but still persisted at lower levels. At this point, the psychologist introduced her second change (day 14). In keeping track of episodes, she realized that these were now almost always confined to a situation (reading group) when Willy was most challenged. Accordingly, she arranged for Willy to spend this time in a quiet area away from the main group, where he worked with his paraprofessional for most of the time, rejoining the class only at the end. Willy's bolting quickly dropped to zero.

Case 2: Johnny

Johnny was a 6-year-old with Asperger's who had begun attending a new primary school. He was quite verbal but also very socially disabled. Although motorically clumsy, he was fascinated with the furnace and the basement of his school (which is where the furnace was located). He quickly developed a habit of sneaking away (whenever the teacher's back was turned). After a search, he was invariably found in the furnace room in the basement. Attempts to reason with him were not successful. The custodian, whose room was next to the furnace, was considerably annoyed by all the trouble Johnny created.

In this case the psychologist's recommendation was to try to use, to the extent possible, Johnny's motivations and interest in a positive way. Accordingly, a token reward system was instituted. When he stayed through an entire class without sneaking away, he received a red poker chip. When he had six chips (and there were six classes during the day), he was able, at the end of the day, to have a prearranged 10-minute meeting with the janitor (Mr. Bob) at the furnace area, who would demonstrate different aspects of the furnace, talk about furnaces, and so on. This turned out to be highly motivating for Johnny, and, somewhat paradoxically, Mr. Bob developed a real friendship with him (after all, they shared an interest in the furnace). The predictability meant that the janitor's life was not constantly disrupted and, in the end, Mr. Bob became a real advocate for Johnny at school and served as his "safe address"; when things got tough for Johnny, he could

always ask for a pass to see Mr. Bob, who would ask him what was going on and have him return to his classroom. At the end of the day, Mr. Bob would check with the teacher to be sure she or he knew about Johnny's trouble.

In this instance it was possible to rapidly address the problem behavior. More importantly, what seemed like a simple subsequent step (having Mr. Bob serve as Johnny's safe address in school) was actually a fairly sophisticated technique. Rather than losing it (for reasons he often was unaware of), Johnny was encouraged to substitute a more appropriate behavior (seeking his adult friend), which prevented/disrupted blowups and got a sympathetic adult involved in the process of monitoring Johnny's behavior.

Case 3: Carla

Carla was a 12-year-old girl with Asperger's disorder. She had (for many years) a preoccupation with small creatures—now focused on the various kinds of protozoans. Her nonverbal problem-solving skills were in the average range, while her verbal skills were in the superior range. Her social skills were more like those of a typically developing 4-year-old. She had a strong desire to have friends but rather limited abilities to make and actually keep friends. Her anxiety was a major problem for her—any kind of pressure (a test, assignment, upcoming school special event) would be the source of tremendous anxiety, and behavioral upset regularly followed. Her parents began to dread "special" days in school because they knew she would be highly anxious and extremely difficult in the day or two before the event.

The school psychologist recommended a local clinical psychologist who was interested in CBT. He worked with Carla on a regular basis for a preplanned 10 sessions. During the therapy, the two of them worked on a set of very specific issues that they outlined together in the first two sessions. This included stress identification and stress management, learned relaxation techniques, increased awareness of the experience of anxiety, and a series of homeworks/practices in which Carla was able to focus on using specific strategies to reduce anxiety. This effort met with considerable success in reducing acute anxiety levels, although both Carla and the therapist realized it has done little to work on her desire for more friends in her peer group. They agreed to continue individual work focused on this issue, and Carla began to attend a social skills group.

In this case, a more cognitively able child could use some of the strategies provided by CBT to focus on acquiring specific problem-solving skills and strategies. As is sometimes the case, having helped her become more able to cope with her anxiety, Carla was then aware of other issues, particularly peer relationships, and she and her family chose to pursue further, focused work on this topic.

Summary

In this chapter, we described some of the more common behavior problems that children with ASDs exhibit. Again, we emphasize that many children with autism do *not* have these problems. Sometimes problems come up at certain times in life or in certain situations (the start of a new school, adolescence), and sometimes they go away on their own. It is important to realize that behavioral interventions can be very effective. Occasionally, problem behaviors are unwittingly encouraged by teachers or parents. It is important that parents and teachers be aware of their own impact on the child and the potential—for good or ill—of significant effects of their behavior on the child.

Thinking about interventions requires a careful look at the entire situation, including the child's environment and a detailed analysis of when, where, and why the behaviors seem to be occurring. The good news is that many problem behaviors can be managed effectively.

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QUESTIONS AND ANSWERS

1. **We have a child with autism who has had severe self-injury. We want to find a specialist who can work with us and the school. What kind of doctor are we looking for?**

   Various specialists might be helpful. These include behavioral psychologists and behavioral specialists as well as adult and child psychiatrists, adult and child neurologists, and developmental and behavioral pediatricians. You should look for someone who has experience in dealing with these problems. Your primary care doctor may be able to give you names of people. Other good sources of information include school staff and other parents.

2. **My child has recently started slapping the side of his jaw. He has never done this before and only slaps one spot. What should I do?**

   You might want to see your doctor and your dentist to check his ears and his teeth. The new onset of self-injurious behavior should usually prompt a doctor visit, particularly in a child who is not able to communicate well with words.

3. **A 10-year-old boy with autism has developed some significant behavior problems in my classroom. He is mainstreamed for most subjects with pull-out time for special services. He gets agitated and increasingly upset just before it is time for the class to move on to gym (he goes to a special adaptive PE class). Should we let him skip gym?**

   You have already made a crucially important observation—you can predict when the trouble starts! Now the thing to do is ask yourself the basic who, what, where, when, and then why to think about what you want to do. If the boy is verbal, you can start by talking to him about this. Depending on what you learn, you may decide to use any of several different strategies. It may be that he is trying to avoid the special PE class for some reason—then the issue is to find out why. Or it may be that he is upset that he is not joining the rest of the class for regular PE; if so, maybe he could join with some supports for at least part of the time to start with. Or maybe it is just because the literal transition from one classroom to another is difficult; if this is so, thinking about having him go a minute or so before the class is over (when the hallways aren't so busy and confusing) might be appropriate. All of these are just some ideas—what you do depends on carefully thinking about the situation. Probably the one thing we would *not* recommend is skipping PE; children with autism have better behavior when they

exercise regularly and because of their social difficulties often don't get enough exercise to begin with.

4. **My 8-year-old daughter has a thing about doors—she loves to open and close them. In the past she did the same thing with light switches, turning them on and off. I know this doesn't sound like a big problem, but it drives me and my husband crazy sometimes!**

   The problems with social development in autism also lead to major problems in play. The kinds of behavior you described (repeated doing and undoing) are more typical of younger (typically developing) toddlers, who enjoy doing and undoing things, for example opening and closing things, and stacking blocks and knocking them down. For children on the autism spectrum, these interests become entwined in the tendency to insist on sameness and don't go on, like those of the typically developing child, to be replaced with more symbolic and imaginative play.

   There are several things you can try. First, see if you daughter can be interested in simple play materials with doors or light switches, for example, a little dollhouse or even a special toy you make with some little doors on it. Look in a toy store for simple cause–effect toys (the child does something and immediately something happens). If you can get your daughter interested in a dollhouse, you can then try to start building in more pretend play with you and with other children. A behavior consultant may be able to suggest some things; for example, you can try to control her interest in doors by using 5 minutes of this activity as a reward for having a good lesson. The idea is to have you gain some control over the behavior so it is not so dominating. Another possibility is to have her be in charge of the doors at home or school; for example, she can be the official doorkeeper, opening the door only when someone knocks.

5. **My 6-year-old son used to have a real problem with spinning things or sometimes flicking things back and forth in front of his eyes. This seemed to have disappeared around age 4, but now that he is going to school, it has started up again. He is now in an inclusion classroom for most of the day. This seems to come up only in the classroom, but the teacher says the other kids really notice it. What should we do?**

   It is always helpful to ask yourself *why* a behavior is coming up. It is possible that your child is overstimulated in the classroom and, as a result, is resorting to some other (although odd) behaviors that make him feel

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more comfortable and in control. Take a look at the classroom setting; you can also think about ways of reducing sensory or information overload (see chapter 5) if the class is too stimulating. Another option is to have the other students be more proactive in helping your child learn more appropriate social skills (see chapter 6). Peers can be very good at both modeling more appropriate behaviors and giving the child on the autism spectrum something to do!

6. **My 8-year-old son with autism was doing relatively well with partial mainstreaming last year. This year he is fully included and his behavior seems to have deteriorated. It always seems like he is on edge and "ready to blow." For the first time in years, we are getting negative reports of his behavior in the classroom, particularly around transitions from one room to another. Should we rethink the mainstreaming?**

   It may be helpful to request a functional behavioral analysis (in which a behavioral psychologist or trained special educator analyzes what exactly sets off and follows the problem behavior. There are many benefits to mainstreaming; that being said, it is not uncommon for children on the autism spectrum to start having difficulties if the academic level of the class is at a much higher level than they understand; that is, the child becomes frustrated and behavior deteriorates. This may happen in only one class (e.g., spelling) and not others. Or it may happen only in some situations, for example, when the child feels like his space is being invaded. Or—and this may be true for your child—it may be that the actual moving around (from one room to another) is the source of the problem. A behavioral psychologist can help identify the cause of the difficulty and help you and school staff put a plan in place to deal with it.

7. **My 16-year-old son with Asperger's has horrible problems in dealing with novelty. Is there anything you can suggest to help him deal with this?**

   You have already done an important part of the work in identifying the source of the problem (novelty). You also mention that he has Asperger's, and so we assume he is more cognitively able. If this is indeed true, several possibilities come to mind.

   First, you can work to help him recognize when he is in new situations—he may be having trouble realizing this and get anxious, and then have behavioral troubles, before any recognition on his part of what is going on. Help him recognize and articulate ways he can (1) tell that he is in a new situation and (2) recognize signs of anxiety (increase in heart rate, feelings of anxiety, sweaty palms, etc.). Once you have done this,

you can then start to think about ways to give explicit coping strategies. For some individuals, the awareness that they are in a novel situation may be helpful. Sometimes it is helpful to teach ways to then apply specific strategies; for example, I can tell myself I'm anxious in new situations and take steps A, B, and C to deal with it. Another approach is to use cognitive behavior therapy procedures (e.g., teaching relaxation techniques). Several good resources are provided in the reading list.