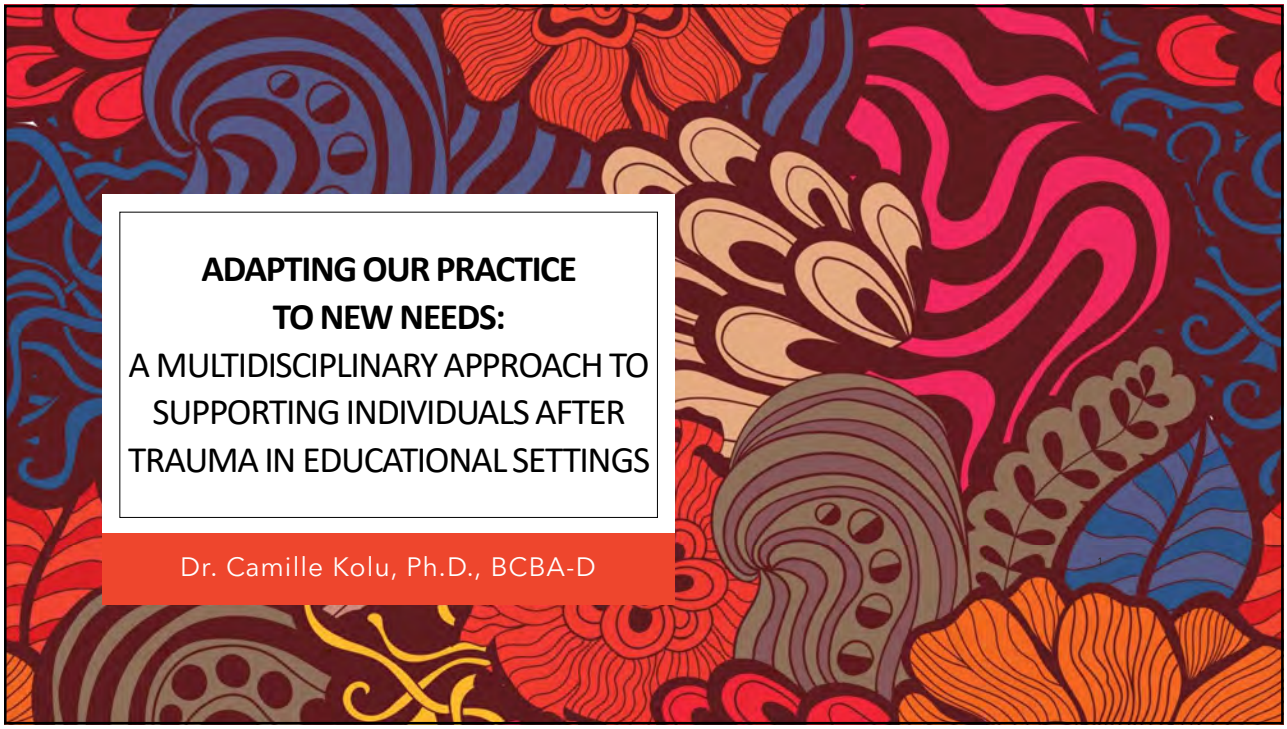
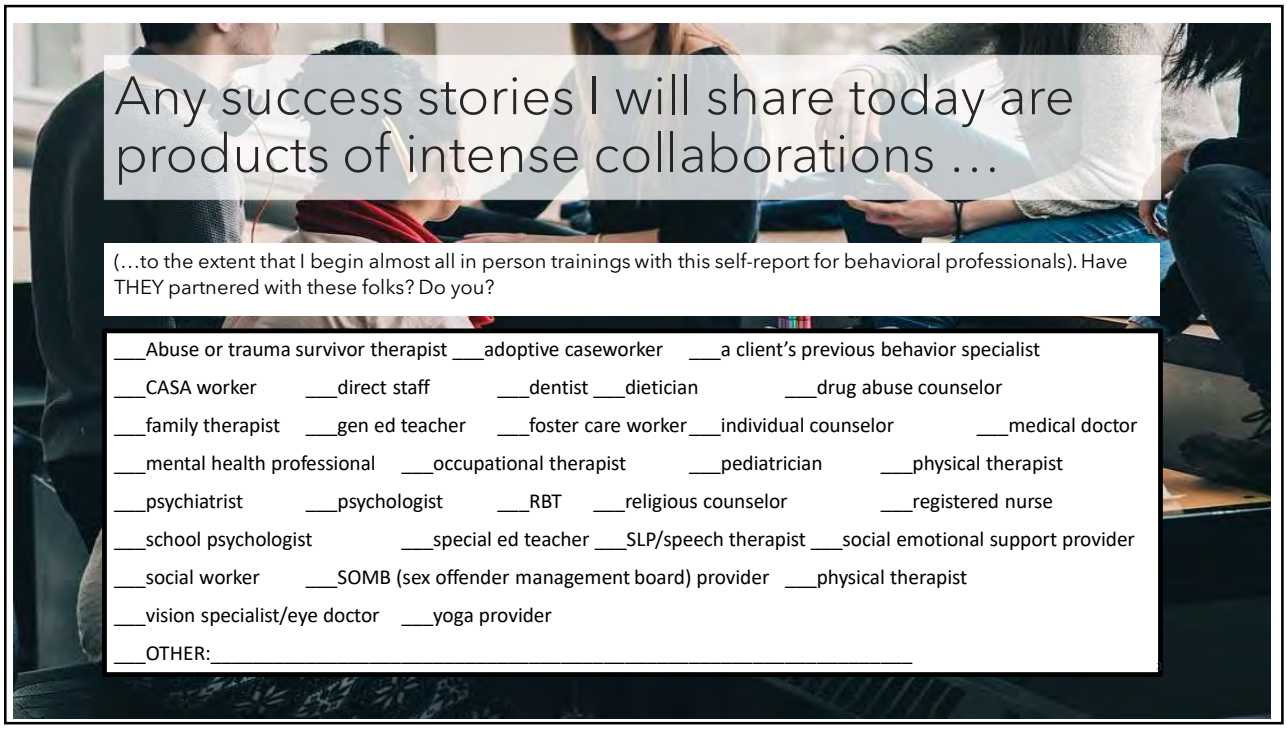

ADAPTING OUR PRACTICE
TO NEW NEEDS:
A MULTIDISCIPLINARY APPROACH TO SUPPORTING INDIVIDUALS AFTER TRAUMA IN EDUCATIONAL SETTINGS
Dr. Camille Kolu, Ph.D., BCBA-D


Today's partners include
APSEA
Atlantic Provinces Special Education Authority
C.E.U.
cuspemergence.com
cusp. university


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 ___individual counselor ___medical doctor
___mental health professional ___occupational therapist ___pediatrician ___physical therapist
___psychiatrist ___psychologist ___RBT ___religious counselor ___registered nurse
___school psychologist ___special ed teacher ___SLP/speech therapist ___social emotional support provider
___social worker ___SOMB (sex offender management board) provider ___physical therapist
___vision specialist/eye doctor ___yoga provider
___OTHER:_____


ABSTRACT
4
cuspemergence.com

Abstract

Despite the cultural movement to extend the inclusive principles of trauma informed services to behavior supports and education, many of us lack the training or support to apply this idea, and 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 students, may be contraindicated for someone with a significant history of adverse childhood (or educational) experiences. This series aims to empower educators from all disciplines to understand some of the links between what students need after trauma, and how we can help, in a context rich with collaboration, risk mitigation practices, and an understanding of how past experiences can shape and inform current needs. Participants will be equipped with useful tools that may support our students with both significant and minor histories of trauma—and those in between, for whom a trauma history may be suspected but cannot be documented.

5

Why TIBA?

Trauma-Informed Behavior Analysis

Children with autism are **2.4x** more likely to enter foster care

Up to **40%** of people in foster care were abused there

About **80%** of people in prison were in foster care system

http://www.foster care2.org/ask-the-pros-2

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.

cuspemergence.com

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

kolubcbad@gmail.com

9

LEARNING OBJECTIVES

10

cuspemergence.com

1

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

11

LEARNING OBJECTIVES

cuspemergence.com

2

2. Participants will select examples of using tools to enhance behavior support practices with people affected by trauma

12

LEARNING OBJECTIVES

cuspemergence.com

3

3. Participants will select features of multidisciplinary case studies in which behavior analytic procedures are supportive components of student support after trauma

13

LEARNING OBJECTIVES

cuspemergence.com

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

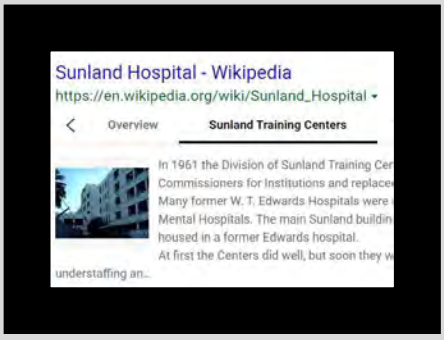
Take special care with…

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**

15

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

16

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

17

cuspemergence.com

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)

18

cuspemergence.com

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 some of their needs may be outside the realm of behavior analysis)

19

cuspemergence.com

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

20

cuspemergence.com

Aniyah

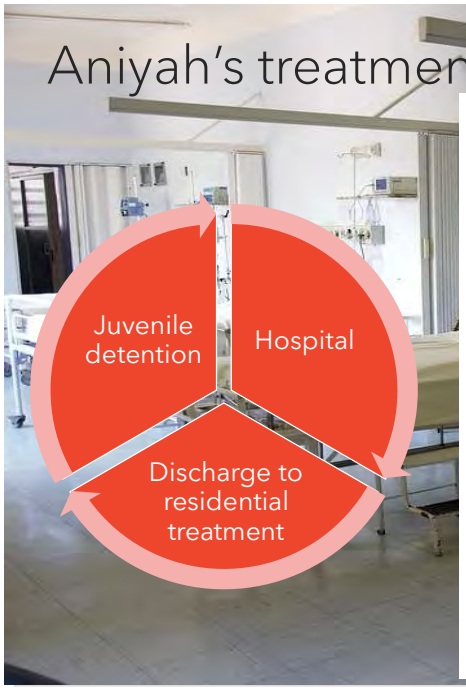
- 14 y/o trans girl
- Living in hospital on "wait list" for residential treatment
- Kicked out of multiple schools
- Many run-ins with law, juvenile detention
- Drinking, prostitution, robbery, gang activity at 9 years old
- Once-adoptive parents "gave her back"; gang related abuse in bio home

Residential ABA school wanted consultation to understand why "nothing was working"; wanted training before bringing her back

What's behavioral about this slide?

- Note the social validity piece and buy-in from the client
- Technology and graphics help guide staff (new staff see video icon and click on her brief training (uses TIPS)
- Two NCR-like schedules are built in (one is the FT 15m staff attention; another is weekly police visits)
- Triggers are mentioned with instructions, see symbol

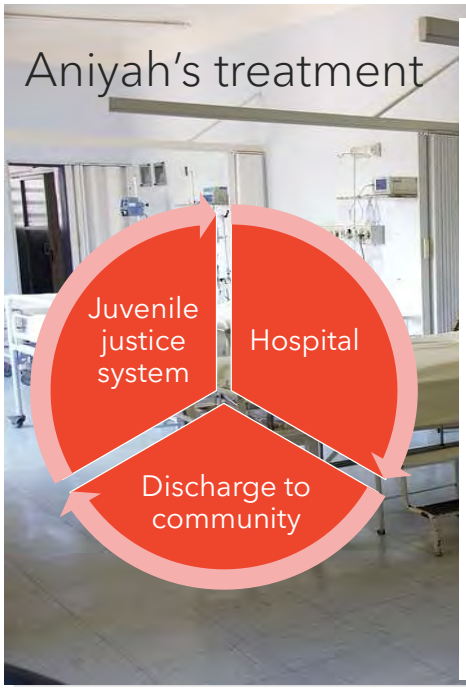
Aniyah's treatment



- **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**

23

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
  - Used staffing huddles to **communicate with the whole wing of the hospital (all residential team)** every few days for about 5 minutes at a time
  - **Used a TIP-like procedure** (Teaching Interaction Procedure) to teach new staff (give rationale, instructions, examples, nonexamples for responding to client

24

Is it SAFE to treat behavior yet?

See Code Items

- 2.03 a, b — **S**upervision: Improved case supervision and systems support, including involving high levels of funding agents, law enforcement, hospital management
- 4.05 b, 7.02 b — **A**ssessment of risks: Added significant risk versus benefit analysis; documented all risks and teamed about them; began to make decisions based on risk mitigation plans
- 3.02 — **FBA 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
- 4.0 — **E**valuation and environmental management: Evaluated team's ability to implement plan; taught preventative skills to all team members before attempting to modify client's behavior; continuously assessed environment for barriers to safety and treatment, etc
- 3.02 a — **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)

25

CODE 1

659HR

26

47th Annual Convention (Online)

Presidential Scholar

Nadine Burke Harris, MD, MPH, FAAP
California Surgeon General

Breaking the Intergenerational Cycle of Adversity

Abstract: A consensus of scientific research demonstrates that cumulative adversity, especially when experienced during childhood development, is a root cause to some of the most harmful, persistent, and expensive health and societal challenges facing our nation. Adverse Childhood Experiences (ACEs) and toxic stress are a public health crisis that require a coordinated cross-sector response. As California's first Surgeon General, Dr. Nadine Burke Harris has set a bold goal to reduce ACEs and toxic stress by half in one generation in California. Dr. Burke Harris will present on evidence-based early interventions, California's ACEs Aware state-wide initiative to train health care providers on how to screen for ACEs and the cross sector approaches needed to truly have an impact on the individual child, their families and the broader community.

Bio: Dr. Nadine Burke Harris is an award-winning physician, researcher, and advocate dedicated to changing the way our society responds to one of the most serious, expensive, and widespread public health crises of

ABAI
47th Annual Convention

REGISTER NOW >

PROGRAM ONLINE >

MAKE A SUBMISSION >

CAREER FAIR >

BRIEF REVIEW

28

cuspemergence.com

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**

29

OBJECTIVE REVIEW

Some critical multidisciplinary team members for Aniyah

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

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

31

But what if we assessed for "adverse conditioning experiences", not just "childhood experiences"?

Adverse, not just "aversive" conditioning 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)

32

- 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**

33

Trauma and "schedule related behavior"

34

- When a child experienced disruption in the everyday rhythms of caregiving,
- This may produce odd, age-inappropriate, long lasting intrusions in the behavior stream of the affected children….
- That appear when the student appears to be doing well otherwise, in relationship to some stimulus event paired with the presence of the disruption in the past
- And that are **not solely a function** of the immediate environment

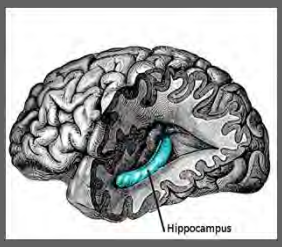
After doing reunification work with families whose children had been removed after abuse or neglect, observed disruption in stimulus schedules (e.g., the child suddenly interacted with typical childhood stimuli differently)

Example: In response to adult praise, or a caregiver 35 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)

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

Is this context safe or unsafe?

37

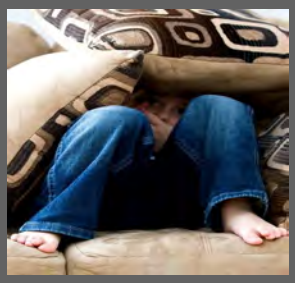
Jonah's story

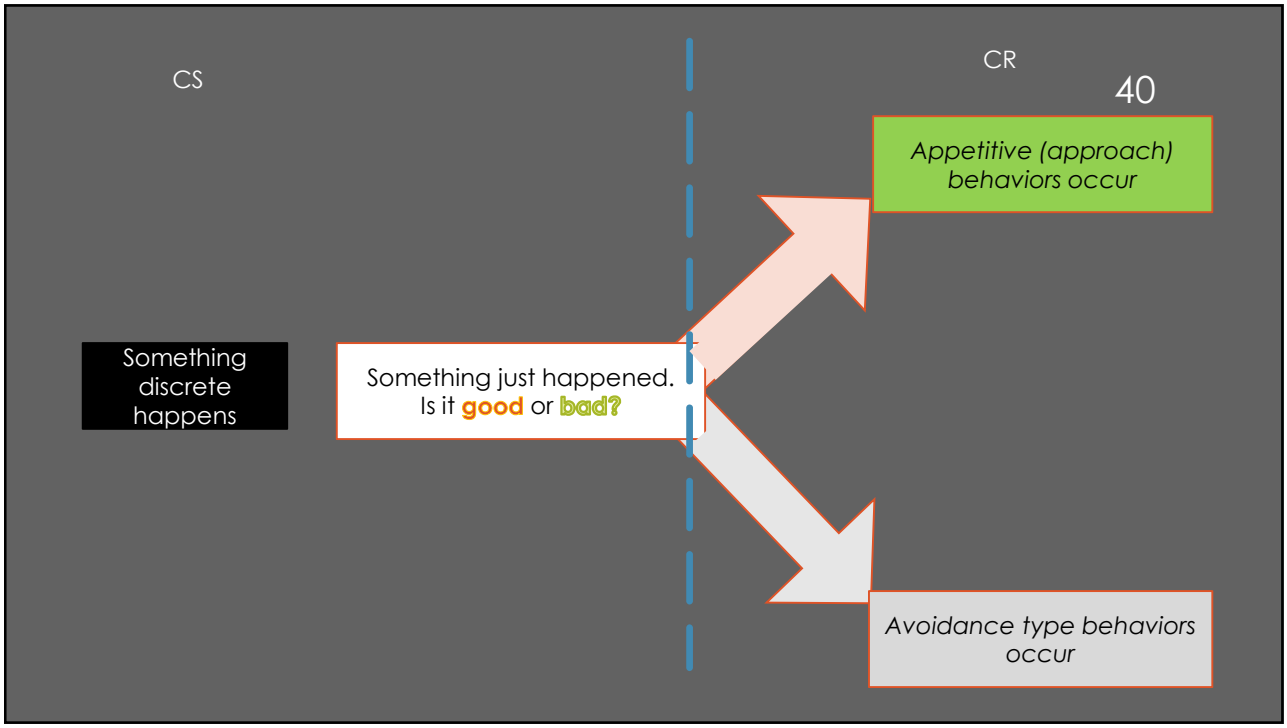
38

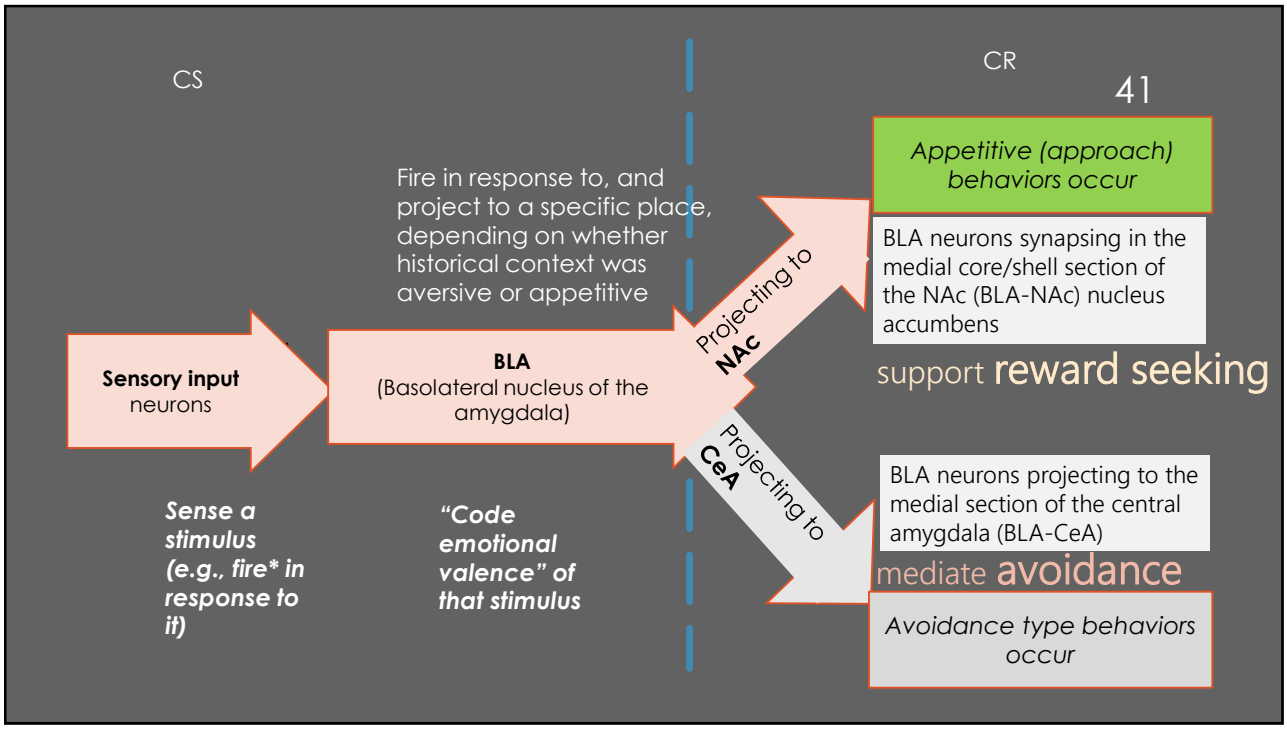
It has been loud all day out in the hallway. Jonah is sitting in his math class when suddenly the political science classroom down the hall erupts again in loud shouts, laughter and excitement. They have been having a debate lesson and were watching coverage of an election. People cheer. Most kids in Jonah's class look around and go back to their work quickly. His teacher notices he has crawled under his desk and is trembling. There is a puddle of urine spreading underneath his desk. She remembers the conversation with his school psychologist last month and all the possibilities they had discussed- Should they have him clean it up or would that be humiliating? is he getting out of class too much? Is this related to how difficult he finds math? She had told the SP it seemed to happen out of the blue but today she pauses and thinks. Although almost no one noticed the noise down the hall, there is no danger, and no one was speaking directly to Jonah, for the first time she wonders if his behavior had something to do with what had just happened in the hall. She sighs as she drafts a note to his foster mother to tell her it happened again.

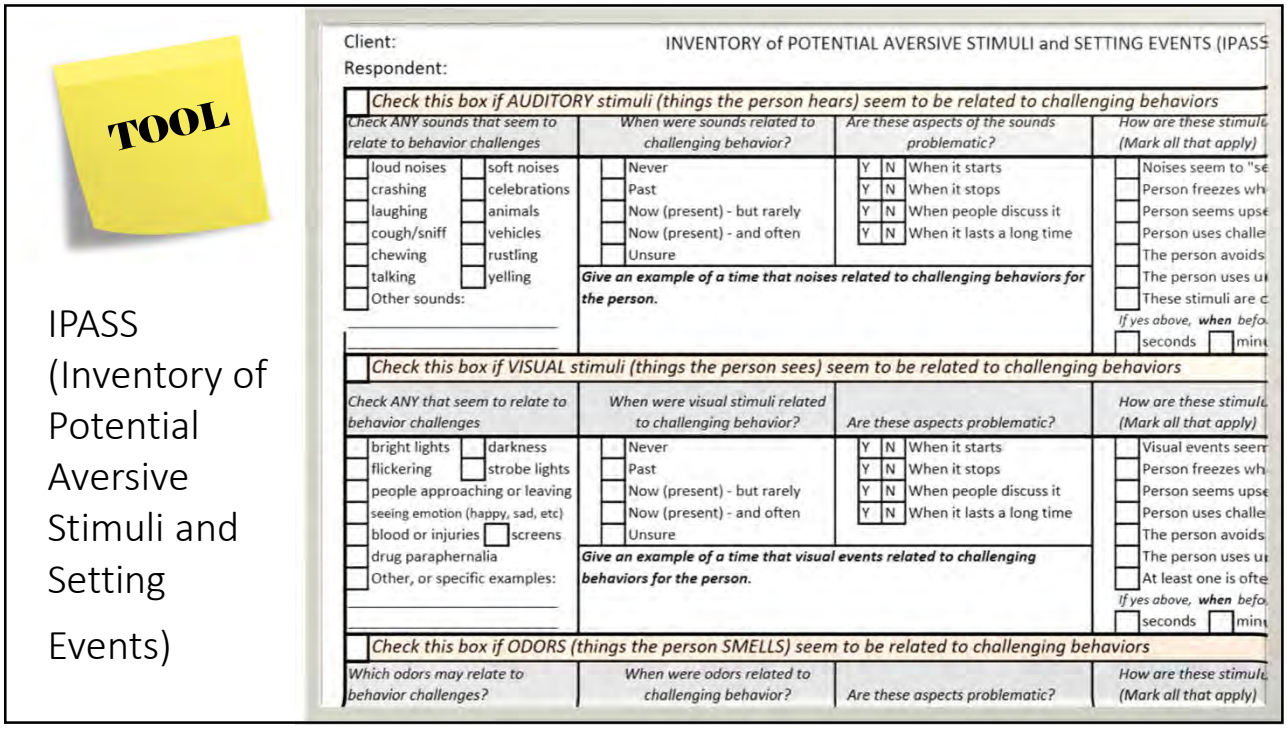
Jonah has been freezing and losing bladder control at school when people are loud or celebrate. One day his behavior analyst does a home visit and learns more.

39

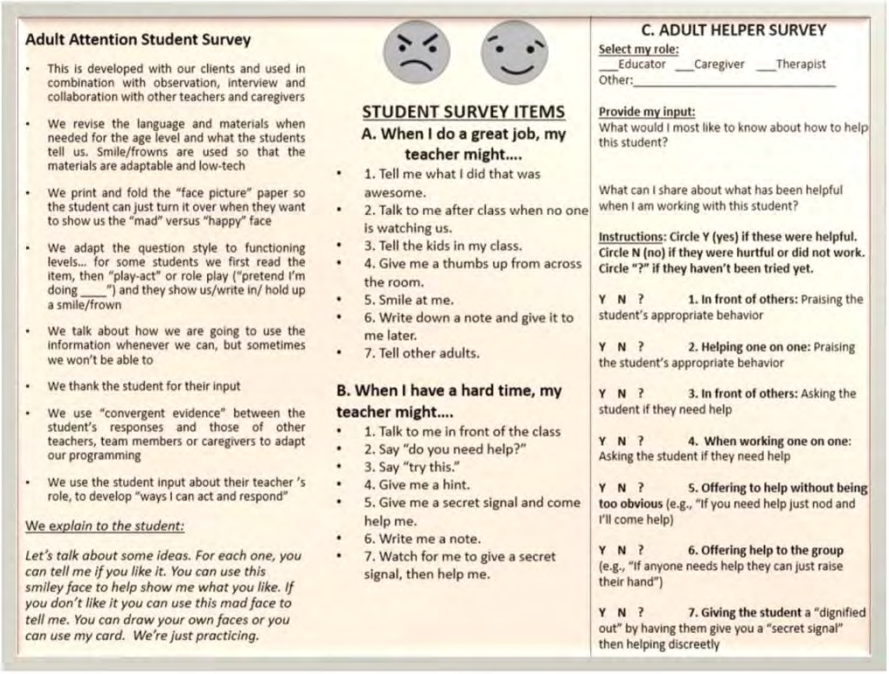
HISTORICAL context	LOCAL Context/ situation	Antecedent variables	Behavior
DISTANT past: In the presence of multiple adults, shouting leads to hitting	**Current situation and recent history:** Living in foster home; recent loss of family		
	Jonah is playing on floor. People are over for a sports watching party.	Screams and shouts	(the boy) **startles/jumps,** then freezes, urinates
	Contextual variables; room; presence of several adults; game	SDs; S-deltas; **unconditioned** and **conditioned stimuli (loud noises)**	**Unconditioned and conditioned respondent responses**, operant responses




CS
CR
41
Fire in response to, and project to a specific place, depending on whether historical context was aversive or appetitive
Sensory input neurons
BLA (Basolateral nucleus of the amygdala)
Projecting to NAc
Projecting to CeA
Appetitive (approach) behaviors occur
BLA neurons synapsing in the medial core/shell section of the NAc (BLA-NAc) nucleus accumbens
support reward seeking
BLA neurons projecting to the medial section of the central amygdala (BLA-CeA)
mediate avoidance
Avoidance type behaviors occur
Sense a stimulus (e.g., fire* in response to it)
"Code emotional valence" of that stimulus


TOOL
IPASS (Inventory of Potential Aversive Stimuli and Setting Events)
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
loud noises
soft noises
crashing
celebrations
laughing
animals
cough/sniff
vehicles
chewing
rustling
talking
yelling
Other sounds:
When were sounds related to challenging behavior?
Never
Past
Now (present) - but rarely
Now (present) - and often
Unsure
Are these aspects of the sounds problematic?
When it starts
When it stops
When people discuss it
When it lasts a long time
Give an example of a time that noises related to challenging behaviors for the person.
How are these stimuli (Mark all that apply)
Noises seem to "se
Person freezes wh
Person seems upse
Person uses challe
The person avoids
The person uses u
These stimuli are c
If yes above, when befo
seconds
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
bright lights
darkness
flickering
strobe lights
people approaching or leaving
seeing emotion (happy, sad, etc)
blood or injuries
screens
drug paraphernalia
Other, or specific examples:
When were visual stimuli related to challenging behavior?
Never
Past
Now (present) - but rarely
Now (present) - and often
Unsure
Are these aspects problematic?
When it starts
When it stops
When people discuss it
When it lasts a long time
Give an example of a time that visual events related to challenging behaviors for the person.
How are these stimuli (Mark all that apply)
Visual events seem
Person freezes wh
Person seems upse
Person uses challe
The person avoids
The person uses u
At least one is ofte
If yes above, when befo
seconds
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)

Adult Attention Preference Assessment



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

In practice,

If I know something about the nature of the person's trauma and how they responded, this could be predictive information about responses to "conditioning situations" we might encounter in treatment.

Example:
Client whose response was learned helplessness may engage in freezing, dissociation/spacing out, etc

If a client has an aversive conditioning history, that client **may use a response that was paired with** (or functional during) their adverse conditioning history.

On the upside…

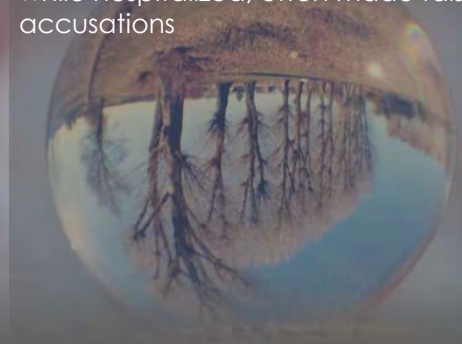
In practice,

45

If a client has an aversive conditioning history, that client **may use a response that was paired with** (or functional during) their adverse conditioning history.

Example:

Older sexual abuse survivor had fled foster care experience, had I.D., and was convicted of assaulting teens; while hospitalized, often made false accusations



Related risks and mitigation:

- Client is at risk of using specific challenging behaviors after moving, after conversations about leaving hospital, in presence of inadequate supervision
- Trained staff before any moves, staffing changes
- Provide increased supervision when around others (e.g., staff and volunteers and hospital visitors), after changes in staffing or residence
- Provide direct staff with training and resources to document false accusations, use surveillance when appropriate, work in collaboration with mental health and trauma therapists

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

46

-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…

When a contribution of *medical* trauma is revealed,

47

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

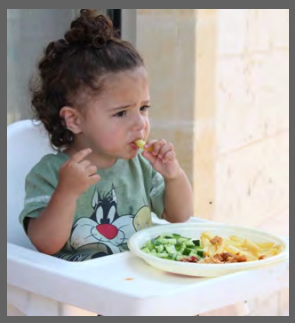
Sophie

48

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.

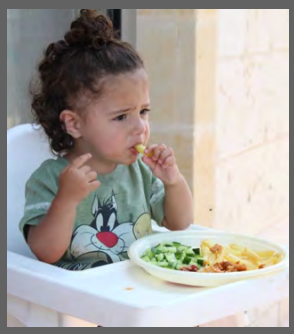
Sophie

49

HISTORICAL context	LOCAL context	Antecedent variables	Behavior
	It's lunchtime. Mom and a therapist are present.	Food on spoon is placed inside Sophie's mouth	Child vomits and turns head
	Contextual variables: room; mom; spoon; learning history	SDs; S-deltas; **unconditioned** and **conditioned stimuli**	**Conditioned respondent responses**, operant responses

Sophie

50

HISTORICAL context	LOCAL context	Antecedent variables	Behavior	C
	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**
	Contextual variables: room; mom; spoon; learning history	SDs; S-deltas; **unconditioned** and **conditioned stimuli**	CRs, **operant responses**	**Behavioral processes: EXT** of avoidance behaviors? SP (presentation of conditioned aversive stimulus)?

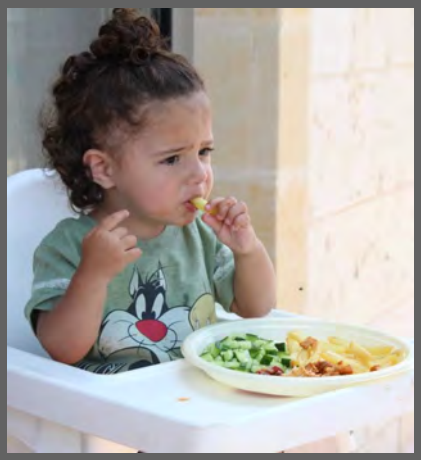
Sophie

51

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

52



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

Aversive procedures are well-known in behavior analysis, but…

53

How might this item apply to clients who experience "everyday" techniques (including "pairing", praise, etc) as aversive due to (often unknown) histories in which people and things were paired with aversive events? And do we have a responsibility to *assess and document* aversive, and not just preferred, variables?

- We have discussed some applications of behavior analysis that can help our clients after trauma (e.g., risk versus benefit analyses, examining historical contributions to behavior)
- We have seen a couple of tools to start documenting relationships between challenging behaviors and setting events and took a look at contraindicated procedures.
- Next time we'll learn more tools, and look at additional case studies putting it all together.

54

BRIEF REVIEW

"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

Thank you, APSEA!

Contact:
Dr. Camille Kolu, Ph.D., BCBA-D
www.cuspemergence.com
kolubcbad@gmail.com