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Behavioral And Daily Challenges In Children With Autism Recorded October 1, 2020

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- [Fawn] Today's course is Behavioral and Daily Challenges in Children with Autism. Our presenter today is Dr. Cara Koscinski. She is the author of the award-winning "Pocket Occupational Therapist Book Series," is a pediatric occupational therapist, and specializes in trauma-informed care, behavior, interoception, and autism. As an educational speaker, Cara incorporates her expertise as a mother of two children with autism. She has published six books and has over 98,000 followers on her blog and social media channels. Cara is also a children's yoga instructor. In addition to her books, Dr. Koscinski regularly blogs and creates fun products for those who work with children who have special needs. She serves on the advisory board of Autism Asperger's Digest Magazine. She's also an instructor for the University of Saint Augustine Occupational Therapy program. Welcome back, Cara. So glad to have you.

- [Cara] Thank you so much. I'm really happy to be here at OccupationalTherapy.com for another wonderful course. I love this topic because it's near and dear to my own heart. As they mentioned, I do have two children with autism. My kids are now older. My older son is 20 and my younger son is 17, and they're at different ends of that autism spectrum. So, I not only work with this as an occupational therapist, but I'm a mom that also lives with the behavioral and daily challenges of autism. Just so you know, here's the disclosure slide. And again, there's my children. If you see the Autism Asperger's Digest, that is when they were about maybe five or six years ago, that photo was taken. But that's them. And they are in a very grassy setting right there. And that was a huge tantrum, as you can imagine, with sensory issues that they had, but we were able to snap that cover photo. And I love to speak with Temple Grandin. She and I have spoken together at over a dozen conferences, and it's really neat to get to talk with her and share her insights regarding all of this. So, I've got a little bit of insight from her to share with you, as well as my friend, Carol Kranowitz. If you're not familiar with Carol's work, she is the author of the "Out-of-Sync Child Series." When my kids were first diagnosed, she was the first, her book, "Out-of-Sync Child" was my first purchase. And it is really neat that she and I call each other friends. And she got to sign

that book that is 20 years old. And anyway, she's a fantastic person. But she's an excellent resource. If you don't have her books, I suggest that you pick them up. I love everything I do. I don't write books for the money. I write books because I wanna help people. So, I want to share this information that learned as a mom and as an OT with you. My website is www.pocketot.com. And I am so happy to say that as of now, when I got my doctorate last year, I am able to teach at the University of Saint Augustine in Florida, the Saint Augustine Campus in their master's and doctoral programs. I interviewed some students today that are future OTs, and it was so wonderful to hear the unique value of OT and how they all came to be occupational therapists.

So, I wanna challenge you in your times of difficulty with your patients, to just take a moment and step back and reflect on why you became an OT or COTA, or whatever professional capacity that you're working in with these kids, just take a minute to step back and reflect on that passion that you have for helping. Because this can get difficult, right? We know this is a tough topic. I am happy to say that one of my books was just named as one of the books of autism books of all times. So, that's kind of an honor. And again, I wrote that simply to help people to understand what life with a child with autism was like, and it's for occupational therapists starting out as well. But today you didn't come to hear all about me. You came to hear about behavioral challenges and how are these a form of communication in kids with autism. So, we're gonna talk about that. We're gonna see what I mean by that.

Next we're going to look at potential behavioral meltdowns during occupational performance and prior to their occurrence. As we know, proactivity is very important to us as occupational therapists, because sometimes it's too late to act, and then in that case everything's a mess, right? We've got a mess. Sometimes the kids can destroy things, or sometimes it's just frustration that is existing at that point. So, we need to kind of learn how to identify these prior to their occurrence. That's gonna be critical. And then what can you do? I never want anyone to leave any of my courses or

anything that you come to for me and not have a strategy to take home. That's so important when you spend the time to come to a course, that you have something you can use at the end of it. So, that is the goal here. Why do we care about behavior? What is this whole point about behavior? Well, we know that I know I personally never wanna fail, right? And I challenge you to think about this, who here listening to this right now wants to fail. And I guarantee you that nobody is gonna say, "Yeah, I do. I wanna fail." Right? We all want to succeed. That's the main takeaway here. We wanna succeed as therapists. We wanna succeed as humans. But guess what? We didn't just wanna succeed as adults. We wanted to as kids too, right? None of the children with whom we're working want to fail either.

So, I think if we keep that in the back of our mind, we might have a little bit of a mindset shift here, I'm hoping. When we look at sensory lens, we know as OTs how to identify the processing of that sensory information. We kinda know that there's all these systems that we need to do and modulate and help regulate and vision, proprioception, vestibular. We know the eight senses. But we also know that we can't function appropriately. And I know when I got my doctorate, they said, don't use the word function, but optimal performance and occupation then, of our bodies occurs when we are strong and balanced and we can meet the demands given to us. I think that's the big challenge for kids when they're exhibiting behavior difficulties, is that they don't have the skillset to meet those demands. They either can't succeed or they've not been given the skills to succeed. But there's a reason why they're showing that behavior. And I like to think that all behavior is communication, right? But we know as OTs, we need some integration of our bodies and capacity to handle these things that are thrown us at. And life moves very quickly, doesn't it? It's not a static thing. So, we need to understand that, that we can have trouble at any point when things get unpredictable. So, if we look at the definition or diagnostic criteria, according to the latest diagnostic and statistical manual, which came out in 2013, just by definition, autism spectrum disorders come with deficits in social communication. We see that in

multiple contexts. So, that's not just at home with families or at church or in the community. That's also at school and anywhere the child is. So, there's communication, foundational communication deficits across multiple contexts. We also see that there's a difficulty receiving and understanding social-emotional pieces of information. In this case, it's called social-emotional reciprocity. That is something that we need through occupation, right?

Let's just say, we're going to go to the store. We have to be able to look around the store, kind of get a gauge of what's going around in that store. Is this a store where there might've been a spill and everyone's, maybe someone fell. You walk into a store and you kinda take the pulse of the setting that you're in, right? That is very difficult for some of our kids with autism to share that, to look and read the room. We also know that there's communication issues, but these communication issues can be very, very challenging. And how would you feel, let's say you had your tonsils out or had a bronchitis and you couldn't communicate, right? So, I had my tonsils out twice in my life. They grew back, but the last time I had them removed was three years ago. And being a talker, this really bothered me because I could not communicate effectively with those around me. So, I had some degree of frustration. I want you to put yourself in the shoes of these kids and young adults or adults, and just think of how frustrating that would be. What about if you couldn't read others' nonverbal communication? That's something that we see with kids with autism. Also relationships then, as you can imagine, might be very complicated for these individuals.

So, I wanna just mention that because someone has a disability or because they have something going on in their lives life, it doesn't mean that that disability is the only thing that contributes to their deficits. What do I mean? Well, I mean that we are humans by nature, right? I'm a human. I came through my genetics with certain predispositions to certain conditions, medical conditions, or I have blonde hair just by, well now by color, but by birth, I had blonde hair and I have brown eyes. I can't change my genetics, but

my environment also shapes me. So, that's how I was raised. That's how my cultural beliefs are. That's my setting, the part of the country or world that I was raised in. So, those things come to us. Every child obviously has a different genetics set and a different environment, different cultural beliefs, different family values, and then there's personality. So, that's another thing we forget to consider in working with kids with autism. They come with certain personalities anyway. Yes, they may be very easy going, but in the same way, some kids may be very challenging personalities. Maybe they challenge authority. Maybe they just are thinkers. I'd like to think that we put those challenging, those behaviors we consider challenging, let's put them into a good category, like that can help them later on in life, right? And then there's the learning style.

So, as you can see, if you're working with individuals with any disability, especially autism in this case, we have a human being is very complicated by nature. As OTs, I hope that you know that we learn through play. My students and I yesterday in our pediatrics course, were talking about toys. They're learning the difference between play and therapeutic play, right? So, cause and effect. We know that little babies are born with this beautiful unwired brain. How do they start to learn? Well, it's by play activities that kids learn, right? Cause and effect toys help them. Looking at a toy, if it lights up, then they're more willing to repeat that. Natural consequences have something to do with that. So, I mean, if the child's hungry and the child eats, then they repeat that behavior, right? You play peek-a-boo with your baby. The baby looks at you, you smile, the baby smiles. Those are natural consequences, natural things that happened. Also, fine and gross motor skills are how we play. Then sensory system wiring. So, we start again with this loose thread and it starts to build beautiful brain connections through interaction and play. And every person wants to succeed, right? But guess what? We know that our kids with autism and special needs might have some challenges in some of those things. How about this? A lot of times we play those finger games with kids like: ♪ Where is thumbkin ♪ ♪ Where is thumbkin ♪ ♪ Here I

am ♪ I'm not gonna sing and bore you, but you get it. We do peek-a-boo. We learn through imitating and watching others. We also learn when we're playing with peers, when we start going to preschool or we're around cousins or siblings that we learn by imitating other people, and parallel play even when kids are playing alongside each other, they're still referencing what the other's doing. They're using their senses, right? They're exploring and grass and messy play with feeding and touching their toes and different textures.

So, that's really amazing that the kids learn through those things. But guess what's difficult for our kids with special needs in particular autism, all of those things. Maybe because of those deficits we spoke of earlier in the DSM surrounding autism, imitating others might be a challenge because those kids might not even care about looking at other people. That may be too intense for them. They just may not even wanna do anything because they're afraid to fail. So, they might not even try hard because they're afraid or maybe they failed so many times that they're scared, right? There are so many things that we have to remember of maybe bad things have happened. How about older kids? Maybe they've been bullied and hurt over and over and over, so they're afraid of everything. They want consistency. And we know sensory issues can cause challenges, right? So, the evidence, I'm not gonna read all this to you because you will have handouts, but we know that we are using information as OTs from other disciplines, specifically from our other articles here, developmental psychology, the work of autism. I love that journal. But we know that these are issues that are contributing to kids deficit.

So, cognitive, neurological, all kinds of delays are contributing to all of these issues with our kids. We know that sensory issues contribute. but we also know through newer research that we can add things like mindfulness. We can add emotional awareness teaching. We can look at proactive interventions that have worked well in psychology and include those into our OT treatment. So, having just received my

doctorate a little over a year ago, I love the research. and my project was on executive function in children with autism. So, I spent a lot of time looking at ABA therapists and behavioral issues. And I learned a lot. I'm not going into all that right now because I don't wanna be an ABA therapist and I don't want to get into the discussion of it, but I can tell you that other disciplines have some things that work. So, we kinda need to pull and learn from them and do it our OT way, right? We need to understand also that consideration of the comorbidities as causes for complex behavior should absolutely be considered. In other words, we can't look at the behavior in isolation. We need to look at foundational things like medical, personality, just like I stated that fruit salad model, the complexity of the child should be considered. Not just looking at that skill in isolation. We know that working on social skills training can be something as OTs that is now the OTPF four.

So, the OT framework version four is out right now. Look at the performance factors in that and say, "Hey, I can use this timing." Right? As a performance factor is looking at timing, looking at initiation of task, looking at control. Use those in your documentation for evidence-based practice when working on these things, because that'll help contribute to the body of evidence as OTs. Okay. Look at this sweet little boy. He's so cute. This is Billy. Billy has just, he's in my OT room. This was taken in my OT session. He is so sweet to look at him. He's just a doll baby, right? He's always willing to play, but sometimes has trouble. This is the work of the same child. Now, if you look at him, let's go back to his cute little face again. Sweet, innocent. Look at this. Now, when I post this on Facebook, at one point, I just wanted to look for reactions. There's oftentimes similar photos posted in occupational therapy Facebook groups, or special needs Facebook groups and so forth. And the reactions vary, right? If I showed you this picture in isolation, not in this course, you might say, "Wow, that teacher had the class out of control." Or, "That student is bad. Make them go back and clean it up." But we don't think of what could have gone wrong in that child's day to cause this kinda destruction. Do you think this was fun for this child to feel so awfully that he had

to do this, that he felt compelled to destroy? Absolutely not. This didn't feel good for this child. So, we've got to, again, change the way we're looking at this in order to reframe this and help get to the crux of what the heck happened here. Right? I see this and my heart breaks. Because I see someone that failed or struggled and didn't want to. All right.

My next question for you is why is this baby crying? I want you to tell me. Enter it in the chat box, right? Wait, nobody knows. Nobody is in writing anything. Well, that's because nobody knows why the baby is crying. But guess what? In our culture, at least in the experiences that I've had with babies, again, mine could be vastly different from yours, and that's wonderful, but before a baby learns to speak or gesture, just because it's a baby and doesn't have the skills, right? Babies can't talk, babies can't point, babies can't indicate wants or needs. They're just existing because we have to help them regulate, right? Our a hundred percent job, my job as a mother for my son when he was born, was to help him to regulate and have regulation and comfort in his environment. That was my job. I tried to read every behavior that he had and anticipate his needs. So, just think about that. At what point though, do we stop looking at the baby and trying to figure out what's wrong? When that baby can communicate. When that baby can tell us, point, all those kinds of things. I want us to get back into basics and think about the fact that we need to read gestures in our kids with special needs because they're not equipped with the same cognitive, the same social, the same physiological skills, and fine and gross motor and speech that other kids are. So, we need to be detective and look at them as these helpless little infants, not demeaning them by any means, but looking at them and thinking, how can I make this child more comfortable? Some of these meltdowns that we all have in life are beyond our control.

We'll talk about that in a little bit here. Some behavioral responses are just reflexes. Wow, isn't that something you all know? We'll talk about this a little bit, the startle reflex, right? These reflexes are designed in our bodies to help us to make the best of

our environment and to function and process our environments smoothly and effectively until we have the physiological skills to do so independently. So, remember that all of our reflexes that we learned, I just rewrote some of our universities movement course programming for the pediatric portion. And I was looking at the reflexes and teaching them to our students. And one of the videos I made, I did a lot of research about what is the cause of reflexes? All reflexes are there until we get the motor. So, would they're involuntary until we integrate them smoothly into voluntary reflexes and then they disappear, right? That's just the way it is. That's not up for debate. But we know autism, kids with autism may have some of those reflexes still existing. But we know autism then has these underlying communication issues. We know that they can't express their once feelings and emotions. And it's common for us to forget that their behaviors may be in relation to something such as hunger, fear, fatigue. How about needing to use the toilet? Constipation? Our kids can't read their bodies well with autism. That's a struggle for those kids due to sensory processing issues.

So, maybe we need to look at them as the babies. Okay? Look at them as helpless, and again, not in a demeaning way, but in a way that we can help them. And when everyone, and I do this at a lot of my courses, everyone just put up your hand, just like this hand is right here with your palm facing you or your palm away. It doesn't matter. But this is where I can visualize the brain. This brain is handy. It's called the handy model of the brain. And it's utilized a lot in psychology these days. But it is with you all the time. So, you can use this for your kids that are able to understand. So, I want you then to put your thumb, bend it in. So, flex it in to the palm of your hand. The thumb is tucked into the palm right now, right? That thumb is gonna be representative of our brainstem. So, we know, excuse me, so we know that in the brainstem, when we're thinking there, our responses are reflexive. Okay? They're reflexive. So, when something happens in our bodies, the reflex says, "Get to safety." Fight, flight, freeze, all those kinds of things. That's the downstairs brain. Look at the bottom where it says

sensory there in the picture. Sensory, that's our sensory brain. Our primitive brain is that thumb tucked in. The flood of hormones comes. The adrenaline, the cortisol, those kinds of things come in, that overrides any kinda conscious choice. When we're in the downstairs brain, we can't be reasoned with them because it's a hormonal response, right? Until those hormones are reabsorbed, that is a non, you cannot reason with anyone there, right? That's like if I said to you, "Okay, you have right now, what's your worst fear?" Let's say mine is snakes. Okay? It's not, I'm not gonna tell you what it is. But let's just say it snakes. And let's say we're all together in a room. And it's a tight room closed. Nice and small. Maybe there's only 20 of us in there. And I say, I've released four boa constrictors in this room. I don't know where they are. You might, if you're super afraid of snakes, or if I said it was a spider in there, like a tarantula, you would have a heck of a time focusing on what I'm talking about then. Wouldn't you? Because you've got a downstairs brain response. It's quite chemically-driven. So, you know then that there's no capability for higher level thinking.

Now, if you go back to your hand again, so your thumbs tucked so nicely, and now put your fingers over the thumb. Kinda like a fist with the thumb inside, right? So, again, a fist with a thumb inside. That top in those fingers are the cortex of your brain. That's where connections are made from the lower brain to the higher brain, right? The hippocampus makes memories there. We know that information when it's in the cerebral cortex, we can process it effectively. That is where we need to be focusing, right? That is when we can make conscious choice. If you've got a kiddo that comes to you for therapy, that is in that downstairs brain and stuck in the downstairs brain, and you want him to think effectively and make this beautiful choices, he's not gonna be able to do that. You're already setting him up for failure. So, what do we need to do? We're gonna get there. I promise. So, the difference between a tantrum and a meltdown sensory-wise so far, is that we know that we are thinking in the upper-level brain and the cortex when we're having a tantrum. So, let's say you want a new pair of shoes, right? You throw a tantrum. You can still raise it and make choices. You're not

under a hormonal or chemical influence at all. You can reason and make choices. And when you get those shoes, you're gonna stop that tantrum. All right, hold that thought. I love this. I adapted this from Doctors, Daniel Siegel and Tina Payne Bryson's book, "The Whole-Brain Child," but this is my own graphic. So, I feel like this is my life. I'm opening my heart and soul to you right now. I'm this person on this boat. And I wish could put a rowboat here, but there were no wonderful, fantastic pictures of a rowboat. I'm gonna have to work on that with my graphic designer. But for now we're in a boat. And let's just say it's the sailboat, but there's no wind. So, we have to use our rows because that's what we have to do.

So, we're just in this boat and the wind starts up. The wind starts in the middle of it and we think, "Oh, thank goodness there's wind." But it starts blowing us toward the rocks, right? The wind is blowing. What do we do? That is a rigid thing we're gonna hit, right? So, our kids are the boat, right? They're paddling and they're catching a nice breeze. And then when the breeze kicks up or something happens that's unpredictable in their lives, they're going towards rigidity. And at that point, they wanna control everything, right? They're going towards the wall. They wanna be in control. They start those routines and those stems and the things that help them to organize. But then sometimes they go over into life's unpredictability and they might go out to the open ocean where it's very unpredictable. So, they need to roll back, row back, row back, into a safe, nice path. They're constantly rowing between chaos and the solid, rigid wall. And they're so hard and rowing so hard that they're so tired. And I think that's where a lot of our kids are right now. That's where I am as a faculty member. With the COVID crisis, I'm exhausted from rowing my boat. But guys, this is your kids that you're working with probably. So, we know that the brain, these kids are just trying to survive. But the brains function is survival. Everyone's brain is wired for energy efficiency here. We know that when kids are stressed, we call that as OTs, dysregulated. Dysregulated kids are incapable of focusing on higher-level brain functions, because they're always looking for threats. They're always looking for that

tarantula. They're looking for that snake. They're looking for the next fire alarm to go off or the next unpredictable noise or the next kid to bump them in the classroom line. They're always startled and they're always in fight or flight. So, that can't be comfortable, right? I just, it breaks my heart, but my own son that's 17 lives like this. I have a course that I do that it's a much longer course. In fact, I have a full-day course on behavior and sensory that I do in person a lot of times when I'm hired. And in that course, I show a graphic of an earthquake. And I feel like it would be like a constant earthquake that these kids are standing in where the ground is shaking underneath of them and they just can't find a secure place to stand that is safe. That's what I feel like it is like. So, that's not fun. And that's what my son is. And anything unpredictable in my home or at church or in my car, we just try to paddle toward that rigidity. And he is tired, and I'm tired as a mom. And I bet you any money that you OTs that see these kids in your practices are tired too, because we're desperate to help. And by nature, OTs are kindhearted people, right? We don't wanna anyone to not have the help that they need to survive. That's what we do. But it's tiring.

All right, let's take a breath here and go back to what we know as OTs. We learn by using many senses. We learn by auditory, vision, taste, olfactory, touch, vestibular, proprioceptive, and the last one is interoception. I'm just gonna touch on that for a few moments, because interoception is often missed by OTs. Interoceptive responses are detecting internal things. Our organs have responders in them, have receptors, our muscles, our skin, our bones, our muscles, our toileting, our bladder, our bowels, everything inside of you and me has a receptor. We know when our heart rate is up. We can feel that because we feel the boom, boom, boom, boom, right? We feel our blood pressure going up. Whether we notice a headache or can feel the extra pulses in our body, that is the awareness of interoception. And in my book about interoception, Dolly Diaphragm and many other, I had someone do clip art for me. And I named these organs inside because I want kids to understand that, our kids with autism are mostly visual thinkers, not all, but a lot of them are visual thinkers. So, I made visuals of every

organ to help them to visualize. Lub Dub Heart is the heart's name and he has eyes and he's cute. And this is Dolly Diaphragm. And when we can't see her, we can feel her when we take a deep breath. But if we forget the fact that a lot of our kids are constipated and have issues knowing when they're hungry or thirsty, that because of sensory processing deficits, they may have decreased awareness of interoception. This also is something we need to utilize in our practice. If we're not considering that, we're missing the boat.

So, we know that emotional awareness is also part of that. Ooh, isn't that something. And there's the book that I wrote. I researched for two years. And it's so funny because I know that Kelly Mahler and I both have books on interoception. I think we're the only two OTs addressing it right now and major works. But we came out with this stuff at around the same time. And I also have an interoception workbook coming out soon, probably in 2021. But it interests me so much because I feel like I've missed the boat. But perspective-taking, remember I said if you walked into the store and someone had just fallen, you need to think, well, that would be embarrassing. Isn't that hard for kids with autism? Maybe they're going on and on and on about their story and you're just sitting there showing boredom by yawning. You're just, oh my gosh, you're rolling your eyes. And they have no idea. They're gonna go on and on. That happens, right? That's all interoceptive and executive function related. So, we know that we feel nervous and our body responds.

So, helping kids to understand that, such as taking their heart rate and breathing exercises and taking bowel and bladder journals, have mom keep the journal for toileting of when the kids have the bowel movements, that all helps us to have better interoceptive awareness. We know that it allows us to feel our skin. So, if you look at the different people here, there's someone excited. Someone's cold, or maybe she's nervous. Someone looks like they have pain. This other person's kinda hiding down like boy, she's had a bad day or he's had a bad day. We have what makes Cara, Cara,

and what makes you, you. It's all different. And that's interoception. That's also to be considered for our kids. Okay, I'm gonna share my screen and I'm gonna show you the pyramid of learning. I wanna tell you something though. Here on the left side, you'll see that at the bottom is heart rate, at the top is higher concrete thought, right? That's going to go into this visual that we're gonna see. So, here is our pyramid of learning right here. We know that at the bottom is the central nervous system. We see the sensory systems there. Of course there's no interoception because this is 2018. And hopefully they add this in there. But we know that the eight senses that we have form the foundation of our security, right? We need to have secure function of all of the sensory systems and in order to access the higher level academic learning, right? We have to have a strong foundation, just like a pyramid, to access higher level academic learning. You see behavior, you see eye-hand coordination, postural adjustment. Yes, as OTs we can scaffold these things. We can, if we're missing some of these like postural security, we can work on some compensatory techniques. But in order to have that access to learning, we need to have a strong sensory foundation. OTs are so good at this, right? This is what we know. We are good at these absolute looking at these and analyzing them, right?

Okay. So, we need to access these in order for the function that needs to come. So, we know for our kids that there's extreme effort needed to screen things out. If we are stuck in the downstairs part of our pyramid, then we need extreme effort to screen out background noise. If we're not processing through the things and challenges that come in our lives, then we know that we're not gonna be balanced at the top. If we're stuck in body awareness and boundary difficulties and sensory overload, we can't get to the top of that pyramid, right? So, what do we do? What do we do? We have to know what to look for in order to know what to do. So, we have fight, flight, and freeze. We all know this. We have to look for these behavioral responses. We have to see when we see the kid, we look at him and we have to be detectives and see, hey, wait a minute. His jaw is clenched. His face is red. He may look like he's getting flushed in the

face. Maybe he looks like he's checking out. So, these are the things we look for because when a behavior is gonna come, when a meltdown is going to occur, these are some things that we need to look for. We need to understand that behavioral responses are in that downstairs brain. They're in the old brain, right? The ancient brain. They're chemically-driven.

So, how do we know that we're seeing these? Stomachaches, headaches, sleeping issues. The pupils may start to get really big. We have the deer in headlights eyes that we see our kids in so many times. So, if they're coming into your clinic and you see any of these things, it is our job to work on regulating them through the sensory challenges that we know we can give them as OTs. We can do swinging, we can do deep pressure, we can use olfactory calming sense because we know that the olfactory bulb has direct connections to the brain. These are things we need to look at and be a detective of. We all need to consider that there's this thing called mind-blindness that happens when kids with autism, that they know that they are right, that they see the world is this black and right rule following. It always has to be like this. They love the always words. They may not know sometimes this changes or sometimes the routine changes. I'm gonna give you an example of this, OTs. As the COVID crisis hit, we all had mind-blindness. It became very difficult for us to put ourselves in other people's shoes. People are still not masking up because they don't wanna say what could happen in someone else's life. The world isn't black and white. It is gray. And if we can't get into that gray and process it, we don't look at social rules and thinking about others in their situation might be different from ours. We're exhibiting mind-blindness. And by definition and that DSM-5, the autism diagnosis, these kids have fundamental mind-blindness. They don't wanna have it. It just happens.

So, we have to teach them facial recognition. We have to teach them body language. Teach them social rules. Again, that is in our job as occupational therapists, because we wanna help them to do their occupations, right? We also need to consider in our

fruit salad model, see it's starting to make sense, right? That these other things can be there too. They're sleep disturbances. A lot of times our kids with autism have GI issues. A lot of them are on special diets. They may have processing delays. They may have food allergies, depression. How about hormones? When we see these kids going through things, we might not even think about their hormone levels. Maybe there's some medical underlying thing. So, when we run this, I get to be blessed to be a member of the pocket, not pocket, the Pediatric OT Facebook group on Facebook. It's 30,000 members. And I'm one of the admins there. So many of the therapists that post there, post similar things. Like, "This child is banging his head. I can't get him to stop. I've tried this and this and the sensory input." Or, "This child, he's always chewing on everything. I try to take it away from him, it won't stop." Well, guess what? We need to look at medical things first. Always make sure that there's no medical issue or reason that this is happening. Because maybe that kid has teeth coming in, or maybe they're putting things in their mouth because they have an ear infection. So, always please rule out the medical.

Alright. Something I hope that you take away from this course right here is that when our students and clients become overwhelmed by big emotions, it is not your job to join them. We have to share our calm. What does that mean? That means we need to get ourselves under control, take a deep breath and share our calm with them. So, we all are tempted as humans to get matched. So, in my house, when I'm yelling at my son, maybe he's done something, he's spilled something or hit the dog or something, I might get a little frustrated and then he raises up. And then there's an energy that kinda builds, right? We all start getting from conscious choice to the downstairs brain and hormones start to rule. We need to stop that. We need to share our calm. How do we do that? Coming up soon. We need to come down to their level. We need to sit down and say, "Hey, it's okay. Jimmy, it's okay." Lower the tone of your voice. That gives a feeling of control, right? You don't want to always raise to that level. Gentle. And then you can remind them, "You have done, you have thrown something at our dog. That

breaks our house rules." And when you break rules, you have to go into cool-down area. That's what we have to do, is get ourselves under control. Or you could give them two choices that you have already predetermined. We can even use planned ignoring here, unless the child's harming themselves. So, there's Jimmy that sits in the classroom. He's throwing his pencil. Teacher, picks it up. He throws his pencil, picks it up, throws his pencil, teacher says, "Jimmy, stop it right now." He's gotten the attention he wants.

So, if we just ignore the behavior, as long as Jimmy is not hurting anyone, we can just say, "Hey, that got no response." And you have the power to do that in your clinic. You have the power to ignore, unless it's something that you have already decided is not gonna be acceptable. How do you know that? Well, you set expectations. Immediately you have rules. I want everyone to put rules up in their clinic, not to be mean, but to let everyone know your expectations. When I did this presentation, I knew what the OccupationalTherapy.com folks wanted me to do. I know how long I need to do it. I know what date, what time. Everybody needs that predictability. Your kids need it too. So, set expectations for the kids, and then say, "Great job. You have followed the number one rule, no hitting. So, right now we're gonna have five minutes on the swing. Great work." You wanna warn them of transitions because remember they need the warning, and so do you. You wanna use empathetic statements. Never make a feel bad, like a bad kid. We wanna say, "Wow, that must have been really uncomfortable for you, right?" Then we need to give choices that we determine and don't negotiate. I love teachable moments. Teachable moments are so great because they occur in a natural time. So, when you see a child doing something that is perceived as good or acting the way you want, tell them that that's wonderful. Tell them that.

So, the question pops up here, is it a tantrum or meltdown? What is the difference? I receive this, gosh, probably at least five or 10 emails a day on this. So, I made a little chart, but we know that meltdowns are just a result of what's happening of those

around you. It's when your skillset doesn't match the things that are happening to you or around you. And again, remember it's the downstairs brain, that thumb tucked into the palm level, because it's hormonal and dictated by adrenaline and cortisol and all of the stress hormones. We know that kids here and adults here, when we're in a meltdown, we lose control because we have no thought, we are not accessing the cognitive, the, I'm sorry, the cerebellum at all. But we know that sometimes we can have kids that start down in a tantrum road and then they go into a meltdown. Their reaction becomes so great and huge that it becomes a chemical reaction. That's just habit. In fact, in the body, in the brain, the amygdala part of our brain can grow to get bigger, the more we use it and the more we live in that moving world, like my son, Joshua, the amygdala can actually start to grow in size. The amygdala is the fear center of the brain. So, when we're used to going into a fear, panic reaction, we need to practice using strategies to calm ourselves down. But we know that the student, when he's in a meltdown, he or she, they cannot control themselves, right?

We'll look at that a little bit more and how to stop that. But then a tantrum, we know as goal-oriented. It's if you want something and you don't get it, and then it ends quickly, or it can end a little bit longer, but we know that there's something that that person wants. There is a demand that they are making or that something they want to happen. Now, if you've got a kid having a tantrum that has autism and decreased communication issues, you're going to need to work with that child on expressing the need. So, that's where communication comes in. All right, we're gonna go ahead now, and I'm gonna share my screen into one of my favorite models. The model that we're gonna talk about is called the rage cycle. This is one of the links right here, but I'm going to pull it up on my computer so that we can work through this together. But we know that there is a time where it is a learning opportunity. All right. So, here we go with the model. This model is the rage cycle visualization. In this cycle, we know that there is a period and it's the green period, called the recovery stage and learning time. When a child is in the learning time, that child is able to follow a schedule, follow a

structure, use their calming tools. They're accessing the upper-level portions of their brain at that time where they're learning. It's a beautiful time when we can do music and learn and homeschool regular school. But then as soon as the those gray areas come where there's those triggers, the emotional triggers start to come. There may be sensory overload, physical overload. We may see that resistance to change or getting toward that routine that these kids so crave. That's called the rumbling stage, right? When these kids start to go into that place of discomfort, that's when we look for the physiological signs. Right then and there, we need to be proactive and use our schedule and our structure in our predetermined things like the timeout zones, or cool-down areas or break cards. Because once we get to this red area right here, the rage state, it is too late. Okay? Too late. That is the time when the child's body is absolutely absolutely driven by hormones, right? This child right here is just in the cortisol level and you need to keep him safe. That's when he needs to be kept safe. That's gonna be when he's raging. Then when he is done raging and he gets more comfortable, then we go back into the teaching area. That's when you start to teach again. I hope this makes sense to you because I love this visualization here. It's so helpful because we can kinda see this cycle happen.

All right, we'll go to our next slide here. I hope that you maybe take that and draw it how it makes sense to you so that you can post that in your clinic or in your office or whatever you have to do to follow that. Encourage teachers, encourage moms, let them see that. So, how then do we prioritize the behavior for our kids? What do we do now? Right? We're almost done. We have to figure out what we're gonna do. Well, we're going to use a prioritization method right here. We need to know exactly what behaviors that we care about. What do we care? We care because if it's dangerous, we really don't want those kids to do it. We know that if our kids are hurting themselves or being hurtful to others or causing some sort of destruction, that would be a high-priority behavior. Now, we're not ABA clinicians, but we still deal with behavior. So, let's do it our way. If it's a problem, it needs to go away. And problem

depends on who you're talking to. Mom's problem area might be different from yours. But when you're working as an OT, you need to consider all the settings, don't you? It's what we have to do. So, let's say in your clinic, because you're coming to my course today, you feel like there's something that's non-negotiable, spitting, kicking, hitting. I don't like any of those in my clinic, so I have a rule list. When any new patient or child walks into my room, that is what they see. That's why as an instructor, I go over the syllabus with my students. It's our third week right now in our trimester. We teach all summer, all year long at my university, but we just reviewed the syllabus two weeks ago. Because my students need to know what I expect.

Now, if they're destructive during my lab times, I'm going to say that's a priority and it's a professionalism, and you're gonna need to stop that. But if they're doing something that's a little inappropriate, maybe they pick their nose, hey, that's low priority, I don't like it. It's distracting, but it's not as much of a priority. But that is up to you as the OT. Usually dangerous behaviors are what I stop. Now, keep in mind though, that when you take a stimulation away from anyone, you've got to replace it with something equally as important. For example, stimming in kids with autism is a regulatory behavior. It is something that they need to keep calm. For example, you can't see me, but I'm sipping on water with a straw. I do what every conference I'm at. They give me a glass of water when I speak and travel, and I say, "I want one with a straw and cold," because that's what my body needs. That oral motor stimulus to suck through that straw in order to calm myself. I oftentimes like right now, while I'm talking to you, I'm adjusting my weight in my seat. It's just something I have to do to move when I'm talking. But that's something that's important to me. If someone took that away from me right now, and if let's say OccupationalTherapy.com said there's no water drinking, it would really affect the kind of class that you're gonna get today. So, can't take that away from someone without replacing it with something else. Okay? Important.

Proactive interventions are always better than reactive. Now, what do I mean by ABC? I promise that this is not, this is gonna be helpful to you. I want you to take a piece of paper and fold it three ways. Fold the paper in landscape. So, grab a piece of paper and put it in the landscape direction and then fold it into three columns, just like when you made columns in a paper for spelling lists in school, right? So, do that and put A at the top of the left column, the middle is the B, and the last one is the C. The behaviors are the things that you're gonna see in these kids. So, you say to mom, or you say to whoever, "Let's take some data here. This is what we're looking for, the behaviors." Make a list of what happens. And then the C is the consequence. What happened after the behavior? And then the A is called the antecedent. So, antecedent is A, behavior is B, and C is consequence. Just maybe three out of five days. Don't pressure mom, because I know I can't take a lot as a mom, giving little bits and pieces of information. But look at those and take data.

We want to intervene between A and B, between the antecedent, the cause, before the behavior comes. This involves proactive planning. This is your rules. This is your practice of social stories. This is setting that kid up for success beforehand. Teach them the break cards, teach them the visual cues, the schedules, show them where the calm down areas are, reinforce the desired behavior. Remember when you're doing all of this, it takes a lot of work, but just like anything, an ounce of prevention is worth more than a pound of cure. It is unbelievable how much proactive interventions can change your whole clinic setting. So, make sure to use these things. But we know reactive interventions come after the behavior. When we're in a reactive intervention and then behavior is there, we have to consider safety, just like in our rage chart, our rage cycle model. We have to remove that child, use visuals. We may even have to help them to regulate their body. That's when you invite them to join your calm, right? Hopefully you're getting it guys. I hope so. I put this back on here. Remember the proactive interventions are before the behavior, because you've become an expert detective now. You know what to look for. But the reactive interventions, guess what?

As you practice this OTs, you're gonna have more reactive interventions. But that's just like anything else. It's messy before it gets better. With practice, you're going to get better at this. So, what do we know as OTs? We're finishing up and rounding all this out. What does this mean to you as an OT? You are an expert at looking at your kids with a holistic point of view. That's what you do as OTs. Right? We're holistic.

We have to look at the reason, we have to see what we can replace that behavior with, how can we help with a new behavior that's more appropriate and occupation-based? What was the behavior and who can we use on our team? We don't have to do this in isolation. We need to have a team. Is the team, the mom, the caregiver, the teacher? It could include the ABA clinician if you want it to, and if that's good for the child. But we need to make sure that we know our role is to say, this child needs this to regulate because that's our job as OTs. Planning interventions. Again, use that ABC chart that I just showed you or talked about, I'm sorry, in landscape where you're folding the paper, use that to look at what behaviors are actually occurring. I think that's super helpful for the caregiver, I loved when someone made me look as a mama at what the behaviors are. It helped me to organize it a little bit. And I hope that's true for you and your families you're working with, or the teacher. We need to be experts, frankly, at distracting and redirecting our kids looking because we get to be experts at proactive behavior. We can start saying, "Hey, wait a minute, I see the rage in Rumble coming. These are the physiological signs. He's tightening his hands. His whole body is changed." That's when we I need to use A, B, and C techniques. I love brain breaks. I think we need to implement them more regularly as OTs. And again, the evidence that I've shown you and it's in your handouts, will help you in evidence-based practice to see these things being researched and helping, because we know that we can be effective and efficient team member.

Remember to use music and movement, use our sensory strategies. Remember that we need to look at transitions and giving mornings for the transitions, with our visual

and our different visual techniques that we use, whether it's a schedule or the time timers. We know we need to use our flexion, our linear calming, swinging, our vestibular inputs, proprioceptive. Use those smells, because again, the olfactory bulb is right behind the nose and it doesn't need any kinda connections through the brain stem or anything. It goes right. It's not an on a cranial nerve or anything. It's right, scent is so important. That's why it's so powerful if you smell something that reminds me or reminds you of your mom or a Thanksgiving dinner. Consider that, smell is powerful.

We know we use crunchy snacks, chewing on ice chips, dehydrated fruit, all those kinds of things can be implemented as calming strategies for proactive interventions. We know that push, pull, lift, and carry are our most effective proprioceptive methods. Decrease that environment stimulus. If you need to shut down the lights or turn down or lower lights, add calming music. I know we're not music therapists, but my sister is a music therapist and she can certainly utilize music effectively for my kids. It's beautiful. There's no reason you can't either in your clinic, play nice calming music, make it set up that child to help to go to the higher level of the brain. All right. A few extra things before we wrap up is that we need to make sure that with the caregiver and the team, we need to look at natural consequences. What are they? If you don't eat, you're gonna be hungry. If you don't bring your homework to school, you're gonna get a poor grade. If you don't bathe, it's gonna be stinky, right? These are things that we need to start teaching our kids early, not when they're teenagers and smelly. We have to make sure that we're consistent, and we say, "Hey, everybody needs to know that if the child hits, this happens." And that's up to you. I can't tell you what the consequence is gonna be. But make sure you make them so that you can follow those consequences. And be consistent throughout the team. That is critical right there. We know that mindfulness is so important and focusing on breath, breathing is critical.

Everybody uses the mind jars now, but they are so powerful. The oily and glitter mindfulness jars, that helps us to anchor our bodies, to connect with our bodies. That's interoceptive awareness. And please look up interoception and help to integrate that into your clinic. It is not something new by the way. Interoceptive awareness has been around for hundreds and hundreds of years. We're just harnessing it now as OTs. There is something called The Incredible 5-Point Scale. Use this in addition to the, how does your engine run to the other mindfulness techniques and engine techniques we use, the colors we use as OTs. We know all the programs, right? The school moves, all of them. But The Incredible 5-Point Scale is something free. You can use it here to say to the child, let's say fire alarms is my thing that sets me off, right? We know that maybe, and this might be too much, five different categories, so maybe just go with green, yellow, and red, but let them have a picture. Cut out pictures of magazines of how they feel when they're calm. Maybe it's someone on a boat. Maybe it's the sunshine. Then how do they feel when they're at number three, where they're starting to rumble, they're getting nervous about the fire alarm going off. And then how do they feel when they're in that rage stage? Is it the hulk? Is it somebody's really angry? So help use them, these visuals with them. And this is so amazing and easy to use. All right, this is the end of our program. But I wanted to make sure the review this young man, this young man, I think we called him Billy this time, but he does not want to fail. He did not wanna tear up the classroom. He just, at the end of the day, the teacher said to clean up, and he didn't want to clean up because he had an abusive childhood at home.

So, I think that if we look at, now that we've concluded, if you look at him with different eyes and look at the fact that he has a reason for his behavior, we might look at this little guy a little differently, right? He could not succeed. He needed more transition time. He needed to feel safe. Maybe we could have sent him for some deep breathing and relaxation techniques. But now we know what happened. We saw the behavior. Just like when I told you to do your ABC chart, you do the same thing. Look at the

behavior and see how you can help this little guy. Because he, and any kid that you work with do not want to fail. I promise you. So, that's my presentation. I hope that you've taken some things away from it. It is my goal always to help you to be the best OT you can be. The thing that would really hurt my feelings is that if you sit here and you say, "Wow, that was intense. I didn't know that. I could have helped so many more people." Because oftentimes that's what I hear. Please know that you always are learning as OTs and humans, that you do the best that you can, until something new comes, and then you learn it and you do better. And that's what I hope that I can help you do as a clinician and through my website and things that I do. I just want us to be always doing better and helping these kids. And I thank you for all the work that you do. As a mama of two kids with special needs, I love OT. Thank you for coming today. Good luck on your post test. And that is it. I have the resources. Just so you know, I've given you extra resources here through the slides and also the fruit salad model, the 5-Point Scale. There's the evidence that I've shared there. And then I've given you some books to read right there about kids with autism and sensory difficulties that I find to be very helpful. So, again, if you need me, I'm always there at the pocketot.com. Thank you so much. Have a wonderful day.

- [Fawn] Thank you so much, Dr. Koscinski for a great talk today. I hope everyone has a great rest of the day. You join us again on [Continued and OccupationalTherapy.com](http://ContinuedandOccupationalTherapy.com). Thank you.