Addressing Problem Behaviors In Children With Autism

Posted on May 12, 2020

There are various forms of autism, ranging from mild to severe. Children suffering from severe autism may fail to learn to speak. On the other hand, in mild autism, only a few characteristics are manifested (Lloyd, MacDonald, & Lord, 2013). It is, hence, important to remember that, like all children, children with autism are individuals who require unique needs. Children with autism demonstrate a wide range of symptoms. To begin with, they demonstrate impairment of social interaction. Under this feature, the children demonstrate impaired nonverbal behaviors, lack of emotional or social reciprocity, lack of impulsive sharing of interests or enjoyment, and failure to make age-appropriate peer relationships (Daniels & Mandell, 2014). In addition to impairment of social interaction, children with autism experience impairment in communication. Here, they demonstrate a lack of or delay of spoken language, idiosyncratic or repetitive language, impairment in maintaining or initiating conversation, and lack of varied, spontaneous, and age-appropriate social imitative play. Moreover, children suffering from autism demonstrate abnormal behavior patterns (Lloyd, MacDonald, & Lord, 2013). For instance, they have unusual responses to sensory experiences, repetitive and stereotyped motor mannerisms, inflexible observance of non-functional rituals, persistent obsession with parts of objects, resistance to the adaptation of daily routines or environmental change, and unusual obsession with restrictive and stereotyped interests. Kenny et al. (2016) further note that the majority of children with autism are visual learners, adding that their strengths can include computer skills and interests, drawing skills, and music skills.

It is essential to address problem behaviors for children with autism. The reason is that inappropriate behaviors can result in social isolation, thereby affecting learning and development (Kenny et al., 2016). Importantly, children on the spectrum usually miss nonverbal social cues. As a result, teaching appropriate behavior needs to be done deliberately and repetitively (Kenny et al., 2016). During my work experience at Samuel Rhodes School for children with special needs, I saw numerous strategies being used to manage autism among children. The first strategy used was behavior modification, whose goal was to change undesirable behaviors to desirable ones. However, before changing a child’s behavior, it was imperative to investigate what caused the behavior to occur.

I learned that, on many occasions, autistic children had sensory processing problems. These made them respond to usual sensory experiences in unusual and exaggerated ways. In such a case, punishing the children was not a suitable response. Rather, giving sensory integration therapy or changing the environment was often considered the best option. I also noted that for behavior modification to be effective and successful, it has to be structured, consistent and clear. Structuring implies that there has to be a clear system of consequences for inappropriate behaviors and rewards for desired ones. Doing this consistently is essential to success. Forgetting or ignoring the process can

potentially undermine the behavioral plan. On clarity, the child has to understand the meaning of the problem behavior, and the consequences of the problem behavior and desired behavior.

Another strategy that was used to manage autism at Samuel Rhodes School for children with special needs was Applied Behavioral Analysis. This is an intensive behavioral approach that is an improvement of the basic reward-consequence model. The approach trains a child in small, progressive steps to achieve larger goals, rewarding each step along the way. Applied Behavioral Analysis can teach desirable social behaviors, academics, and language skills. The approach is most effective when initiated before the age of 5 and carried out in an intensive program that involves not less than 20 hours a week of personalized training with therapists.

The creation of a routine was also a key behavioral strategy that was used to manage autism at Samuel Rhodes School. I noted that children with autism often tend to behave better with structure since they understand what is expected of them and what to expect. Routines are critical to decreasing anxiety and making it easier to transition from one activity to another. Bringing in small changes to a child's routine is important in developing coping strategies to address transitions. In case changes to routine are required, strategies like social stories should be used to help reduce the anxiety presented by transitions.

Setting Meaningful Consequences was also an important strategy used to manage autism at Samuel Rhodes School. Usually, children on the spectrum have difficulties understanding why things are being removed. Children should understand the consequences set for particular behaviors. Additionally, the consequences provided should not accidentally reinforce negative behaviors.

Epilepsy

Epilepsy is a neurological disorder whereby brain activity becomes abnormal, resulting in seizures or stages of unusual sensations or behavior and loss of awareness. Epilepsy is demonstrated through a wide variety of symptoms (Engel, 2013). Some children suffering from the disorder repeatedly twitch their legs or arms during a seizure, while others simply stare blankly. However, having a single seizure does not necessarily mean you have developed epilepsy. For an epilepsy diagnosis, at least two unprovoked seizures are required. Seizures are, hence, the major symptom of epilepsy (Vezzani et al., 2013). However, symptoms of epilepsy vary from one child to another and according to the type of seizure. For a simple partial seizure, there is no loss of consciousness.

The symptoms of partial seizure include dizziness, alterations to a sense of touch, sight, taste, hearing, and smell, and twitching and tingling of limbs. On the other hand, complex partial seizure, loss of consciousness or awareness is demonstrated. Other symptoms include unresponsiveness, staring blankly, and performing repetitive movements. For generalized seizures, the whole brain is involved. There are six types of generalized seizures, each having its unique symptoms. Absence seizure causes a blank stare, repetitive movements such as blinking or lip smacking, and a short

period of loss of awareness. Tonic seizure leads to muscle stiffness, while atonic seizure causes loss of muscle control hence may make a child fall down suddenly. Myoclonic seizure leads to spontaneous, quick twitching of legs and arms. On the other hand, tonic-clonic seizures have numerous signs, such as loss of bowel or bladder control, biting of the tongue, stiffening of the body, loss of consciousness, and shaking.

Following a seizure, a child may feel slightly sick for a few hours or may not remember having one. What is more, it is often difficult to recognize a seizure since some seizures do not include unusual muscle movements or convulsions. At times, the child may appear to be daydreaming or not attentive. Some seizures do not last long, and after a while, the brain of the child returns to normal. However, if the child keeps developing seizures, over time, untreated seizures may be disastrous as they may get in the way of the learning or growth of the child. Since infants and babies cannot communicate how they feel, it is often difficult to recognize seizures in them. As a result, teachers, parents, and healthcare practitioners should understand the signs of epilepsy since some of these signs are normal behaviors demonstrated by children. Nonetheless, if the behaviors happen often and appear unusual, it is important to seek medical attention Devinsky et al., 2014).

It is also important to note that a child having seizures may not necessarily be suffering from epilepsy, following that seizures can be caused by certain illnesses and high fevers. The doctor should, hence, take time to carry out the correct diagnosis. Common signs of epilepsy include sudden, repeated anger or fear, unusual clumsiness, frequent stumbling, sudden falls, short attention blackouts, memory gaps, dazed behavior, unusual irritability when woken up, unusual sleepiness, and repeated unusual movements like rapid blinking and head nodding. Children with epilepsy also tend to have more behavioral and learning problems compared to those who do not. However, these problems are not always because of epilepsy. According to Engel (2013), children suffering from epilepsy often experience uncertainty in their lives. The feelings of the prospect of a sudden seizure among classmates and friends can be stressful and can make the child withdraw or act out of social situations.

Samuel Rhodes School managed epilepsy through various strategies. Caregivers and parents were advised to talk to healthcare providers for the purpose of ensuring that the seizures are controlled. The parents were also advised to learn more about treatment options for their children suffering from epilepsy, particularly through clinical trials. What is more, healthcare providers could encourage the children to take part in self-management programs. The school also had healthcare professionals who trained providers in self-management support. While in Samuel Rhodes School, I also learned that medical treatment alone is not enough to give children with epilepsy the relief they are looking for. Rather, self-management programs are at the heart of epilepsy management as they help children learn more about their condition while also teaching them skills for improving their ability to cope with their health. In particular, self-management programs helped children better communicate with health care providers, adhere to their medication schedule, and lessen their depressive or stress symptoms.

Down’s Syndrome

Children with Down’s syndrome normally have a certain level of developmental disability. However, this is usually mild to moderate. Social and mental development delays may imply that the child has poor judgment, slow learning capabilities, short attention spans, and impulsive behavior (Wilcock & Griffin, 2013). Down syndrome is normally accompanied by medical complications such as hearing loss, clouded eyes, congenital heart defects, poor vision, hip problems, for instance, dislocations, chronic constipation, leukemia, thought and memory problems, obesity, low thyroid function, interrupted breathing during sleep, late tooth growth hence problems with chewing, and Alzheimer’s illness later in life. Moreover, children suffering from Down syndrome are more prone to infection. In particular, they may struggle with urinary tract infections, respiratory infections, as well as skin infections.

Down Syndrome is the most common genetic condition and is a chromosomal abnormality. Most children suffering from this condition have a mild to moderate degree of cognitive impairment (Kucik, 2013). Physically, a child suffering from Down’s syndrome can be easily recognized due to features such as a smaller overall stature, protruding tongues, flat facial profile, low muscle tone, and thick epicanthic folds in the eyes. However, these children are capable learners who are eager and excited to learn (Kucik, 2013). What they need is the opportunity to excel. While they may learn at a relatively slower pace, they are extremely capable of learning. Such children are strong visual learners, implying that they tend to understand better what they see as compared to what they hear. Overall, children suffering from Down’s syndrome have certain points linked to their learning development. Particularly, they tend to understand more than they can say, they are visual learners, they can follow classroom routines and rules, and they require help to remember instructions, for instance, visual clues or shorter phrases.

Much as children suffering from Down’s syndrome can learn, their teachers should make compromises to meet their educational needs in classrooms. Following that, they are visual learners, so teaching them reading has to be characterized by a robust emphasis on visual learning. To assist in offering effective instruction in various subject areas of the curriculum, illustrations, pictures, and visual demonstrations should be successfully used. What is more, the curriculum for children with Down’s syndrome should include lessons in phonics. When teaching math concepts to children with Down’s syndrome, the use of physical demonstrations is important. Similarly, using manipulatives is critical to the development of a number of concepts among Down syndrome patients. Wilcock and Griffin (2013) established that overall, children with Down’s syndrome demonstrate good social skills that can be made use of to increase teaching and learning opportunities. When addressing such children, it is advisable to speak directly to them, making use of short sentences and clear language. Adequate time should be allocated for such children to process responses to what they have been asked. To boost their positive learning experience and self-esteem, positive reinforcement needs to be used for children with Down’s syndrome, both in school and at home.

Since Down's syndrome is incurable, efforts to manage the disorder are focused on proper support and care, education, and early childhood intervention. Some of the strategies for managing Down's syndrome that I witnessed at Samuel Rhodes School included creating an inclusive classroom climate. This was done by creating a positive attitude towards the disorder as well as other special educational needs in the entire school community. Secondly, the school liaised closely with parents. This involved operating a school/home diary system in which teachers and parents were able to share information and report on progress every day. Such regular sharing of information with people who know and understand the children best was an important management strategy for the disorder.

Thirdly, referring closely to the Individual Education Plan of children with Down's Syndrome was an effective management strategy at Samuel Rhodes School. Since all children suffering from this condition had an IEP, the teachers had the responsibility of being aware of the targets that were set for each child and tailoring their teaching to minimize the barriers to learning that the children could experience. Additionally, the promotion of language development played a critical role in managing Down's Syndrome. Usually, children suffering from Down's Syndrome struggle in this area. As a result, teachers could place the children near the front of the classrooms and speak clearly and directly to them while also using simplified language supplemented with visual reinforcements.

The lessons were also made short and appealing, accompanied by an emphasis on numeracy in daily contexts, for instance, using money. Teachers at Samuel Rhodes School also reinforced positive behavior among children with Down's syndrome. The teachers only gave attention when the behavior of the children was appropriate. Besides, they provided opportunities for the children to interact and make friendships with peers, urging and teaching them to share.

Consider the possible effects of disability on siblings. Please explore this belo.w

Disability has considerable effects on siblings of children with disability. First, such siblings may develop several difficulties. These include stress, anxiety, and emotional issues (Burke, 2010). Such problems may present themselves as internalizing issues that are not easily visible. The siblings may also encounter peer problems and a lack of engagement in academic issues and extracurricular activities due to limited money and time. Secondly, siblings of children with a disability may become independent and overly responsible. Due to the attention accorded to the disabled child, his siblings are likely to neglect their personal issues. Such siblings may experience parentification when they are anticipated to have several responsibilities for themselves and other siblings, thereby developing similar duties to those of their parents (Dearden and Becker, 2004). This may compel the siblings to assume their desire to act like children. While such additional responsibilities may appear positive to parents, they can essentially be heralds of emotional distress.

Thirdly, siblings of children with a disability may have a feeling that their parents have neglected them. The reason is that by focusing on the disabled child, parents are likely to minimize the attention

required by the siblings (Skirton, 2008). What is more, time spent on therapy and medical appointments for the disabled child limits the length of time that such parents can spend with the rest of their siblings, bringing about a feeling of neglect among these siblings. Fourthly, siblings of children with disability are likely to feel in the dark from service providers and parents. For instance, when left to wait in the waiting rooms during doctor visits, siblings may have unanswered questions about the disabled child, including whether the disorder can be transmitted. As a result, they can develop their own ideas about the situation, which is far worse than it is. However, the situation can also provide opportunities for the siblings. For instance, they may develop some positive traits, such as cooperation, altruism, empathy, self-control, tolerance, responsibility, and maturity, due to their frequent dealing with the situation (Skirton, 2008). What is more, sibling involvement in nursing activities may lead them to consider future professions in the nursing profession.

1. Respite as well as emergency care services
2. Family Therapy and Support Groups
3. Advocacy and legal support

Accurate information on a wide range of aspects is needed to render admission less stressful for the child and the family. People with disability and their families require information about the risks of the disorder and the available support resources (Hewitt-Taylor, 2008). Additionally, as they get older, children with disability need increasing information on the implications of the disorder for their future.

The individual medical record of an individual patient identifies the patient and carries information about the case history of the patient at a specific provider. Therefore, on admission, proper identification of the patient needs to be recorded (Hewitt-Taylor, 2008). These include the patient's name, age, and gender of the patient. Further information to be recorded will vary depending on the medical history of the individual patient.

The members of the multi-disciplinary team that may be involved in a child's care include a parent, and not less than two professionals from various disciplines, and one of whom has to be the service coordinator. The parent here can be the child's biological parent, legal guardian, foster parent, or anybody acting in place of the child's parent (Hewitt-Taylor, 2008). The person offers critical information on the history, needs, and strengths of the child. The service coordinator is the healthcare professional who assists the child as well as his or her family to access relevant or appropriate services. The tasks performed by the service coordinator include making referrals to providers, coordinating assessments, services, and IFSP, and scheduling appointments. The position of the second professional can be filled by any professional from a different discipline from that of the service coordinator to give room for the inclusion of numerous professional perspectives in the process of decision-making (Hewitt-Taylor, 2008). This can be an evaluator or an early intervention service provider.

To help children with their communication and learning, special schools make use of various interventions. To begin with, teaching reading to special students, for instance, those suffering from

Down syndrome, requires the use of visual demonstrations, illustrations, and pictures to assist in offering effective instruction in various subject areas of the curriculum (FernáNdez-LóPez et al., 2013). Additionally, the use of activity learning and manipulatives is critical to the learning of number concepts. For example, Numicon© visually-based mathematic resources are designed to facilitate the learning needs and strengths of children with Down's syndrome.

Special schools also use assistive technology to help children with their communication and learning. The most commonly used assistive technology tools include abbreviation expanders, alternative keyboards, audiobooks and publications, speech-recognition programs, and portable word processors, among others (Kostelnik et al., 2014). These tools serve to increase children's self-reliance as well as a sense of independence.

Disabled children tend to be more vulnerable to being abused because of the way they are perceived and treated by society. For instance, the abuse of disabled children is often under-reported and usually hidden (Wissink, 2015). What is more, several stereotypes and myths surround the abuse experienced by disabled children. While disabled children usually make clear revelations of abuse, they are hardly heard (Flaherty et al., 2014). Additionally, after being abused, some disabled children show challenging behavior, which is usually assumed to be linked to the impairment of the disabled child and not as a sign of abuse.

Signs of possible abuse can alert individuals to the possibility that children with special needs have experienced abuse. These signs include cuts and bruises, unusual behavior or sudden changes in behaviors, complaints about painful genitals, burns, and broken bones that are not because of a medical condition (Flaherty et al., 2014).

If you think a child has been abused, you should seek expert advice from a doctor and support from Childhelp National Child Abuse or the police.