Chapter 1 : Behavior modification for weight loss: The Johns Hopkins Digestive Weight Loss Center

Treatment differences in the therapeutic relationship and introject during a 2-year randomized controlled trial of dialectical behavior therapy versus non-behavioral psychotherapy experts for borderline personality disorder.

Children also learn from poor examples presented in media. Activities that modify behavior help children avoid specific actions and learn constructive ways to substitute positive for negative behavior. The success of the modification activities depends on the child, parents and the amount of time spent teaching kids alternative ways to handle family, school and social situations. Game Playing Gaming allows kids to explore different behavior, and when played with family members or an adult, games teach appropriate actions. Commercially manufactured games offer a way to review specific behavior changes, but parent-made games can focus on targeting specific ways to change. The American Academy of Pediatrics says children frequently exhibit undesirable behavior when they are under stress or are angry or frustrated. Games introduce children to the behavior options available and allow kids to select from several appropriate behaviors. Children can see through gaming that there are several options to try before resorting to bad behavior. Modeling Fun Modeling activities teach children the correct behavior and reactions. Children sometimes behave badly in new or unfamiliar situations. Modeling creates imaginary situations that show the child new behaviors that fit the event or situation. Parents can create a fun demonstration by incorporating simple rewards for modeling the correct actions. Fictional scenarios at home allow children to practice appropriate behavior before moving into real world situations. Tracking Behavior Formal charts keep track of behavior over a period of time. Once children learn a new behavior, charts help monitor the use of the new information. Formal charts also set reasonable expectations for families, teachers and children, according to the New Mexico Public Education Department. Parents and teachers use charts, along with positive reinforcement, to help children change behavior. Charts offer concrete proof of modifications. Tracking appropriate behavior helps focus on the positive, rather than monitoring mistakes and punishing bad actions. Media Help Watching films and television programs and reading books help introduce and change behavior. These activities also introduce concepts for parents and children to discuss at home about poor behavior. Age-appropriate media encourages children to identify with the book character or movie or show actor. Previewing media helps parents direct the discussion to topics that tie directly into home behavior problems. Monitoring regular viewing controls the types of programming children see, and this helps avoid kids tuning into shows that feature negative behaviors.

Chapter 2 : (behavior modification) AND alternative treatment - PMC - NCBI

Behavior modification is an intervention that is based on the premise that the manner in which people in a child's environment attend to a given behavior either strengthens or weakens that behavior.

Chaining Some areas of effectiveness[edit] Functional behavior assessment forms the core of applied behavior analysis. Many techniques in this therapy are specific techniques aimed at specific issues. Interventions based on behavior analytic principles have been extremely effective in developing evidence-based treatments. With children with attention deficit hyperactivity disorder ADHD , one study showed that over a several year period, children in the behavior modification group had half the number of felony arrests as children in the medication group. There is strong and consistent evidence that behavioral treatments are effective for treating ADHD. A recent meta-analysis found that the use of behavior modification for ADHD resulted in effect sizes in between group studies. They have shown success in reducing recidivism for adolescents with conduct problems and adult offenders. One particular program that is of interest is teaching-family homes see Teaching Family Model , which is based on a social learning model that emerged from radical behaviorism. These particular homes use a family style approach to residential treatment, which has been carefully replicated over times. One area that has repeatedly shown effectiveness has been the work of behaviorists working in the area of community reinforcement for addictions. For example, Forgatch and DeGarmo found that with mothers who were recently divorced, a standard round of parent management training programs based on social learning principles that teaches rewarding good behavior and ignoring bad behavior combined with communication skills could help elevate the divorced mother out of poverty. Thus, such intervention can have profound effects on socializing the child in a relatively cost effective fashion and help get the parent out of poverty. This level of effect is often looked for and valued by those who practice behavioral engineering and results of this type have caused the Association for Behavior Analysis International to take a position that those receiving treatment have a right to effective treatment [19] and a right to effective education. Mod represents a behavioral approach to the management of human resources in organizational settings. These behaviors must be observable, measurable, task-related, and critical to the task at hand. Next, a baseline measure of the behavior must be assessed and functional consequences analyzed. If the intervention is successful in modifying the behavior, it must be maintained using schedules of reinforcement and must be evaluated for performance improvement. Mod on job performance found that using money as a reinforcer with O. Mod was more successful at increasing performance compared to routine pay for performance i. Skinner argues in Beyond Freedom and Dignity that unrestricted reinforcement is what led to the "feeling of freedom", thus removal of aversive events allows people to "feel freer". This premise is at odds with research conducted by Albert Bandura at Stanford University. His findings indicate that violent behavior is imitated, without being reinforced, in studies conducted with children watching films showing various individuals "beating the daylights out of Bobo". Bandura believes that human personality and learning is the result of the interaction between environment, behavior and psychological process. There is evidence, however, that imitation is a class of behavior that can be learned just like anything else. Children have been shown to imitate behavior that they have never displayed before and are never reinforced for, after being taught to imitate in general. Some desire to limit such restrictive procedures only to licensed psychologists or licensed counselors. Once licensed for this group, post-licensed certification in behavior modification is sought to show scope of competence in the area through groups like the World Association for Behavior Analysis. Level of training and consumer protection remain of critical importance in applied behavior analysis and behavior modification.

Chapter 3 : Behavior modification - Wikipedia

Safety-related applications of behavior-based interventions from both the behavioral and medical literature are critically reviewed. Potential OBM targets in health care settings are integrated within a framework of those OBM techniques with the greatest possibility of improving patient safety on a large scale.

Most importantly, make it fun! Education and Your Body: Although we often take it for granted, the body is a complex system. Recognizing this and making an effort to learn more are essential to your weight-loss and health. There are a wide variety of ways you can learn about your body, ways to properly nourish it and more, such as: It is important to be prepared for this visit. Here are some quick tips to help you prep for your visit: Write down food consumed in a food diary even snacks. List any exercise activities you participate in daily, weekly. List any family history of conditions type 2 diabetes, heart disease, etc. Bring a list of any medications and dietary supplements you currently take hint: Speak to a Dietitian â€" Dietitians are an excellent resource for an individual wanting to lose weight and improve health. Dietitians can provide you with the following: Meal plans Information on foods and how they impact your weight and health Help developing nutritional goals Support Groups: The journey of weight-loss can often be a difficult one and a lonely one. Most individuals battling obesity or severe obesity find themselves needing support. Support groups are an excellent resource to share your story and learn from others. Here are some quick tips to help you find and engage in support groups: Ask your PCP for support group references. There are a wide variety of support groups available women-only, men-only, faith-based, etc. Not ready to meet face-to-face? There are numerous online support groups available. Ask your PCP or dietitian for some of their favorites. When developing your goals for weight-loss, exercise, eating healthy and more, it is important to keep them realistic. Quite often, individuals become frustrated when they do not see immediate weight-loss results. It is important to not let yourself become frustrated with your weight-loss plan. Changing your diet, incorporating exercise and more can all be significant life changes and they need to be taken seriously. Here are a few tips for developing realistic goals: Average weight-loss is one to two pounds per week. Start slow with exercise and find an activity you enjoy. Ask your spouse, family member or friend to exercise with you. Make meal times a family affair. Have your children help with cooking and let them choose healthy foods as well. Continue a proactive mindset and remember that each day is another day forward. Feel like you might be slipping with your eating or exercise routine? Behavior modification is the cornerstone of any weight-loss option. It may also be one of the most difficult aspects of weight-loss or weight maintenance. Our behaviors are engrained in our daily routines, families, lifestyles and more. It will take time, but it is important to stick with your behavioral changes, as they will greatly help you in your weight-loss journey. Always remember, YOU are the leader of your healthcare team!

and behavioral assessment and treatment interventions will be reviewed. Behaviorists believe that Trichotillomania is basically a coping behavior that develops in response to stressful stimuli.

Cunningham, MS and E. Medical errors continue to be a major public health issue. This paper attempts to bridge a possible disconnect between behavioral science and the management of medical care. Epidemiologic data on patient safety and a sampling of current efforts aimed at patient safety improvement are provided to inform relevant applications of organizational behavior management OBM. The basic principles of OBM are presented, along with recent innovations in the field that are relevant to improving patient safety. Safety-related applications of behavior-based interventions from both the behavioral and medical literature are critically reviewed. Potential OBM targets in health care settings are integrated within a framework of those OBM techniques with the greatest possibility of improving patient safety on a large scale. Introduction Organizational behavior management OBM focuses on what people do, analyzes why they do it, and then applies an evidence-based intervention strategy to improve what people do. The relevance of OBM to improving health care is obvious. While poorly designed systems contribute to most medical errors, OBM provides a practical approach for addressing a critical component of every imperfect health care systemâ€"behavior. Behavior is influenced by the system in which it occurs, yet it can be treated as a unique contributor to many medical errors, and certain changes in behavior can prevent medical error. This paper reviews the principles and procedures of OBM as they relate to reducing medical error and improving health care. First, we need to define medical error. This task is neither simple nor straightforward because the definition of a medical error varies markedly across different hospitals and health care systems. This latter prevention-focused definition best fits the application of OBM. This distinction is relevant to interpreting the patient safety literature, since research results typically focus on frequencies of adverse events outcomes rather than process-level errors or behaviors occurring during health care. However, a single error does not guarantee that a patient will experience a medical injury. An examination of case studies of errors presented in the Annals of Internal Medicine suggests as many as 17 separate individual errors may occur before a patient is actually harmed. They include 16 classes of patient safety incidents Table 1. Although this is a useful classification system, prevention requires a specification of actions leading to these types of patient safety incidents. Two widely used taxonomies for patient-safety incidents and medical errors. Leape 5 has provided a brief and practical typology of medical errors that includes four main domains: Within these domains is a more specific list of 14 types of errors that can be seen as a hierarchy of severity Table 1. In comparing these two methods of classification, the difference between outcome and process measurement is salient. The most common types of preventable errors resulting in adverse events have been identified as: A more recent report 6 suggests that almost 60 percent of all patient safety incidents include: This report also suggests the most lethal patient safety incidentsâ€"or those most closely associated with mortalityâ€"include failure to rescue and unexpected death during a low-risk hospitalization. Between and , an increasing trend of certain types of events suggested a need for special attention. These included postoperative medical- and nursing-related adverse events, such as respiratory failure 31 percent ; infection due to medical care 14 percent ; decubitus ulcer 19 percent ; septicemia 41 percent ; thromboembolism 42 percent ; and accidental punctures and lacerations 7 percent. Specifically, anesthesia reactions and complications decreased by 18 percent, and foreign bodies left during procedures were reduced by 7 percent. While small, these improvements are encouraging in terms of current proactive efforts to address patient safety. Preventing Errors in Health Care As depicted in Figure 1 , patient safety outcomes are influenced by a number of factors, including several sources external to the hospital e. Within-hospital sources include the health care culture, the institutional patient safety agenda, the specific environmental context in which the health care worker operates which includes the patient , and the focus of this paperâ€"the behavior of the caregiver. These multiple influences are, in turn,

affected by patient safety outcomes in a reciprocal system most certainly affected by innumerable additional factors in varying degrees. An overall model of patient safety. Domains of influence relevant to OBM are shown enlarged and in italics. Errors Addressed by System Change Medical mistakes caused by latent errors, such as similar sounding drug names or delays in treatment due to lack of staff, are best addressed by system change. For example, it would be reasonable to expect these errors to be reduced if drug names were altered and more personnel were hired. Yet, additional room for improvement often remains even after quality gains from system change are realized. Advances in infection control often have been addressed by increasing hand hygiene among caregivers. One relevant system change has been the installation of antibacterial, alcohol-based rub dispensers in patient rooms and near sinks. This change should lead to improved infection control, because alcohol rubs reduce the volume of infection-related microorganisms by 88 percent, compared to hand washing with soap and water, which reduces the volume by only 49 percent. However, despite these promising initial findings, adoption of CPOE has been slow. This puts administrators in the uncomfortable position of choosing whether to make protocol improvement voluntary or mandated. Patient safety can be engineered into a health care system, but peak performance also requires systematic attention to environmental hazards and at-risk behaviors related to patient safety. This paper reviews practical solutions to motivating the adoption and sustained practice of patient safety behaviors that have produced large-scale community and organizational change. Organizational Behavior Management OBM is defined as the application of behavior analysis to organizational settings. A consequence C is an event that follows a given behavior and increases the probability the behavior will recur. For this reason, it can be said that consequences motivate behavior, 17 since we tend to act in response to the consequences we expect to receive. This approach has been shown to successfully increase safe behavior and decrease at-risk behavior in a variety of different nonmedical settings. The long-term objective of OBM is the institutionalization of contingencies needed to support the desired behavior in the absence of intervention agents. Several factors are critical for behavioral maintenance, including: This occurs, notably, when physicians learn how to use CPOE and eventually find it more efficient and reliable than ordering prescriptions by hand. However, it often takes time to experience the intrinsic qualities that reinforce a behavior. People need to engage in a behavior fluently to experience its inherent, beneficial consequences. This means that external contingencies are often necessary to motivate the initiation of a target behavior. Organizational Applications for Large-Scale Change The OBM perspective has informed an innovative people-based patient safety approach to health care, 31 which strategically integrates behaviorism and humanism in the design of interventions to benefit patient safety. This comprehensive approach to patient safety is based on the following evidence-based guidelines, which are derived from applied and experimental behavior analysis see Geller 17 for a comprehensive description and analysis of these guidelines: Focus on external factors to explain and improve behavior. Direct with antecedents and motivate with consequences. Focus on positive consequences to motivate behavior. Design interventions with consideration of internal feelings and attitudes. Apply the scientific method to improve intervention. Use theory to integrate information, not to limit possibilities. Safety-Related OBM Research in Health Care Settings Intervening to Improve the Safety of Health Care Workers Several successful applications of OBM in health care settings, based on the seven guidelines listed above, provide the foundation for designing interventions to initiate and maintain behaviors relevant for patient safety. Additionally, nontargeted precautionary behaviors increased as a result of the intervention, including recapping needles with one hand from 45 to 61 percent ; removing gloves from the inside out from 61 to 93 percent ; and wearing gloves when discarding waste from 31 to 52 percent. Whereas these examples of OBM research targeted the safe behavior of caregivers, each of these interventions indirectly advanced patient safety. Patient safety cannot be separated from caregiver safety. For example, a systematic, behavior-based evaluation of a gradual, voluntary CPOE implementation found that CPOE medication orders were safer and more efficient compared to the standard paper-based ordering method. For example, a number of strategies were evaluated to increase the use of CPOE among physicians. These included a presenting evidence in support of CPOE use; b rewarding CPOE use with

small trinkets; c providing individual access to computers; d adding clinical decision support; e instigating relevant peer pressure; and f providing financial compensation for the extra time required to become proficient with the CPOE system. The financial compensation strategy was found to be most effective in the short term, increasing CPOE use from 35 to 57 percent. After financial compensation was discontinued, though, CPOE use declined to 42 percent after several months but did not fall to baseline levels. However, the lack of peak maintenance raises the concern that external consequences of a financial incentive may over-control or over-justify the behaviors targeted for intervention, reducing self-persuasion or the influence of intrinsic consequences. OBM for Patient Safety In one study, 40 providing feedback to caregivers on their frequency of hand washing led to an increase in hand washing following patient contacts from 63 percent at baseline to 92 percent post-intervention. The impact of this intervention was significantly greater than adding an emollient hand washing agent to the environment. A number of other OBM intervention studies have demonstrated significant increases in hand washing among caregivers. Moreover, nonbehavioral attempts to increase hand washing among caregivers suggest that hand-hygiene interventions targeting attitude change, intentions, or self-reported practice are likely to fail at altering actual behavior. However, additional field research in this domain is clearly needed. The patient safety literature often contains rather illustrative case examples of how particular errors led to dramatically adverse events for patients. In addition, standards of valid evidence differ between the fields of medicine and OBM. In medicine, the results of randomized, controlled trials from different institutions are considered to be evidence of the highest grade, whereas observational studies within the same institution are viewed as having less validity because they reportedly overestimate treatment effects. Health Care Organizational Structure Within the vertical hierarchical structure that tends to be the norm in health care settings, differences in levels of authority contribute to many communication errors. The uncertainties of the health care profession have caused physicians to accept risk 55 and to view error as an unavoidable and necessary feature of their work. Medical Errors to Target with OBM Errors Remaining After System Change It is acknowledged that several types of errors are already being addressed by well-informed system-based changes, but a number of categories of errors persist. These include technical errors during care procedures, failures in communication among caregivers and between provider and patient, contamination errors due to ineffective employee and patient hygiene, and lapses in patient monitoring. To be of maximum benefit to medical professionals and OBM practitioners, the categories of errors discussed here are based on already established classification methods and priority areas e. Also, given the aim of proactive measurement and intervention, they are process- rather than outcome-based and include: Diagnosis errors, such as using the wrong test, delays in diagnosis, and failing to act as indicated on test results. Treatment errors, such as ordering a wrong drug or dosage, accidental puncture or laceration, and incorrectly executing a procedure. Monitoring errors, such as bedsores, failure to rescue, and patient falls. Infection-control errors, such as failing to wash hands, lack of glove use, and compromising sterile-field maintenance. Communication errors, such as failing to inform other caregivers of acute risk, changes in care, and critical hand-off information, as well as ineffective communication with patients. These intervention targets are not identified as independent of system influences, but rather as activators for specific kinds of OBM intervention. Behavior is a part of the health care system, which can be targeted for change within a supportive or unsupportive culture. OBM Interventions to Address Medical Errors Behavioral antecedents, including prompts, pledge cards, and communication strategies, as well as consequences, are the primary types of OBM intervention techniques for a comprehensive description of available OBM techniques, see Geller et al The overarching theme of the intervention approach suggested here is to reduce the probability of error by increasing the frequency of safe standards of practice. Several behavioral targets might be relevant for a particular type of medical error, and one target behavior may be related to several categories of error. Table 2 depicts a framework for classifying OBM interventions and specific behavioral targets for error prevention.

Chapter 5 : Benefits and Drawbacks of Behavior Therapy | My Child Without Limits

Differential Reinforcement of Alternative Behavior (DRA) health issues and for addressing behavioral concerns of persons with mental retardation and other.

Special Programs Behavior Modification Ideas for Weight Management Weight management involves adopting a healthy lifestyle that includes a knowledge of nutrition and exercise, a positive attitude and the right kind of motivation. Internal motives such as better health, increased energy, self-esteem and personal control increase your chances of lifelong weight management success. Remember to have realistic goals and think long-term success. Believe in yourself and you can do it. The following information will give you ideas to help you meet your goals. Control Your Home Environment Eat only while sitting down at the kitchen or dining room table. Do not eat while watching television, reading, cooking, talking on the phone, standing at the refrigerator or working on the computer. Keep tempting foods out of sight. Have low-calorie foods ready to eat. Unless you are preparing a meal, stay out of the kitchen. Have healthy snacks at your disposal, such as small pieces of fruit, vegetables, canned fruit, pretzels, low-fat string cheese and nonfat cottage cheese. Control Your Work Environment Do not eat at your desk or keep tempting snacks at your desk. If you get hungry between meals, plan healthy snacks and bring them with you to work. During your breaks, go for a walk instead of eating. If you work around food, plan in advance the one item you will eat at mealtime. Make it inconvenient to nibble on food by chewing gum, sugarless candy or drinking water or another low-calorie beverage. Do not work through meals. Skipping meals slows down metabolism and may result in overeating at the next meal. Control Your Mealtime Environment Serve your plate of food at the stove or kitchen counter. Do not put the serving dishes on the table. If you do put dishes on the table, remove them immediately when finished eating. Fill half of your plate with vegetables, a quarter with lean protein and a quarter with starch. Use smaller plates, bowls and glasses. A smaller portion will look large when it is in a little dish. Politely refuse second helpings. Daily Food Management Replace eating with another activity that you will not associate with food. Wait 20 minutes before eating something you are craving. Drink a large glass of water or diet soda before eating. Always have a big glass or bottle of water to drink throughout the day. Avoid high-calorie add-ons such as cream with your coffee, butter, mayonnaise and salad dressings. Do not shop when hungry or tired. Shop from a list and avoid buying anything that is not on your list. If you must have tempting foods, buy individual-sized packages and try to find a lower-calorie alternative. Compare products to help you make the healthiest choices. Chew a piece of gum while cooking meals. Use a quarter teaspoon if you taste test your food. Try to only fix what you are going to eat, leaving yourself no chance for seconds. If you have prepared more food than you need, portion it into individual containers and freeze or refrigerate immediately. Remember it takes about 20 minutes for your stomach to send a message to your brain that it is full. The ideal way to eat is to take a bite, put your utensil down, take a sip of water, cut your next bite, take a bit, put your utensil down and so on. Do not cut your food all at one time. Cut only as needed. Take small bites and chew your food well. Stop eating for a minute or two at least once during a meal or snack. Take breaks to reflect and have conversation. Label leftovers for a specific meal or snack. Freeze or refrigerate individual portions of leftovers. Do not clean up if you are still hungry. Eating Out and Social Eating Do not arrive hungry. Eat something light before the meal. Try to fill up on low-calorie foods, such as vegetables and fruit, and eat smaller portions of the high-calorie foods. Eat foods that you like, but choose small portions. If you want seconds, wait at least 20 minutes after you have eaten to see if you are actually hungry or if your eyes are bigger than your stomach. Try a soda water with a twist of lime. Do not skip other meals in the day to save room for the special event. Order some vegetables or a salad for an appetizer instead of eating bread. If you order a high-calorie dish, share it with someone. Try an after-dinner mint with your coffee. If you do have dessert, share it with two or more people. Ask for a doggie bag to take extra food home. Tell the server to put half of your entree in a to go bag before the meal is served to you. Ask for salad dressing, gravy or high-fat

sauces on the side. Dip the tip of your fork in the dressing before each bite. If bread is served, ask for only one piece. Try it plain without butter or oil. At Italian restaurants where oil and vinegar is served with bread, use only a small amount of oil and a lot of vinegar for dipping. Offer to bring a dish, appetizer or dessert that is low in calories. Serve yourself small portions or tell the host that you only want a small amount. Stand or sit away from the snack table. Stay away from the kitchen or stay busy if you are near the food. Limit your alcohol intake. Use a salad plate instead of a dinner plate. After eating, clear away your dishes before having coffee or tea. Use single-serving foods like chicken breasts or hamburger patties. Prepare low-calorie appetizers and desserts. Decorate the house without using food. Have low-calorie beverages and foods on hand for guests. Allow yourself one planned treat a day. Eat regular, planned meals. Exercise Well Make exercise a priority and a planned activity in the day. If possible, walk the entire or part of the distance to work. Get an exercise buddy. Go for a walk with a colleague during one of your breaks, go to the gym, run or take a walk with a friend, walk in the mall with a shopping companion. Park at the end of the parking lot and walk to the store or office entrance. Always take the stairs all of the way or at least part of the way to your floor. If you have a desk job, walk around the office frequently. Do leg lifts while sitting at your desk. Do something outside on the weekends like going for a hike or a bike ride. Have a Healthy Attitude Make health your weight management priority. Have a goal to achieve a healthier you, not necessarily the lowest weight or ideal weight based on calculations or tables. Focus on a healthy eating style, not on dieting. Dieting usually lasts for a short amount of time and rarely produces long-term success. You are developing new healthy behaviors to follow next month, in a year and in a decade. This information is for educational purposes only and is not intended to replace the advice of your doctor or health care provider. We encourage you to discuss with your doctor any questions or concerns you may have. How to Reach Us.

Chapter 6 : Activities for Behavior Modification | Healthfully

Activities that modify behavior help children avoid specific actions and learn constructive ways to substitute positive for negative behavior. The success of the modification activities depends on the child, parents and the amount of time spent teaching kids alternative ways to handle family, school and social situations.

We were reminiscing about the early infancies of our children and how we celebrated the moment when our youngsters began sleeping through the night or somewhere close. That is, most of us did. Her two children had Autistic Spectrum Disorders and, into early elementary school, were not predictably sleeping through the night. Practitioners and researchers who work with Autistic Spectrum Disorder have increasingly taken notice of the wide-spread and serious matter of sleep disruption in ASD children, teens, and adults. More and more, as professionals are developing intervention priorities, improving sleep is at the top of the list. Sleep difficulties can take different forms including: Problems with sleep latency difficulty falling asleep Waking through the night; sometimes staying up for prolonged periods of time. Early waking Poorer quality of sleep, such as restlessness The reasons for the rate of sleep disruption in this population is an on-going question for researchers, but some likely causes include: Possible abnormalities in brain systems that regulate sleep Differences in hormones such as melatonin and other brain chemicals that affect sleep. Poor sleep hygiene the environment and routine that are provided to support sleep Behavioral issues such as difficulties setting and maintaining limits. Sleep disorders such as apnea, sleepwalking, nightmares, night-terrors, and restless leg syndrome. It may be helpful to use the following as a guideline for trying to determine whether normal variations in sleep have reached the level of a sleep disruption: If it takes longer than 30 minutes from the end of the bedtime routine to get to sleep. If a child is unable to get to sleep without the presence of another person. Based on review of the research in the area, The National Sleep Foundation recently revised their sleep recommendations for specific age groups and now recommends the following ranges: Sleep range narrowed to hours each day previously it was Infants months: Sleep range widened two hours to hours previously it was Toddlers years: Sleep range widened by one hour to hours previously it was Preschoolers Sleep range widened by one hour to hours previously it was School age children Sleep range widened by one hour to hours previously it was Teenagers Sleep range widened by one hour to hours previously it was 8. Sleep range is hours new age category Adults Sleep range is hours new age category We have all experienced the effects of the lack of good sleep on our daytime functioning, but these effects may have more profound implications for children with ASD. Research has shown that ASD children with sleep problems have lowered cognitive functions particularly with verbal skills that typically require more effort and concentration on their part , have more difficulty with social skills and increased emotional distress, increased hyperactivity, and poorer motor control. These impairments in turn make it difficult for ASD children to benefit as much as they might from the schedule of interventions that often make up their day. Sleep problems in an individual child have implications for the entire family: I want to pause for a moment to acknowledge the obvious: Sleep along with eating and toileting is behavior that parents can not directly control by physically manipulating or exerting their will on their child. There is a significant amount of stress involved in attempting to improve sleep, and parents need to feel supported rather than judged as they begin to make changes. I will be making some suggestions about how to support better sleep in the next few paragraphs, but acknowledge that sleep difficulties are rooted in problems with neurobehavioral regulation and, as such, are often challenging to alter. While keeping this in mind, parents should know that there is encouraging evidence to support the idea that parental efforts at improving sleep can lead to very positive outcomes. This is an important step because your doctor can help rule out potential medical issues or determine whether a more specialized appointment is necessary such as a sleep specialist, ENT, or a neurologist. Your primary care provider would also be the appropriate person to see in order to discuss whether medication or a supplement such as Melatonin would be a reasonable avenue to consider. Melatonin is a naturally occurring neurochemical that assists in regulating the

sleep-wake cycle. Children with Autistic Spectrum Disorders have been found to have abnormal Melatonin levels, particularly at night. Over twenty clinical studies have shown a significant improvement in sleep length and sleep latency for ASD children who were given Melatonin before bedtime, even at relatively small doses mg. Medications used to treat other ASD symptoms can sometimes affect sleep regulations and sharing information about this dynamic will be important for your pediatrician or psychiatrist as they work with you to find an optimal regimen. Regardless of the cause or nature of sleep disruption, there are environmental and behavioral mechanisms that can be put in place to support sleep. While the initial effort required to implement some of these strategies may seem overwhelming, often substantial change can be seen within a relatively short period of time two weeks is a commonly reported time frame for seeing improved response. A tool-kit is also available for teen and young-adults: Their research-based suggestions focus on the following strategy for tackling sleep problems: Provide a Comfortable Sleep Setting: Is the room too hot, too cold, too bright, too dark a dim night light is usually optimal? Pay attention to trying to keep the room and the surrounding environment quiet. Some children benefit from increased sensory input such as weighted blankets. Establish a Regular Bedtime Routine: The routine should be done in the same order each night. To the extent possible, it is important that all adults involved in putting the child to bed follow the same routine. The more consistently the routine is implemented, the more it will be useful in helping your child regulate to sleep. Tips for ensuring a successful bedtime routine: Consider the use of a visual schedule to help your child anticipate sleep. Choose activities that are calming listening to music, rocking, reading a book, a massage rather than those that are stimulating. For example, if bathing is a stimulating rather than a relaxing activity for your child, move this activity to a time earlier in the day. Try as best as possible to keep bedtime and wake-time the same throughout the week. Restrict the use of electronic equipment while a child is winding down at night as this can be emotionally and visually stimulating, and the light from the equipment may interfere with Melatonin production. Teach your child to fall asleep alone: Many modern parents place some value on co-sleeping, which is not necessary wrong in itself. One approach to teaching a child to sleep alone incorporates principles of graduated sleep training e. Regulate nap-times to end before 4: Avoid giving your child caffeine watch the chocolate! Daytime exercise can make it easier to fall asleep and children who exercise tend to have deeper sleep. The Autism Show Podcast: Solving Autism Sleep Problems http: As always, the providers at Alternative Behavior Strategies are here to support you. Feel free to reach out with further sleep questions if you have them.

Alternative school placement continues to be a final option for many students who have experienced ongoing academic and behavioral difficulties.

The health coaches met with their participants on a weekly or biweekly basis during the first 6 months the weight-loss phase and once a month during the last 6 months the weight-loss maintenance phase. In addition to a monthly visit, the health coaches made at least one monthly telephone call to each participant to discuss progress, address concerns, and provide encouragement during the maintenance phase. The health coaches met with each participant individually, except for spouses who attended educational sessions together. The DPP lifestyle modification curriculum described elsewhere 11 consisted of 16 core sessions that each participant completed within the first 6 months. The primary diet-related goal was to reduce the amount of dietary fat. Each participant was assigned a weekly fat gram goal based on their initial body weight. Participants recorded their fat intake during the weight-loss phase. In addition, Fitness Plus participants had one weekly physical activity ie, personal training session with their health coaches during the weight loss phase. A physical activity session usually followed an educational session, or a participant could choose to return on a different day. The health coaches developed an exercise plan and worked with each participant on increasing their competence and self-efficacy in health-related fitness. In addition to dietary goals, each participant had a weekly physical activity goal, depending on their physical abilities and fitness level. Participants were asked to record the number of minutes spent in moderate-intensity physical activity between appointments. However, there were several key differences between the 2 programs. First, some of the DPP lessons were modified. For example, an old version of the Food Guide Pyramid was presented as a model for healthy eating in one of the DPP lessons. This lesson was revised to include the current MyPyramid. Second, the Fitness Plus program had limited resources and thus did not implement some of the features of the DPP. These items were not available to Fitness Plus participants. Third, the Fitness Plus intervention was delivered on a university campus by trained graduate students who were majoring in Exercise Science whereas the DPP lifestyle coaches were primarily registered dietitians. Fourth, Fitness Plus participants were allowed to take oral medications for diabetes. Finally, the Fitness Plus program lasted 12 months whereas the DPP participants were followed for up to 5 years. Measures All measurements were collected at baseline and 6-month and month time points. Anthropometric and blood pressure measurements were obtained by trained Fitness Plus staff according to standard protocols. Participants were weighed on a Seca electronic scale Seca Corp. Height without shoes was taken twice with a digital, wall-mounted stadiometer. Waist and hip circumferences were taken twice by the same investigator at all time points to prevent the chance for interobserver bias. Blood pressure readings were also taken twice with a RelyOn digital sphygmometer DuPont, Wilmington, DE after at least a 5-minute rest. The same arm was used at each time point. For measurements taken twice, the average of the 2 values was used in the statistical analysis. A central laboratory was not used. It should be noted that certain laboratory values were not available for some participants. For example, hemoglobin A1c values were missing for some of the participants because the test is not routinely ordered for prediabetic patients. The numbers of participants whose laboratory tests were available for analysis are indicated in the Results section. Medication usage during the study was recorded for each participant. The participants were instructed to bring their current medications and any new medications to appointments with their health coach. The medication form was updated at least once a month or at any time the participant had a change in medication. Self-reported physical activity levels were assessed using a standard, 7-day physical activity log, which was completed by each participant 1 week before each assessment. They were provided with an explanation of what comprises moderate vigorous activity and a handout with examples of activities in light-, moderate-, and vigorous-intensity categories. Statistical Analysis One participant was excluded from data analysis because of incompliance, as explained earlier. A paired t test was used to examine differences in the outcomes between

baseline and 6 months and baseline and 12 months. Pearson correlation analysis was used to examine the association between weight loss and hemoglobin A1c concentrations. All outcome variables were checked for normal distribution. Log transformation was performed for glucose and triglyceride values. Changes in medication an increase or decrease in dosage, a new drug, or the discontinuation of a drug were summarized using descriptive statistics. All decisions about medication changes were at the discretion of the primary physician and occurred as part of usual medical care. The medication usage analysis was limited to drugs used for diabetes, hypertension, and dyslipidemia. Changes in medication costs of drug therapy regimens for these 3 conditions were calculated using online prices. The participants showed weight fluctuations during the course of the study; some continued to lose weight after the mid-study assessment whereas some regained a certain portion of the lost weight. However, as a group, Fitness Plus participants achieved an average 6-kg weight reduction at 6 months and maintained that weight loss until the end of the study Figure 2. In a new window Figure 2. The effects of the intervention on anthropometric and blood pressure measurements are summarized in Table 2. With the exception of the waist-to-hip ratio, significant reductions in all anthropometric measurements occurred between baseline and 6 months. These changes were sustained during the maintenance phase. Diastolic blood pressure was significantly lower at 6 and 12 months compared with baseline.

Chapter 8 : Behavior Modification and Activity - Obesity Action Coalition

based interventions from both the behavioral and medical literature are critically reviewed. Potential OBM targets in health care settings are integrated within a framework of those OBM techniques with the greatest possibility of improving patient safety on a large scale.

Chapter 9 : Alternative Behavior Strategies | Behavior Alternatives to Open New Opportunities

Positive Behavioral Interventions and Supports (also referred to as School-Wide Positive Behavior Support), which the literature identifies as effective in supporting students with conduct disorders and other behavioral issues.