

Aggression in persons with IDD and ASD may be learned behavior, have a medical etiology, or stem from a psychiatric disorder (Antonacci et al., 2008; Im, 2021). Theories of causation are the foundation of treatment methodology which in the case of aggression is dominated by behavioral, pharmacological, and combined behavioral-pharmacological interventions (Matson & Dempsey, 2008; Poling et al., 2017).

Page 2

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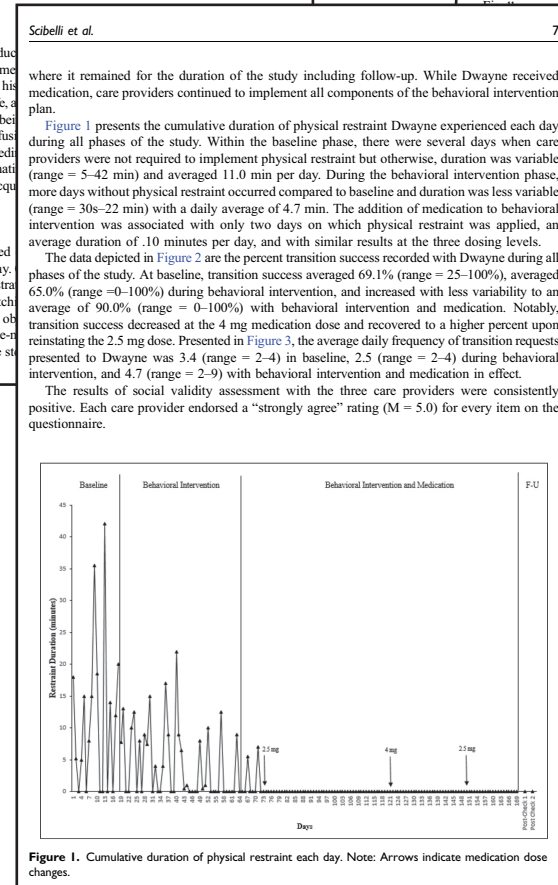
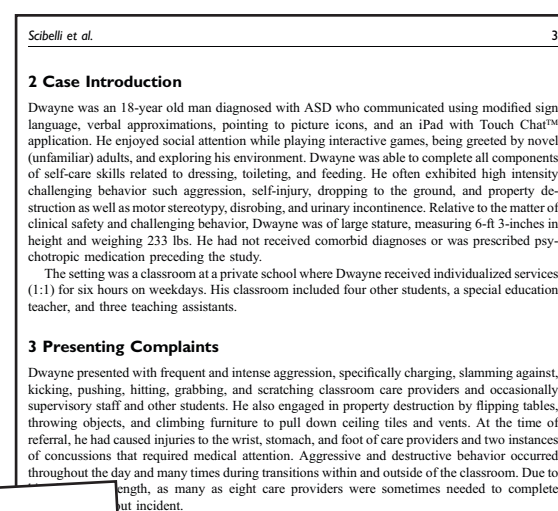
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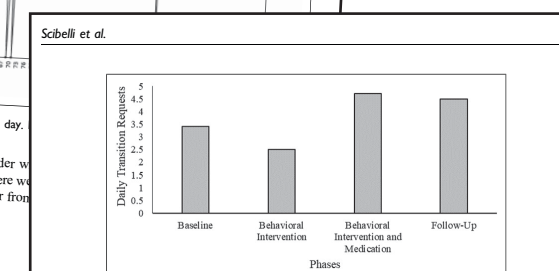
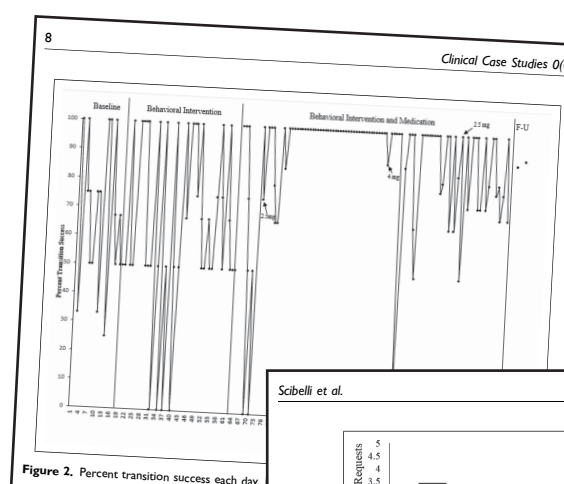


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persons with ASD may have been exposed to traumatic events, often enduring, that predispose them to anxiety disorders, PTSD, and other psychiatric comorbidities (Hoover, 2015; Rumball et al., 2020). Prolonged physical intervention including restraint is restrictive and despite clinical justification in many cases, could be trauma-inducing with resulting negative sequelae.

Page 11



10 Follow-Up
Dwayne continued to benefit from behavioral-pharmacological intervention long-term. Follow-up results at one-month and two-month post-checks shown in Figure 1 documented absence of physical restraint. Across both monthly post-checks, transition requests average 4.5 per day (Figure 2) and transition success per day averaged 91.3% (Figure 3).

11 Treatment Implications of the Case
The issues raised in this case are not uncommon in service settings for persons who have intellectual and neurodevelopmental disabilities and engage in aggressive behavior (Fisher et al., 2013; Luiselli, 2021a). A child's or adult's prior treatment failure, injury risk, need for physical intervention, and extensive care provider training are notable considerations. Dwayne could not be served adequately in several previous specialty programs, posed externalizing behavior that was dangerous, and demanded unique staffing arrangements as a prerequisite to clinical safety. Though behavioral intervention was associated with variable reduction in aggression-contingent physical restraint, we did not observe a complete and sustained therapeutic effect until pharmacotherapy was added. The combined behavioral-pharmacological intervention eliminated behavior outbursts with aggression and implementation of physical restraint while increasing Dwayne's transitional compliance and engagement with purposeful activities. In illustration, care providers observed that he completed academic and vocational tasks with greater consistency, appeared more attentive during instructional activities, and acquired skills rapidly. Follow-up maintenance of these outcomes with ongoing behavioral-pharmacological intervention was clinically significant. However, daily application of physical restraint and restraint duration were decreasing during the behavioral intervention phase before medication was prescribed. Accordingly, it is possible that physical restraint may have continued to decrease without medication. Note, too, that the transition compliance data did not suggest treatment success until a few weeks into the behavioral intervention and medication phase and the effect appeared to differentiate according to the medication dose Dwayne received. Also, there was never a medication withdrawal condition. Thus, the precise contribution of behavioral and pharmacological treatment components toward clinical success in this case cannot be interpreted unequivocally, notwithstanding the dramatic and long-standing therapeutic response achieved with Dwayne.