

## Behavior Management Plan for Internalizing Behavior

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Undesired behavior can be divided into two broad types: *Externalizing Behavior* and *Internalizing Behavior*.

*Externalizing behavior* typically includes one or more of the following:

- Task refusal
- Verbal aggression
- Physical aggression
  - Directed at other persons
  - Directed at physical property
  - Self-injury

Externalizing behaviors are immediately apparent in the classroom, and by definition they are disruptive to the environment. These behaviors almost always result in the creation of a behavior management plan, that rewards desired behavior and provides aversive consequences for undesired behavior. Time Out, Token Economies, and mildly aversive techniques such as overcorrection and logical consequences are commonly employed to address externalizing behavior.

*Internalizing behavior* typically includes one or more of the following:

- Anxiety
- Perfectionism
- Cognitive Rigidity (difficulty changing mental expectations)
  - Obsessive thought patterns
  - Problems with unmet expectations
  - Problems with changes in routines
- Depression

Internalizing behaviors can occur in isolation, or in combination with other developmental or behavioral issues, including Anxiety Disorder, Autism Spectrum Disorder (ASD), ADHD, Depression, Learning Disabilities, Intellectual Disability, Obsessive-Compulsive Disorder (OCD), and Tourette Syndrome (TS).

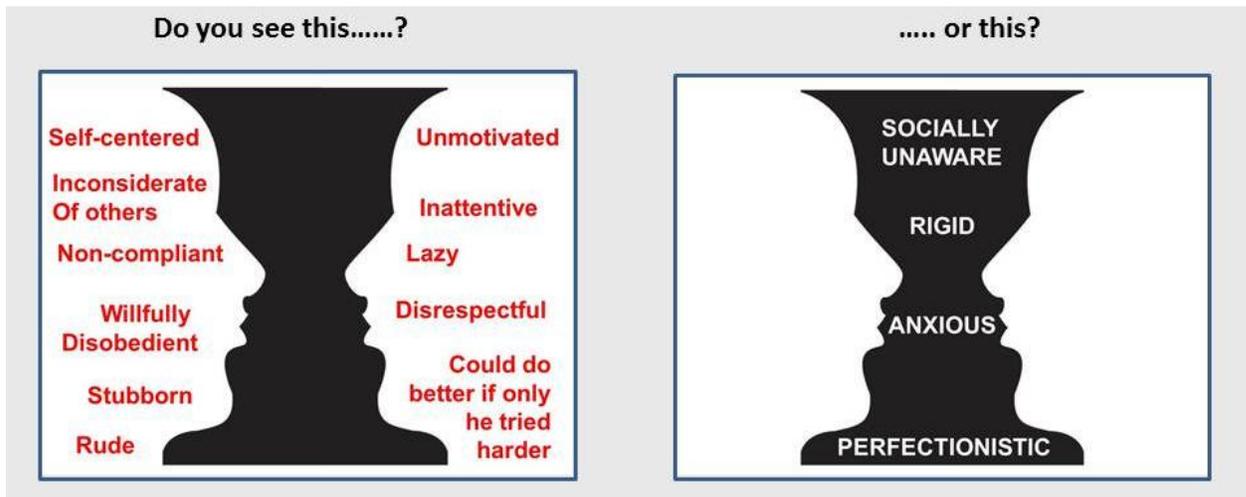
As the name indicates, Internalizing Behaviors are internal to the person. That is, they are not visible on the outside. Internalizing behaviors can be a huge obstacle for the child who is experiencing them, but they do not disrupt the classroom. As a result, internalizing behaviors often go unrecognized until the child becomes so distressed that he or she begins to engage in externalizing behavior. By then, however, much time has been lost, and much damage has been done to the child's self-esteem.

Furthermore, unlike externalizing behaviors, internalizing behaviors cannot be reversed with Time Out, Token Economies, logical consequences, and overcorrection. Rather, internalizing behaviors call for an entirely different approach from externalizing behaviors – starting with the realization that “disruption of the classroom” is not a useful marker or criterion for initiating intervention. By the time the child has become disruptive, the horse is already out of the barn.

A Behavior Management Plan for internalizing behavior should include one or more of the following elements:

1. Staff education: The child’s educational and therapy staff need to become conversant with the features of anxiety, perfectionism, cognitive rigidity, and depression in children. When a child is engaging in maladaptive, externalizing behavior, the staff need to ask themselves: “Could this be the result of underlying internalizing behaviors that have gone unrecognized or untreated up to now?”

We recommend “Worried no more. Help and hope for anxious children,”[1] by Aureen Pinto Wagner, as a primer on the manifestations of internalizing behavior (with a focus on anxiety) in children. We also recommend the web site of the Anxiety Disorders Association of America (<http://www.adaa.org/>).



**Figure:** The first task is to “see” the vase, and recognize that externalizing behavior may be the downstream consequence of internalizing behavior.

2. Student education: Unlike externalizing behaviors, which can be objectively measured by behavior charts (episodes of task refusal per hour, etc.), there best way to get at internalizing behavior is to ask the child. Give the child a way to *identify* and *quantify* his/her level of distress, and to *report* this information. We recommend *When my worries get too big*, [2] and *The incredible 5-point scale*. [3]

3. Direct intervention:

- a. Provide the student with ways to de-stress, *before* he or she becomes overwhelmed and begins to engage in externalizing behaviors such as task refusal, verbal defiance, or physical aggression. Techniques can include:
  - i. Stress-reducers “in place” (i.e. in in the classroom): Deep breathing, mental imagery, isometric exercises, “fidget toys”
  - ii. Give the student three “Break” cards per day, and the opportunity to use these as-needed each day to go to a calming area of the building. (However, these cannot be used for task-avoidant purposes. The student needs to complete the task upon return.) The cards do not carry over to the next day.
- b. Especially for children with autism spectrum disorder:
  - i. Be sure the child always knows what he or she is supposed to be doing *now*, and what he or she is supposed to be doing *next*. This can be facilitated through the use of visual schedules, and verbal preparations before transitions.
  - ii. If the child has perfectionism, it may be helpful to provide the child with a box where he or she can “hand in” their papers (rather than to the teacher), along with reassurance that the child will be permitted to go back and work on the paper some more, if the child feels the need to do so. This can sometimes reduce tantrums around transition times.

4. Outside of school:

- a. The parents should consider mental health services for their child, that may include some combination of play-, insight-based, and/or Cognitive-Behavioral Therapy.
- b. Medication: Internalizing behaviors are often biologically based - just like diabetes, asthma, or seizure disorder. As with other biologically-based conditions, medication is often helpful. Medication should not be used alone, or as the first-line response. However, medication is often an essential component of the treatment plan, and enables other parts of the program to “gain traction.” See Coplan 2010[4] for a review of psychopharmacology in children, including treatment of anxiety and related internalizing behaviors.

5. Family Function:

Internalizing behaviors often have a genetic component. One or both parents of a child with internalizing behavior often have similar traits themselves (Anxiety Disorder, Depression, OCD, etc.). If this is the case, then getting help for the parent(s) is an essential ingredient in getting the child’s behavior turned around. Efforts to help a child, without simultaneously addressing parental issues, are often suboptimal or ineffective.

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## References

1. Wagner, A.P., *Worried no more. Help and hope for anxious children, 2nd edition.* 2002, Rochester (NY): Lighthouse Press.
2. Buron, K.D., *When my worries get too big.* 2006, Shawnee Mission (KS): Autism Asperger Publishing Company.
3. Buron, K.D. and M. Curtis, *The Incredible 5-Point Scale.* 2003, Shawnee Mission (KS): Autism Asperger Publishing Company.
4. Coplan, J., *Making sense of Autistic Spectrum Disorders: Creating the Brightest Future for Your Child with ASD by Finding the Best Treatment Options* (Chapter 12: Behavior management and psychopharmacology). 2010 New York: Bantam-Dell Press.

