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Extending use of the Establish, Maintain, Restore Intervention to the Therapist-student Relationship: A Case Report

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The authors present a three-year case report for an adolescent student with Autism who has academic, behavioral, and mental health needs requiring collaborative school-based intervention. The case report outlines specifically how the student's mental health needs were supported through the application of a relationship-building framework. The authors discuss how elements of the Establish, Maintain, Restore intervention were applied to the therapist-student relationship. Results of the intervention consisted of stable connections with school staff and academic support for the student's educational success. Major takeaways and implications for school teams are discussed.

Keywords: **Mental Health, Autism, Relationship-building, EMR Intervention, Therapist-Student Relationship**

Introduction

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder that causes impairments in verbal or nonverbal social communication, social interaction, and restricted interests, activities, or repetitive behavior that significantly impair social, occupational, or other areas essential to function in society (APA, 2013). ASD represents a range of functioning and students with ASD, to varying degrees, can exhibit behavioral, academic, social, and mental health struggles in the school setting. Best-practice in supporting students with ASD who demonstrate impairments across these areas of functioning involves a collaborative, team-based approach in which different service providers work together to meet the unique needs of the student (Kunze & Machalicek, 2021).

While much attention has been paid to describing effective behavioral, academic, and social-emotional interventions for students with ASD, fewer resources exist that outline how the mental health needs of these students can be supported in the school environment. To this end, below we outline a case report for a student with ASD who was receiving collaborative school-based supports, but we focus specifically on how his mental health needs were targeted using relationship-building strategies to promote success across all areas of functioning. First, we discuss the pertinent literature related to supporting the mental

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health of students with ASD and its connection to learning outcomes. Then we describe one relationship-building intervention model, Establish, Maintain, Restore (EMR; Cook et al., 2018), and how it can be applied to the therapist-client relationship in order to support the ongoing success of these students. Third, we detail how EMR strategies were used to support one adolescent student's learning outcomes, and finally discuss implications for practice.

Mental Health, Relationships and Autism

Research has shown that students with ASD are more likely to experience mental health issues and struggles, compared to typically developing individuals (Lai et al., 2019). Furthermore, students with ASD can often experience significant distress because of co-occurring mental health struggles, often due to social-communication difficulties (Brown et al., 2016). Thus, it has been recommended that mental health supports should be implemented in the school setting for students with ASD, when indicated (Drmic et al., 2017). Often, school-based therapists provide these supports and prior research stresses the importance of high-quality connections and relationships between students with ASD and their therapists for fostering long-term school success (Brewe et al., 2021). Particularly important elements of the student-therapist relationship appear to include therapist empathy (Elliott et al., 2011), warmth and trust (Corey, 2020), and the use of strengths-based approaches for empowering students (Gallo et al., 2016; Geltner & Leibforth, 2008).

An added element of the learning environment that can be quite salient for students with ASD and emotional/behavioral struggles is the level of inclusivity present and how effectively student difference and diversity are valued. Often, classrooms in the United States can become aversive environments for students with impairments due to overarching educational priorities that can perpetuate ideas about disability that focus on labeling, excluding, and "remediating" student difference (Baglieri, 2017). These values can result in mainstream practices that actively ostracize and stigmatize individuals with impairments, especially those with behavioral difficulties. Cultivating authentic, accepting relationships with these students can serve as one component of a more inclusive and welcoming school experience (Chennat, 2019).

Relationships, EMR, and Student Outcomes

Prior research has indicated that the quality of such affective adult-student relationships in school is connected to a variety of student outcomes including behavioral, academic, and interpersonal (Kincade et al., 2020). Higher-quality (i.e., closer) relationships are associated with increases in school/classroom engagement (Cook et al., 2018; Roorda et al., 2011), improved peer relationships (Birch & Ladd, 1998; Lucas-Molina et al., 2015), and improved academic outcomes (Ansari et al., 2020; Hamre & Pianta, 2005) for K-12 stu-

dents. Relationships with adults at school appear to be especially important for students with disabilities (Granot, 2016), particularly those who exhibit emotional/behavioral struggles in the classroom (Van Loan & Garwood, 2020; Zolkoski, 2019).

The EMR intervention has been shown to be effective for improving relationships between educators and students and associated with improvements in student classroom behavior (Cook et al., 2018; Duong et al., 2019; Gaias et al., 2020). EMR is an intervention package that includes specific strategies intended to help teachers first build the foundation of a positive relationship (*Establish*), promote continued connection (*Maintain*), and actively repair damage done to the relationship because of conflict (*Restore*; Cook et al., 2018). EMR targets teacher skills and behaviors to promote better connections with students, thus improving student outcomes in the short and long-term (see Appendix A for more information about the specific strategies). EMR strategies stem from behavioral best-practices (e.g., 5-to-1 praise to correction, providing student choice) as well as attachment-related theories of student-teacher connection. Understanding school relationships through the lens of attachment means that relationships with school adults can mirror those that students develop with their primary attachment figures (often parents), and that educators should work to interact with students in a way that signals unconditional acceptance and interest (Verschueren & Koomen, 2012). The resulting deeper connection between teacher and student promotes student exploration, openness to learning, and a feeling of safety when making mistakes (Bergin & Bergin, 2009).

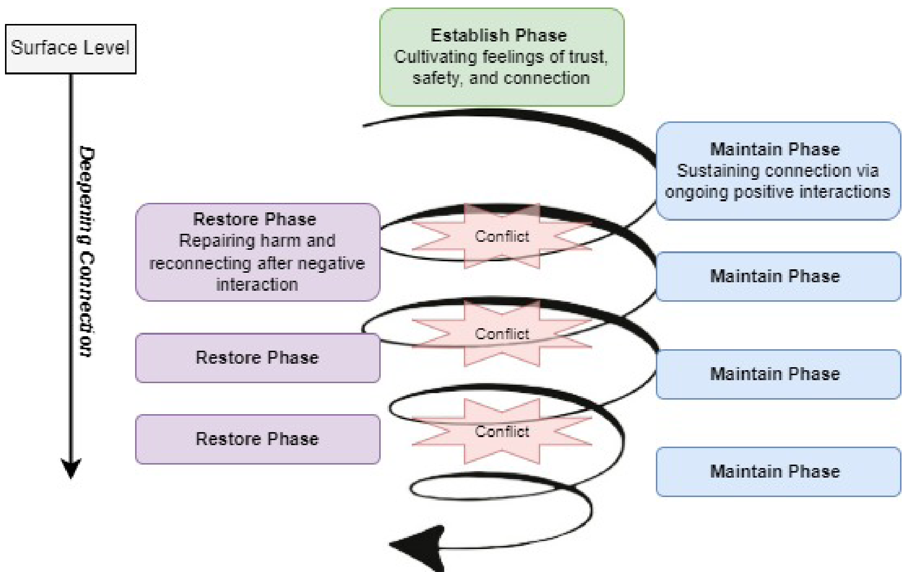

Figure 1. *Representation of EMR Processes in the Therapist-Student Relationship Across Several School Years (Adapted from Cook et al., 2018)*

The developers of EMR typically present this process in a linear fashion to illustrate relationship-development over the course of a school year (Appendix A). However, due to prolonged engagement with the target student and the need to sustain a high-quality therapeutic relationship with him over time, we have expanded the EMR steps to represent how we conceptualized the developing relationship over multiple years in Figure 1. The first phase of relationship-development (*Establish*) is at the top of figure to represent initial steps to connect with a student that occur at a more superficial or surface level. The downward spiral represents deepening connection as the adult engages in ongoing positive interactions with the student (*Maintain*) and navigates conflicts as they arise by reconnecting and reaffirming their commitment to supporting the student (*Restore*). Because some level of conflict is viewed as a natural element of most close attachment relationships, particularly for adolescents (Moed et al., 2015), Figure 1 illustrates how the adult-child relationship over time can be characterized by alternating between maintaining and restoring connection as closeness develops.

While the EMR approach, as well as most other relationship-focused interventions, have targeted the specific relationship between teachers and students, research has indicated that other adults in the school environment can also serve as sources of connection and safety for students (Chopra et al., 2004; Pittman et al., 2020; Tillery et al., 2013). With this in mind, and in light of the importance of high-quality mental health supports, we sought to extend the use of EMR principles to the therapist-student relationship for one adolescent with ASD as a means of supporting his learning success. We use the term therapist in this paper to refer to a direct mental health service provider working in a school-based setting. In this case, the therapist (and first author) was a white male licensed social worker with 27 years of experience practicing in school settings. He is also a board-certified behavior analyst and has obtained his PhD in special education. EMR was specifically chosen because it is one approach that clearly operationalizes the steps for forming relationships with students in a way that is easy to follow. While guidelines do exist for best practices in therapy delivery (e.g., NASW Standards for School Social Work) often these guidelines provide general descriptions or suggestions, rather than distinct strategies and behaviors service providers can employ. For example, although a plethora of resources exist that examine how therapists can build rapport (e.g., Kazdin et al., 2005; Lugo et al., 2017) and improve their therapeutic alliance with students, rarely are

operationalized strategies for all phases of the relationship-building process provided. Thus, EMR was chosen so that the therapist could use specific, observable behaviors throughout the process of becoming closer to the student to promote ongoing connection across the span of several years.

Case History

Psychological Background

The research was approved by the appropriate human subjects protection agency from the university of the authors. Therefore, the authors have permission to report the student's diagnostic information as well as written case notes.

Carl has a diagnosis of Autism Spectrum Disorder (ASD) and has been receiving special education services since first grade (2015). He meets the following autism definition criteria: verbal/nonverbal communication deficits, social interaction deficits, repetitive activities deficits, resistance to environmental change/change in daily routines, and sensory experiences. He also qualified for special education services on 5/1/2015 under the disability category of speech or language impairment.

Carl is a 14-year-old, 8th grade boy and attends a Social Communication Classroom (SCC) which he has attended since 6th grade. The program serves students with moderate to intensive needs in a school district in medium sized Midwestern town in the United States. Prior to attending the SCC classroom, Carl attended kindergarten through the fifth-grade in a general education classroom environment.

According to his records and parent report, Carl has the following diagnoses: Trichotillomania, Unspecified Anxiety Disorder, Attention Deficit Hyperactivity Disorder (inattentive type), Sensory Processing Disorder, Intermittent Explosive Disorder, Oppositional Defiant Disorder, and Autism Spectrum Disorder. Carl also has a history of picking/eating his scabs, eye lashes, hair, and other non-edibles. He takes a variety of medications to support behaviors affected by these diagnoses.

Occupational Therapy and Speech and Language Services

In March of 2018 an educational reevaluation indicated social pragmatics, articulation, fine motor, and emotional/sensory regulation difficulties. Those services were added to his IEP and provided by an occupational therapist and speech and language pathologist. According to the Sensory Processing Measure-2 Adolescent School Form that provides information about sensory preferences, Carl scored at the Moderate Difficulty level (15 raw score; 64 T-Score) for the sub category of Body Awareness. Typical T-scores fall in the range of 40-59.

Carl receives occupational services for 60 minutes a month. He reports liking to look at lights and doesn't report any specific sensitivities that appear to

impact his daily routines. He dislikes loud and unexpected noises. He dislikes tactile input from others and avoids being touched by others. Depending on the type of fabric, he occasionally has difficulty tolerating tags on his clothes. He does demonstrate some differences in sensory processing when compared to typically developing, same-aged peers. The areas on the Sensory-Processing Measure in which his experiences were rated as falling outside the typical range included Vision, Hearing, Touch, Taste & Smell, Body Awareness as well as in the overall Sensory Total score, and Social Participation. However, those differences are not severe enough to be considered clinically significant.

Carl has participated in speech therapy to address deficits in the production of speech sounds. He was administered the Goldman Fristoe Test of Articulation, Third Edition (GFTA-3), which is a norm-referenced assessment used to measure speech sound abilities in the area of articulation. The GFTA-3 measures speech sounds in single words and in sentences. Carl's scores indicated "severe" concerns in both the areas of Sounds-in-words, and Sounds-in-sentences.

Carl demonstrates the phonological pattern of gliding or producing the /r/ and /l/ sounds as /w/. He has difficulty with /l/ in the middle of words and in blends, and in all positions of words when they are in longer sentences. He also demonstrates intermittent distortion of the /th/ sound in sentences and conversation. Carl's difficulty with production of these sounds has a negative impact on his ability to communicate his thoughts and ideas with peers and staff in the classroom setting. According to the Social Language Development Test-Adolescent, Carl demonstrates social language skills that are within normal limits when compared to peers his age.

Social Skills

Carl can come up with solutions to social situations such as rejection, compromise, annoyance, and advocating for others. He demonstrates the ability to assert himself honestly and was often able to produce multiple solutions to problems. At times it is difficult for him to take the perspective of the other person and understand how they would feel about what he said. He scored in the below average range on the Making Inferences subtest of the Social Language Development Test-Adolescent, which required him to analyze facial expressions and body language within the context of the picture to determine the person's thoughts or feelings and describe the visual cues. According to his latest multi-factored evaluation completed on November 1st, 2021, a goal is to improve his ability to understand nonverbal communication cues (facial expressions, body language, vocal tone) in order to function and communicate in an educational setting with same-age peers.

Intelligence

According to the Wechsler Intelligence Scale for Children- Fifth Edition (WISC-V) administered on March 4th, 2017, Carl's Full-Scale IQ fell in the average range, along with all of his subtest scores, except for Working Memory (very low range) and Processing Speed (below average range). His scores are listed in Table 1.

Table 1. **Carl's WISC-V Scores**

Scale	Score
Verbal Comprehension Index	= 100 (average)
Visual Spatial Index	= 97 (average)
Fluid Reasoning Index	= 94 (average)
Working Memory Index	= 76 (very low)
Processing Speed Index	= 86 (below average)
Full Scale IQ	= 92 (average)

Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) was given to Carl. The SDQ is a brief behavioral screening questionnaire for children aged 4–17 years. His scores for all subscales on this questionnaire are presented in Table 2. Scores for Carl indicated "high" or "very high" difficulties across all domains except for Hyperactivity and Prosocial Skills, which fell into the "close to average" range.

Table 2. **Carl's Scores on the Strengths and Difficulties Questionnaire**

Scale	Score	Descriptor
Emotional Problems	7	Very High
Conduct Problems	4	High
Hyperactivity Scale	4	Close to Average
Peer Problems scale	5	High
Prosocial Scale	7	Close to Average
Impact Score	4	Very High

A non-standardized SEAT/Behavior Assessment was completed. SEAT stands for Sensory, Escape, Attention, or Tangible and it provides an opportunity to review patterns of behavior to assess what purpose the behavior serves to better understand if the source of behavior relates to sensory needs or if other needs are the cause. Carl appears to demonstrate behavior patterns that primarily support Escape and Attention from non-preferred tasks or situations, particularly in mathematics.

Educational Needs

According to his teacher, during math lessons Carl will typically complain about the work, break his pencil, put his head on his desk and occasionally leave the classroom or the school building. Carl needs to continue to work on complex numbers and functional math skills such as budgeting or measuring and working with decimals or percentages. Because Carl gets easily frustrated when he performs math, especially fractions, it is important for him to use self-regulation skills and recognize when he is becoming upset, use his words or picture cards and ask for a break before he wants to leave the classroom.

Case Study

Year One

Carl was referred for mental health services by his teacher in September of 2019. The teacher was in her first year of teaching. She had taken a classroom management class with the first author and graduated from the special education program in May of 2019. Therefore, rapport and familiarity had already been established with the teacher and the first author. Her concerns were that Carl was feeling anxious about being away from home, particularly from his grandmother, being teased by a peer, and work avoidance with math. As a result of these problems Carl had difficulty regulating his emotions and would get upset and be aggressive towards staff, peers, and property. The first author, working as a therapist, initiated mental health supports for Carl. He took extensive case notes during his sessions with Carl as well as carefully documented challenges and communications with other team members to help ascertain necessary updates to the therapeutic strategy and determine ongoing success. This process is akin to composing field notes for case study research in which a researcher collects extensive information about a case and the context surrounding that case to develop an in-depth understanding (Yin, 2018).

Establish Phase

All sessions occurred in the student's classroom. The student felt safe being in the classroom. All steps in the establish phase were used although they may not have occurred in any particular order. First *banking time* was used to set a regular time to meet with Carl which was once a week for at least 30 minutes. Open-ended questions were asked, and active and reflective listening was used

to address any of Carl's concerns. Within several sessions, *knowing the details of their lives* was implemented to gather information about Carl's preferred interests as well as his concern about being away from his grandmother and his feeling of missing her. He likes dolphins, playing Minecraft, and helping the teacher clean the room and the windows in the hallway of the school. He also liked to take staples that were no longer being used off the bulletin boards in the hallway. By the fifth session *high expectations and beliefs* were expressed about Carl's success. He was told that the therapist had a belief in his ability to eliminate anxiety about being away from his grandmother and confidence in his ability to form positive peer relationships. Carl was told that although sessions only occurred once a week, the therapist was available any time during the entire day to *offer help, proactively and reactively*. That is, if Carl needed to talk or deescalate the therapist was always available. Carl did not choose to talk to the therapist outside of the sessions. The therapist implemented interventions based upon Carl's input (*gather input*) and *options were provided*. For example, sessions were held in the classroom at Carl's desk or in a corner of the room where children relaxed and read on bean bags. A choice was provided where Carl would like to go. Around the 10th session, Carl began to discuss his problematic interactions with a peer or his anxiety without being prompted by the therapist. These were referred to as unprompted self-disclosed (USD) statements and were an indication that rapport was being established with Carl. During the next several sessions and with Carl's permission, the peer who was teasing Carl was asked to join at the end of the sessions on a bean bag in the corner of the room. The peer, Otis, was told that they would take turns going first in watching a preferred YouTube video. This helped reduce the teasing and establish a more workable relationship. Anytime Carl experienced success, the therapist used a *positive farewell* and acknowledged on the way out of the classroom something Carl did well that day even if it was a small change such as making a classroom transition without being redirected by the teacher. In the final step in the establish phase (*talk them up to another adult*), the therapist shared the successes with the teacher, the paraprofessionals, and the principal.

Maintain Phase

Two of the steps in the maintain phase were applicable for sessions. *Non-contingent positive interactions* were easily implemented by using greetings, farewells, and check-in statements (i.e., "How's it going?"; "How was your week?"; "How is your morning going so far?") as well as finding opportunities for shared laughter and fun particularly while watching YouTube videos of Carl's favorite animals. *Contingent positive interactions* were also used to acknowledge Carl's specific behavior of being open to share any difficulties he was having, acknowledging his effort, willingness to fail, and persistence to work on his goals and receiving help when he was struggling to ignore the peer who

was teasing him. Carl was particularly open to having the peer join at the end of his therapy session to watch his favorite videos on YouTube. In the following sessions the peer and Carl took turns on who would go first in selecting which videos to watch. After a few sessions the peer and Carl played well together, and the teasing decreased to almost zero levels. There was no need to apply the skill of *responding progressively to behavior* because there was not a need to redirect problem behavior. On one occasion the therapist did use the skill of *responding to unwanted behavior with empathy.* Around the 14th session the therapist visited Carl while he was deescalating in a time out room. The therapist approached Carl in the room and Carl kicked the therapist's left hand as he was approaching the threshold of the room. At the end of the day the therapist asked Carl to come out of the classroom. Before the therapist could speak Carl said, "I know you are going to tell me that I kicked you and that was wrong." Instead, the therapist used an empathic statement and stated that he apologized for getting into Carl's "personal space" as he was still deescalating. This interaction moved the relationship into the restore phase of the EMR practice.

Restore Phase

Carl was surprised by the apology because he expected to be reprimanded. The therapist considered this interaction as a turning point in therapy because Carl started trusting the therapist. The incident also allowed the therapist to have empathy for Carl's classroom teachers. For example, he understood that one subtle miscue or misperception could result in a response that could escalate Carl's behavior. The therapist initiated *letting go conversations.* For example, he found a time to have a private conversation at the end of the day when Carl was calm and open to processing the earlier incident. The therapist *took ownership* of getting in the personal space of Carl, thus escalating his behavior. They *mutually problem-solved by* collaboratively identifying solutions for the next time when Carl was upset. The solution was that when Carl was upset and not able to use his words, he would be given the time needed to calm down.

After the turning point incident there were more *contingent and non-contingent positive interactions.* Carl's anxiety decreased, there were fewer teasing incidents by his peer, and there were more USD statements during therapy sessions. Therapy sessions continued until the school was closed in March 2019 due to the pandemic. Carl requested to meet twice a week rather than once a week, giving further evidence of the establishing of a positive student-therapist relationship. Meetings occurred online throughout the spring semester. Positive outcomes of meeting online were that the therapist was able to meet the grandmother and his brother (sessions were at the grandmother's house) while the parents worked at home. Carl was able to show items that had value to him such as a train set in the basement, a remote-controlled truck, and a riding mower

(his grandmother emailed a picture of Carl on the riding mower cutting grass).

Online sessions consisted of working on Carl's body awareness in combination with emotional regulation. The therapist was trained in using The Interoception Curriculum: A Guide to Developing Mindful Self-Regulation (IC) in children with ASD (Mahler, 2019). The curriculum consisted of three sections, body (16 lessons), emotions (four lessons), and action (five lessons) for a total of 25 lessons. One lesson was completed each week and consisted of three parts, 1) Using a descriptor menu where a visual list of words was displayed on screen that one might feel in a body part (e.g., sweaty, tight, loose hands etc.), 2) Focus area experiments where the descriptor menu was used to describe interoception sensations with a body part such as the ears through listening to a variety of sounds (e.g. nature sounds, quiet space, video game music) and 3) Body check chart where Carl checked a specific body part, noticed how it was feeling, and matched that feeling to a descriptor word (e.g., growling stomach and heavy muscles = hungry).

At the end of the school year Carl asked his parents for continuation of therapy sessions. Carl met online with the therapist once a week for eight sessions during the summer and they completed the interoception curriculum. The parents and grandmother indicated that Carl had a good summer compared to the previous summer where he had been hospitalized for 10 days due to his aggressive behavior at home. The family also indicated that fighting between Carl and his brother decreased, although they still fought over taking turns on the computer. His brother began therapy sessions with a counselor at the local hospital's children's clinic. In the upcoming year Carl would have a new teacher and a new classroom with new peers. Therapy sessions would continue the first week of school.

Year Two

Maintain Phase

Rapport had been maintained throughout the summer, so the second year of Carl's therapy sessions consisted mostly of the maintain phase. Sessions now took place one-on-one in a small office located within the school. Upon returning to school, Carl's anxiety about being separated from his grandmother emerged. He complained that his stomach hurt and that he was afraid of returning to school. Returning to school after a break (summer or extended holiday) would be a recurring problem for Carl because of the change in routine and environment. His grandmother contacted the therapist and said that at home Carl had been cussing more and getting into arguments with his brother.

Carl shared with the therapist that he did yell at his brother and used profanity and wanted help with these problems. The therapist used *respond to unwanted behavior with empathy.* He was empathetic with Carl that he could not change his behavior immediately and encouraged him not to go into a "shame

spiral" (i.e., being hard himself after he cussed or got in a conflict with his brother). Rather, Carl's *effort, willingness to fail, and persistence was acknowledged* by the therapist. To address Carl's self-esteem, the therapist discovered that Carl wanted to learn to play chess. The therapist taught Carl to play chess within five weeks. Carl was now able to play chess with other boys in his class and in another classroom with middle school and high schoolers.

Near the end of the semester Carl's anxiety increased. The therapist did not know why as there were no changes in the home or classroom. Carl began to put his shirt over his head when he refused to do math or other non-preferred activities in the classroom. Putting the shirt over his head was a precursor to more aggressive behavior. During one session when the therapist asked about this behavior, Carl put his shirt over his head, pushed a paper tray off a desk and items off a shelf in the office. The therapist called for help and Carl had to be transported to a time out room where it took him two hours to deescalate. Carl was absent for two of the four sessions before the holiday. The therapist's perception was that Carl felt shame about having to be transported and the relationship had to be restored.

Restore Phase

To restore the relationship after the restraint incident the therapist used *mutual problem-solving,* particularly using the skills of *starting with an empathy statement, expressing his perspective,* and *collaborate to identify possible solutions* (with the school's Board Certified Behavior Analyst (BCBA) as well as the teacher), and *picked an idea, try it, repeat.* In the classroom, Carl's positive behaviors as well as his effort during math would be acknowledged. In therapy, the therapist and Carl identified asking for a break as a replacement behavior for putting his shirt over his head. Carl brought a chess set that he got for Christmas during the therapy sessions and the relationship was restored through playing chess and refining his skills.

Maintain Phase

For the following two months Carl did not have any aggressive behavior. The therapist continued to play chess and used lessons from a social skills curriculum. Carl did have to be secluded as a last resort in a safe area several times during March, 2021. The school staff presented the therapist with a note from Carl's psychiatrist indicating that he should not be secluded or restrained. Unfortunately, Carl interpreted this note as being able to do what he wanted, and his behavior drastically escalated. A meeting with school staff and the parents was held and it was explained that it was not possible to keep Carl in the current placement without being able to safely control Carl's aggressive behavior because he was hurting himself and others. The behavior support team consisting of the teacher, therapist, and BCBA developed an effective behavior intervention (i.e., proper use of reinforcement, extinction, and consequences) that reduced the

problem behavior to almost zero incidents of restraints and seclusion. The remaining therapy sessions for the year consisted of working on calming routines, the social skills curriculum and asking for breaks when Carl noticed early signs of frustration. After the end of the school year, Carl again asked to work with the therapist during the summer. The six sessions consisted of continuing the social skills curriculum and focused on getting along with his brother.

Year Three

Maintain Phase

Returning to school after the summer break was difficult for Carl because of the change in routine and being in the school environment. For the first two months he tested the durability of the intervention from the previous Spring. He had eight restraints in August, 14 in September and nine in October. He let go of testing the intervention and did not have any restraints or seclusions from November until the present writing of January 2022.

Carl met with the therapist twice a week. During this period the therapist used *non-contingent positive interactions*, particularly using *check-ins,* and asking, “How is your day going?” “How was your week?” Carl and the therapist found *opportunities for shared laughter and fun.* Sessions consisted of playing preferred board games and using the social skills curriculum. Contingent positive interactions, and acknowledging specific behavior were used for the times Carl used his picture cards to ask for a break. Carl’s anxiety increased due to a mandated call to children protective services regarding an incident that occurred in the home. He was afraid that he would be removed from the home. Carl struggled with using a mindfulness curriculum. Instead, he used tags from clothes as a calming routine in the classroom and during therapy sessions. He would place the tags in between his thumb and index finger and rub them in a circular motion.

Carl started to use more unprompted self-disclosure (USD) statements during therapy. He shared about the time he was bullied at his previous school and left school and to go see his grandmother who lived close by. He was also able to listen to music while playing a game that involved an animal that had a negative association. At this time Carl became interested in a girl in the middle school/high school classroom.

Restore Phase

The therapist helped Carl use restorative skills to repair relationships with his teacher and paraprofessionals. They used the skill of *taking ownership*. For example, Carl shared with the therapist that he said an unkind remark to a paraprofessional while being restrained and told the therapist that he was not a racist. In therapy the skill of *identify what you could have handled differently* was used. By using *mutual problem-solving* skills Carl decided to carry his picture cards with him to the calming room when the room was being occupied and

request to go to another room. Other issues in therapy consisted of problem solving, how to handle disappointments of his mother forgetting to pack his lunch and being anxious about getting sick before the break.

Carl left for a family vacation two weeks before the holiday break. The rapport with the therapist continued to be developed. For example, Carl asked his mom to take a picture of the rental car they used and text it to the therapist while the family was on vacation. The car was the same model that the therapist owns.

After the break Carl began using more USD statements and brought up during a session a recent incident about being teased by a boy in the middle school/high school classroom. To *restore* this relationship, Carl *took ownership* of his overreaction to the teasing. The therapist and Carl used *mutual problem-solving* and concluded that the benign teasing with the current peer triggered earlier trauma of being bullied at his previous school as well as by his brother. Carl learned to separate the previous incidents from the current one and apologized to the boy for getting upset and hitting him

In the next sessions, Carl was also able to use more USD statements. He shared with the therapist that he broke up with his girlfriend and that she "expected too much from him." He began talking about other incidents in his past that were traumatic. Particularly being secluded in a room in a therapy office, his brother breaking a special pencil used for drawing and being handcuffed by the police at the previous school. The therapist continued to use *maintain practices* and *contingent positive* interactions. On the final day of the last session of this writing Carl helped the therapist carry a box of donated items into his office. Carl noticed an item in the box that he had been searching for on the internet. The therapist gave the item to Carl upon receiving the item Carl asked, "Can I give you a hug?" They hugged and Carl went back to class. In the evening Carl's mother shared a text that Carl had sent to his extended family showing a picture of the item and that he received the item from his school therapist.

Discussion and Implications for Practice

School teams are increasingly recognizing the importance of collaboration and holistic supports for students with ASD who present with struggles across emotional, behavioral, social, and academic domains. For this student, the collaborative school team consisted of the student, his classroom teacher, Occupational Therapist, Speech-Language Pathologist, BCBA, paraprofessionals, family, and the therapist. Specifically attending to mental health needs, including the need to feel valued and accepted by such key adults in the school environment, can significantly improve outcomes for these students. For Carl, a framework dedicated to explicitly building connection and closeness with one trusted adult enabled the student to feel safe in trying newly-taught skills and

making mistakes at school. This is connected to the attachment ideas of "safe haven" and "secure base" (Ainsworth, 1989). Because of concerted efforts to build a quality relationship with Carl, the therapist served as an ad-hoc attachment figure in the school setting. This meant that Carl could seek out and obtain comfort from the therapist when feeling stressed as well as feel secure enough in the learning environment to explore and try new things with the support of the therapist. These elements of the relationship are illustrated in Carl's increased use of USDs during therapy sessions signaling his recognition of the therapist as someone to trust with his doubts, stresses, and struggles (safe haven) as well as in Carl's willingness to interact and work together with a non-preferred peer when the therapist was present (secure base). Furthermore, as a result of feeling safe with the therapist, Carl could be more open to actively learning and implementing appropriate self-regulation and social skills in the classroom as well as building relationships with other adults in the school.

Another common thread throughout the 3-year relationship building process was the therapist's acceptance of the presence of (sometimes significant) conflict in the relationship and the need to explicitly reconnect with Carl after these incidents. Prior research has shown that educators tend to report higher rates of conflict with students with disabilities (Freire et al., 2019), but that feelings of closeness and connection can still develop in spite of this conflict when adults are able to separate the student from their behavior and reassert their care for the student (McGrath & Van Bergen, 2019). In this case, the therapist was able to sense when restore practices were necessary as well as when Carl appeared ready for them and the EMR framework provided him with a structured formal for how to do this. For example, the therapist learned from his year one experiences that Carl seemed to experience feelings of shame after being physically aggressive and he applied this knowledge when responding to a similar incident the following year by intentionally reconnecting with Carl after he needed to be restrained.

According to Carl's latest ETR report from November 1st, 2021, he had made progress with the supports in place but continues to demonstrate deficits in verbal and nonverbal communication skills and social skills that adversely affect his educational performance. Carl was still resistant to changes in the environment or to his routine and continued to demonstrate difficulties with emotional regulation when feeling upset. It was these behavioral and emotional challenges that seemed to impact his academic learning difficulties the most. As mentioned above, Carl exhibited learning struggles in math, despite generally having grade-level academic skills. This was understood as Carl having the skills to access grade level content, but his behavior was impeding his ability to show what he knew in the classroom. This is sometimes referred to as a "won't do," (vs. "can't do") problem. For these situations, students are best supported by

altering the environmental consequences to prevent interfering behaviors and produce appropriate behaviors likely to promote continued success. As a part of this effort, in addition to the use of effective applied behavioral supports and high-quality instruction, the development of the therapist-student relationship through EMR helped to create a learning environment that was less aversive and more inclusive for Carl. Thus, enabling him to demonstrate his skills and strengths more consistently in the classroom.

One limitation of this study is that generalizations cannot be made to practice from one case. Carl's story illustrates the need to attend to developing quality trusting relationships between students and key adults in the school setting to promote mental health and positive school outcomes. A failure to do so can seriously hinder the effectiveness of all other educational interventions (Long, 2008). Another limitation is that following all the components of the EMR strategy may be overwhelming for beginning teachers and therapists. However, reviewing the components of each phase before an academic lesson or therapy session may help in gaining fluency in delivering EMR. Even though there may be an initial required effort, educators and therapist can use the strategies outlined in the EMR approach to promote increased closeness and sustained connection with students. Building rapport and supporting the emotional needs of students is important especially for those students with disabilities.

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Appendix A

Teacher Self-Report Intervention Fidelity Tool (Cook et al., 2018)

ESTABLISH PRACTICES: For students who were in the "establish" phase, reflect on the degree to which you delivered specific establish practices as planned.

To what extent did you use each of the establish strategies with these students?	Not at all	Slight extent	Some-what	Moderate extent	Great extent
Banking time: 1. Find an existing window of time to connect with a student. 2. Ask an open-ended question. 3. Actively and reflectively listen. 4. Express interest or empathy in what the student is saying.	0	1	2	3	4
Know the Details of their Lives: 1. Gather information from students with a questionnaire, using an assignment, or in conversation. 2. Keep track of the information in a source that you can easily reference to increase your recall of information about student. 3. Find opportunities to acknowledge something about the student that you have learned and think is relevant.	0	1	2	3	4
Express High Expectations and Belief: 1. Express specific and high-level expectations. Be clear what your expectations for success entail. 2. Make explicit a fundamental belief in the student's ability to meet those expectations.	0	1	2	3	4

To what extent did you use each of the establish strategies with these students?	Not at all	Slight extent	Some-what	Moderate extent	Great extent
Offer Help, Proactively and Reactively: 1. Let students know you're available, and how they can access your help 2. Proactively communicate ways in which students can request help in class if they encounter a challenge 3. Remind students that you are available to help 4. Look for signals throughout class that particular students are struggling 5. Initiate interaction to offer to help when you see students struggling	0	1	2	3	4
Gather input and act on it: 1. Identify topics that students would find relevant to give input about 2. Determine the best ways to gather the input 3. Review the input 4. Develop a feasible plan to act on the input 5. When you're new to this, negative feedback will hurt at first, but will become easier over time	0	1	2	3	4
Provide options: 1. Work with students to identify ways you can feasibly incorporate choice into class. 2. Provide both academic and non-academic choices. 3. Determine the acceptable options for each choice point. 4. Clearly describe the options to students. 5. Monitor how it goes and revise as needed.	0	1	2	3	4

To what extent did you use each of the establish strategies with these students?	Not at all	Slight extent	Some-what	Moderate extent	Great extent
Positive greetings and farewells: 1. Positive Greetings a. Position yourself at or around the door as students enter the room b. Use the student's name c. Make it your own d. Acknowledge it if they've been absent 2. Positive Farewells a. Position yourself at or around the door as students leave the room b. Acknowledge something they did in class, if appropriate	0	1	2	3	4
Talk them up to another adult: 1. Identify something that the student did, said, or achieved. 2. Identify another adult to deliver the positive recognition through (caregiver, another teacher, administrator, school counselor). 3. Communicate this to the other adult and ask them to recognize the student.	0	1	2	3	4

MAINTAIN PRACTICES: For students who were in the "maintain" phase, reflect on the degree to which you delivered specific maintain practices as planned.

To what extent did you use each of the maintain strategies with these students?	Not at all	Slight extent	Some-what	Moderate extent	Great extent
Non-contingent positive interactions: 1. Greetings & farewells 2. "How's it going?" check-ins 3. Find opportunities for shared laughter and fun	0	1	2	3	4
Contingent positive interactions: 1. Acknowledge specific behavior. 2. Acknowledge effort, willingness to fail, and persistence. 3. Offer help if the student is struggling.	0	1	2	3	4
Responding progressively to behavior: 1. Pause a. Remind yourself that most behaviors are minor and that simple solutions can work best 2. Proximity control a. Move within the vicinity of the student and stay close to that area while maintaining the flow of instruction 3. Redirection a. Break up the behavior by asking the student to do something where there is a high probability that they will comply 4. Prompt a. Provide a private, direct, gentle , positively stated prompt	0	1	2	3	4
Respond to unwanted behavior with empathy: 1. Empathy statement 2. Label the behavior of concern 3. Label alternative, desired behavior 4. Provide a Rationale 5. Create a decisional dilemma for the student 6. Follow through	0	1	2	3	4

RESTORE PRACTICES

For students who were in the "restore" phase, reflect on the degree to which you delivered specific restorative practices as planned.

To what extent did you use each of the restore strategies with these students?	Not at all	Slight extent	Some-what	Moderate extent	Great extent
Letting go conversation: 1. Internally find ways to let go. 2. Briefly think through how you want to convey this to the student. 3. Find a time to have a private conversation.	0	1	2	3	4
Taking ownership: 1. Identify what you could have handled differently. 2. Briefly think through how you want this conversation to go. 3. Find a time to have a private conversation.	0	1	2	3	4
Mutual problem-solving: 1. Start with an empathy statement. 2. Express your perspective while diffusing the power struggle. 3. Collaborate to identify possible solutions. 4. Pick an idea, try it, repeat.	0	1	2	3	4
Statement of care: 1. Identify at least one positive quality about the student. 2. Briefly think through how you want this conversation to go. 3. Find a time to have a private conversation.	0	1	2	3	4