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Reframing Aggression in Autism Spectrum Disorder: A Position Paper on "Uncontrolled Restlessness," Receptivity, and the Role of Medication

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Abstract

Background: Aggressive behaviors in children with Autism Spectrum Disorder (ASD) are frequently encountered in clinical practice and are often interpreted as intentional or oppositional, leading to variability in management.

Objective: To propose a clinically applicable reframing of aggression as "uncontrolled restlessness" and to define "receptivity" as a practical therapeutic endpoint guiding intervention.

Methods: This position paper integrates clinical observations with existing literature to outline a stage-based approach to management, incorporating both behavioral and pharmacological strategies.

Results: Behaviors such as hitting, biting, screaming, and object-directed force are better understood as manifestations of dysregulated arousal states. In a subset of children, persistent high-arousal states limit their ability to engage with behavioral interventions. Pharmacological agents such as risperidone and aripiprazole can reduce arousal and enable engagement with therapy.

Conclusion: Management should prioritize restoration of receptivity rather than suppression of behavior. Pharmacological intervention, when clinically indicated, facilitates engagement and should be integrated into care in a time-bound and goal-directed manner.

Keywords: Autism Spectrum Disorder, Aggression, Irritability, Arousal Dysregulation, Receptivity, Risperidone, Aripiprazole

Introduction

Aggressive and disruptive behaviours are a common reason for consultation in children with Autism Spectrum Disorder (ASD). These behaviours often include hitting, biting, screaming, and throwing objects,

and may result in injury, caregiver distress, and disruption of therapy.

In clinical settings, these behaviours are frequently interpreted as deliberate or oppositional. However, this interpretation does not adequately explain why such behaviours often occur in predictable contexts such as sensory overload, fatigue, or change in routine, nor why they are resistant to standard behavioural strategies in some children.

Based on clinical observation, many of these presentations are better understood as expressions of dysregulated arousal rather than intentional aggression. This paper proposes the term "uncontrolled restlessness" to describe this state and introduces "receptivity" as a clinically useful construct to guide management.

Clinical Conceptualization

- **Uncontrolled Restlessness**

In practice, children presenting with so-called aggression often demonstrate a recognizable progression:

- Increasing motor activity
- Reduced attention and eye contact
- Heightened sensitivity to sensory stimuli
- Escalation to self-injurious or outwardly directed behaviours

This pattern is consistent with a state of escalating dysregulation. The term "uncontrolled restlessness" is proposed to describe this clinical state, emphasizing loss of regulation rather than intent.

- **Receptivity as a Therapeutic Endpoint**

From a clinical standpoint, the success of any intervention depends on whether the child is able to:

- Attend to external stimuli
- Process instructions or cues
- Sustain interaction, even briefly

This functional state is referred to here as "receptivity."

In day-to-day practice, children who are non-receptive:

- Do not respond to name or instructions
- Are unable to participate in therapy sessions
- Show minimal or inconsistent engagement

Receptivity therefore serves as a practical marker of readiness for therapy.

Therapeutic Approach

- **Behavioural and Environmental Strategies**

Initial management should focus on:

- Establishing predictable routines
- Minimizing sensory triggers
- Using structured behavioural techniques
- Supporting caregivers in consistent responses

These measures are often sufficient in children with mild to moderate dysregulation and can prevent escalation.

- **When Behavioural Strategies Are Insufficient**

In a subset of patients, despite appropriate implementation:

- The child remains persistently hyper aroused
- There is minimal engagement with therapists or caregivers
- Sessions are frequently interrupted due to behavioural escalation

In such cases, the limitation is not the strategy itself, but the child's inability to process the intervention. This distinction is critical in avoiding prolonged ineffective therapy.

Pharmacological Intervention

- **Clinical Indications**

Based on clinical experience, pharmacological intervention should be considered when:

- Dysregulated behaviour persists for several days despite structured intervention
- There is risk of harm to the child or others

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- The child is unable to participate in therapy due to poor engagement

These situations indicate a need to reduce baseline arousal to allow further intervention.

- **Mechanism and Expected Clinical Effects**

Medications such as risperidone and aripiprazole are commonly used for irritability in ASD.

Clinically observed effects include:

- Reduction in motor agitation
- Improved tolerance to environmental stimuli
- Increased ability to attend and engage

Importantly, the goal is not sedation but improved regulation.

Clinical Transition to a "Therapy-able" State

Following appropriate pharmacological intervention, a shift is often observed:

Pre-intervention	Post-intervention
Constant movement	Periods of stillness
Poor eye contact	Intermittent engagement
Frequent escalation	Reduced frequency and intensity
Inability to participate	Tolerates structured activity

This transition allows initiation or continuation of therapies that were previously not feasible.

Integrated Model of Care

A staged approach is recommended:

Stage	Clinical Focus
Early	Behavioural and environmental regulation
Escalation	Intensified support and structured intervention
Persistent dysregulation	Addition of pharmacological therapy

This approach allows timely escalation without unnecessary delay.

Discussion

The proposed framework aligns with clinical observations that:

- Behavioural output is closely linked to underlying arousal state
- Engagement must precede skill acquisition
- Some children require biological modulation before behavioural therapy is effective

Reframing aggression as uncontrolled restlessness shifts the focus from intent to regulation, which has practical implications for both clinicians and caregivers.

Clinical and Ethical Considerations

This approach may help:

- Reduce attribution of blame to the child or caregivers
- Avoid prolonged ineffective behavioural interventions
- Support earlier, appropriate use of medication
- Encourage goal-directed and regularly reviewed pharmacotherapy

Conclusion

In clinical practice, aggressive behaviours in ASD are often manifestations of dysregulated arousal rather than intentional acts.

The primary goal of management should be to achieve a state in which the child can engage with the environment and therapeutic inputs.

When behavioural strategies alone are insufficient, pharmacological intervention can play a key role in enabling this transition.

The emphasis should remain on improving functional engagement rather than merely suppressing observable behaviours.

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