

Childhood behaviour in the context of disability

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Hunter New England and Central Coast, 2020



Overview of child development

Most children develop physically, intellectually and emotionally, in a predictable way

Variations in development:

- Expected difference in the population – eg Intellectual Disability
- Genetics
- Temperament – how someone responds
- Neurological disorders
- Chronic illness
- Environment – attachment, emotional availability, consistency and safety



As child progresses through stages of development, behaviours change

Many behaviours in children are developmentally normal

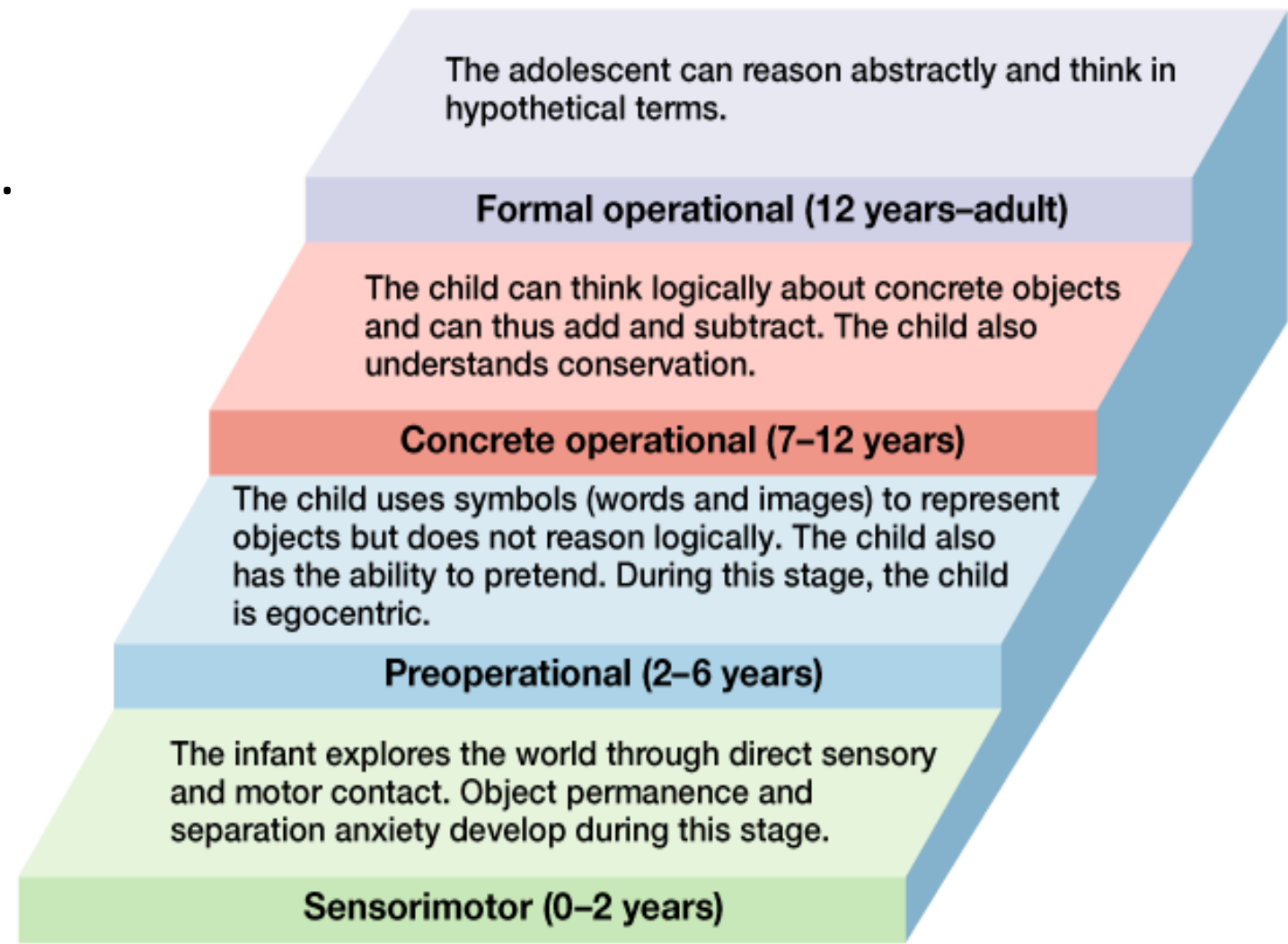
Behaviour change is the commonest manifestation of emotional problems



Piaget's stages of cognitive development

These get “wobbly” with Developmental Delay

- Primary age child comes to understand that things stay the same even if appearance changes. They can begin to infer and use deductive reasoning (predict)
- Toddler/pre-schooler feels they are the centre of the world
- Infant “thinks” using senses, learns cause and effect



Nature *versus* nurture/environment

- Health, disease or condition
 - Perinatal stress
 - Hearing or vision impairment
 - Attachment
 - Temperament
 - Learning
 - *How does the child respond to the world?*
- Cultural
 - Language
 - Socio-economic status and opportunities
 - Role modelling and expectations
 - Early stimulation
 - Relationships
 - *What is the child's world like?*



Behaviour

- Many behaviours we discuss are common at a particular time in childhood, or expected given a set of circumstances.
- Behaviours almost always communicate something
- “Challenging Behaviour”
 - no longer matches child’s developmental stage
 - is overly intense or frequent
 - when the behaviour causes harm
- Many behaviours can have a physical cause, so careful evaluation is needed, often by a doctor taking a history and performing examination

Behaviours can be related to:

Sleep

Pain

- Too much

- Impulsivity
- Persistent tantrums

Environmental factors e.g carers, peers, noise, occupation

- Too little

- Regression
- Withdrawal
- Inattention

Intellectual disability

Autism

Attention Deficit Hyperactivity Disorder

Anxiety

- Harmful

- Aggression
- Destructive

Illness

Tics

Depression

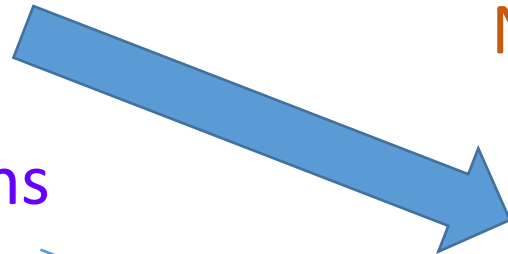
Personal factors e.g temperament/ resilience

An approach to behaviour in children with ID

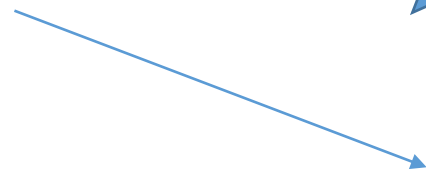
Health
Sleep
Mental health
Could there be any harm to child, DV?
Are any investigations needed?



GP or Paediatrician to assess child's health
Speech Pathology
Occupational Therapist
Psychologist or Behaviour therapist
NDIS supports and activities

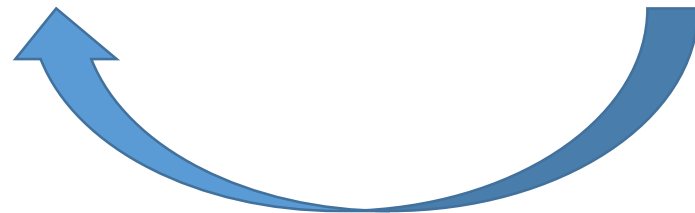


Informal supports: family, friends, groups
Family support services, parenting groups
GP and counselling for families



Is there a role for any medications?
Antipsychotics, anti-depressants, hypnotics

Review



Breakout discussion 1

When parenting/caring is hard –

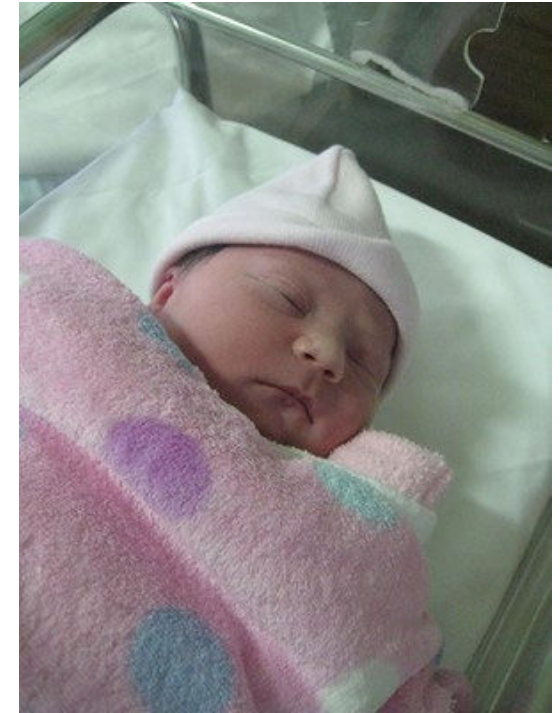
where have you found your best supports?



GP: Health (and sleep)

Familiarity facilitates physical examination
Take off “behaviour blinkers”

- Growth, nutrition
- Teeth
- Reflux
- Constipation
- Skin
- Hearing, vision
- Sleep
- Mental health
 - Mood
 - Anxiety
 - Early psychosis
 - Frustration tolerance
 - Self regulation
 - Harmed in any way?



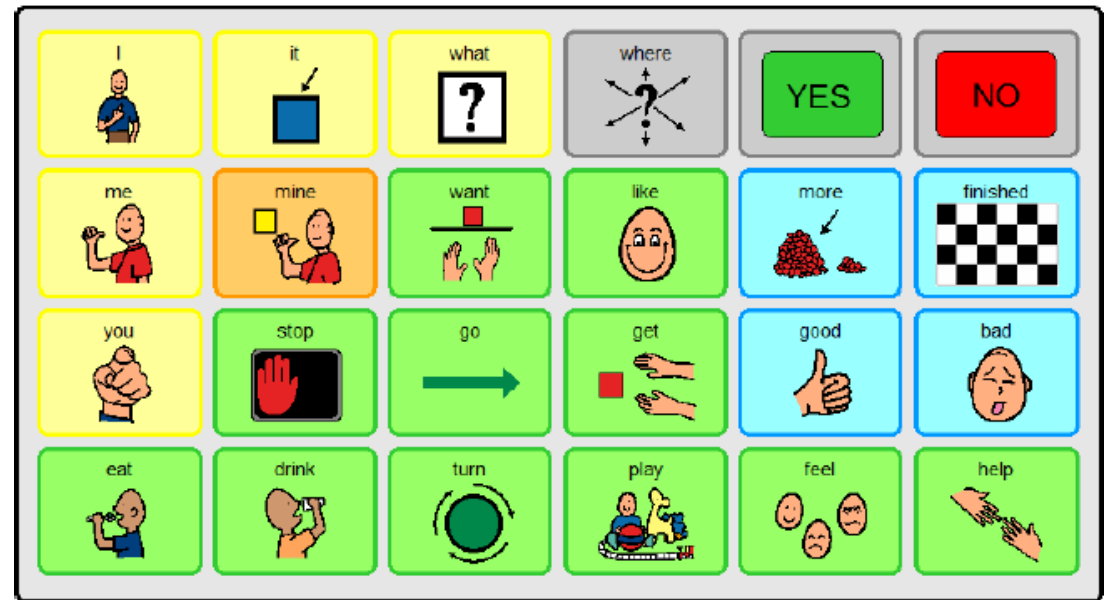
Tuberous Sclerosis Complex

<https://tsa.org.au/information/brain/>

- Enormous variation in people with TSC
 - Tubers in Brain, Heart, Kidneys
 - Epilepsy in about 80%
 - Subependymal giant cell tumours (SGCT or SEGA) in about 10%
 - Behaviour change – consider change to the epilepsy, vision, headache, tubers
- Bimodal IQ: 50% have Intellectual Disability (30% profound)
- Autism phenotype in about 35%
- Attention deficit hyperactivity disorder also more common than general population, but estimates range from 30-60%
- Self-injury and aggression are most often seen in children with ID (particularly profound) and ASD

SpP: What is the behaviour communicating?

- Assessment of skills, current modes and communication partners
- Impacted by severity of ID
- Trial/Training of “another way”
 - Hand-over-hand choice making
 - Photographs
 - PECS
 - Boardmaker
 - Switches
 - Key word signing

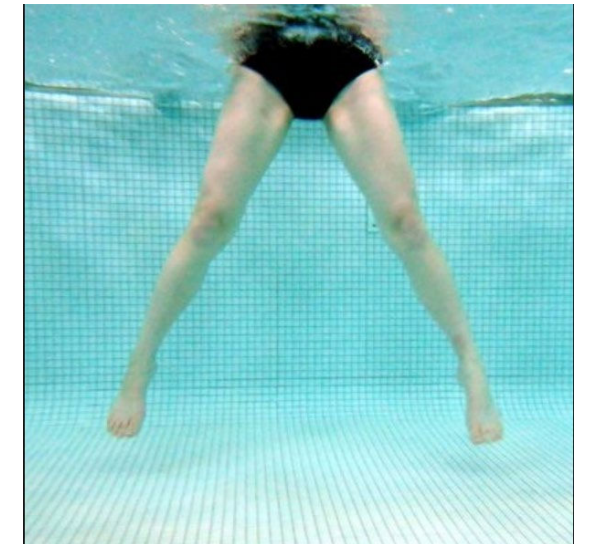


OT: Behaviour as an “Occupation” and Sensory likes and dislikes

- Antecedents and triggers become more obvious
- Explore – “what does a good day look like?”
- Patterns – habitual behaviours, repetition, rigidity
- Using Sensory profile to “prescribe” daily input to decrease usual level of arousal
 - Music
 - Brushing
 - Physical activity “heavy work”
 - Likes as enjoyable calming or rewards

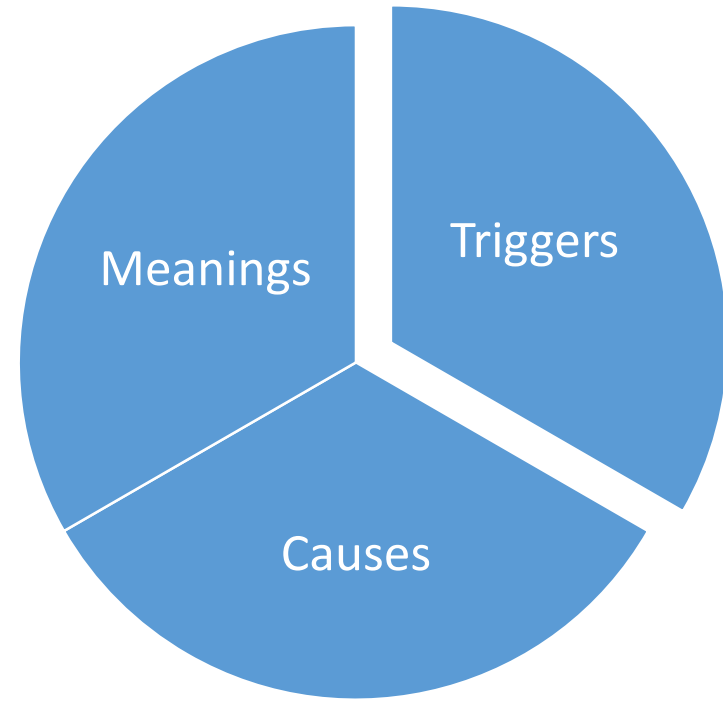


Examples from google images



Breakout discussion 2

What lightbulb moments have you had about behaviour?



Psychologist: Behaviour Support

- Test out ideas - **what do carers/parents/teachers/ allied health team think the purpose of the behaviour might be?**
 - Sensory stimulation
 - Social contact
 - Access to tangible items
 - Avoiding demands
- The Behaviour Support Plan - **activities and opportunities for positive experiences, behaviour modelling by carers, structured learning**
 - Catch and reward positive behaviour, requests for help
 - Targeted teaching for communication or other, ABA
 - Consistency – all on the same page
- Least restrictive ways of managing challenging behaviour

In a critical incident:

1. **De-escalate the situation**
 - neutral posture
 - calm
 - create personal space
 - withdraw
2. **Assess risk**
3. **Call for assistance**
4. **Give something positive**

Note. This is not the time to teach

Questions and discussion

- over to you



Wilde, L et al. Persistence of self-injury, aggression and property destruction in Children and adults with tuberous sclerosis complex. *J of intellectual Dis Research Vol 62(12) p1058-1071 2018*

Tye, C et al. Long-term cognitive outcomes in tuberous sclerosis complex. *Developmental Medicine and child Neurology Vol 62(3), p322-329 2020*

Goh, S et al. Subependymal giant cell tumours in tuberous sclerosis complex. *Neurology Vol 63(8) p1457-1461 2004*