

case study...

"The following case study gives a nice exposition of how small things that require little time can make surprisingly large differences. Christopher Z is an 8 year old boy with epilepsy, autism, and severe intellectual disability, who comes from a non-English speaking background. He was referred for a psychological consult by his neurologist owing to a recent exacerbation of behavioural difficulties in both the home and school environments. At the time of referral Christopher was attending a support class for children with an intellectual disability, having transitioned from an SSP the previous term, at his parents' insistence. His parents were requesting support and advice regarding Christopher's needs, in view of his slow progress academically, and escalating behavioural issues.

Initially, the family expressed that their main worry was Christopher's slow academic progress. They also expressed concerns about behaviours such as frequent loud vocalisations, and perseverative interests (e.g. repeatedly taking milk bottles from the fridge and pouring the contents down the sink, taking keys and coins and dropping them into drains). He also required a lot of attention and time at home – with dressing, feeding, toileting; and also with supervision (vis a vis the above behaviours, and also because he would abscond – to go looking at gutters on the street). They also expressed frustration because they were repeatedly being called to collect Christopher from his new school due to absconding, and behavioural problems.

From talking to the different agencies involved with supporting Christopher, the most evident issue concerned various communication breakdowns. Although well-informed about his medical condition and needs, Mr. & Mrs. Z had had very little access to information about autism and intellectual disability, and conceptualised Christopher's issues in a medical rather than developmental framework. They were also very reluctant

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to accept 'help' (which for cultural reasons they associated with obligation and indebtedness), but were very amenable to advice and direction. They also held a number of misconceptions around the role of government 'disability' services, and the different schooling options available for children with high support needs. As such, by reframing interventions (such as school, disability, respite) as entitled services (rather than 'support'), and portraying them as part of Christopher's recommended medical treatment, the family were much more willing to engage. They were also very grateful for the opportunity to discuss and learn about autism and intellectual disability, as a way of making sense of many of the behaviours they had struggled to manage in Christopher, and his slow progress and development.

Transitioning Christopher back into a more specialised school setting (once the family understood and was happy to support this) redressed the key school-based concerns (which had been around the inappropriateness of the support-class' general curriculum, leading to Christopher becoming bored & frustrated with general classroom activities (which was leading to some emerging aggression, and exacerbating the problems with absconding). A collaboration between the ADHC community team and school staff then enabled integration of school based behaviour and communication strategies into the home environment.

Ten months on, and Christopher clearly remains a young boy with significant disability, and his family continue to face their own challenges in coming to terms with his high and ongoing support needs, and his medical prognosis. However, what was striking for me about this case was how, through inviting a dialogue with the family, and opening communication channels and encouraging collaboration between public health, education, and disability services; doing remarkably little was successful in bringing about some very real changes for both Christopher and his family. ●

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