A COLLABORATION ON DEVELOPMENT: DEVELOPMENTAL APPROACH TO SUPPORTING FASD AND TRAUMA

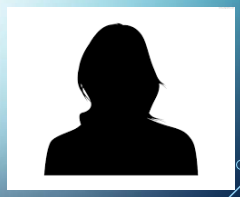
ELIZABETH MCWILLIAMS HEWITT, MA,ED
BEHAVIOUR CONSULTANT
KEITH LANDHERR, MA., OT
OCCUPATIONAL THERAPIST

MEETING JANE

Jane, 14 years old, has been described by her treating psychiatrist as "the most complex individual" he has worked with.

In care, Jane has an extensive history that includes;

- Multiple placements and breakdowns of care homes
- Trauma
- Multiple school placements and failures
- A complex neurological and developmental profile



DIAGNOSIS

At the time of referral, Jane had been diagnosed with the following;

- Fetal Alcohol Syndrome
- Anxiety Disorder-NOS
- Autism Spectrum Disorder
- Moderate Mental Handicap

It had been suggested that Jane be assessed for a trauma related diagnosis and there is documentation to suggest Reactive Attachment Disorder.

THE TEAM….

At the time of the referral, Jane had the following services/care providers involved;

- Social Worker, Guardian
- Social Worker, Resources
- Psychiatrist
- Developmental Disabilities Mental Health team (consultant and psych nurse)
- Care home staff (4-6 depending on time)
- Manager of care home staff and the house
- School-based resource team; teacher, Resource teacher, Autism Support, EA, district principal, school principal, school district OT

WHAT THE PRESENTING CONCERNS WERE….

- High levels of aggression and SIBs
- Extensive list of medications
- School failure and unable to attend regularly
- Sleep disordered
- Staff burnout

*Jane had been referred to PAC and was waiting for a space to become available.

WHAT THIS MEANT IN THE DAY TO DAY…

- Data recordings show "hits" of even 100 incidents in a day
- Unable to "play" or engage in any meaningful social interaction
- Increasingly Jane was becoming isolated; unable to leave her house or attend activities she use to enjoy
- Name calling of staff and strangers
- "Work refusal" and "defiance"
- Hitting herself and damage to the home (holes, broken tile, etc)
- Multiple concussions
- Unable to remain at school, even on a reduced schedule
- Hitting staff at school and being sent home early every day

WHERE DID WE START…?

- I got to know Jane….what she liked, what she could do and what was important for her?
  - Jane wants a family (her words!)…this tells me, she wants a connection with the people in her life.
  - Jane loved a routine… she could cook and clean and follow her routines in her home, with minimal support.
  - Jane could tell who enjoyed spending time with her and who did not
  - Jane was determined!

WHERE DID WE START?

- Staff training and agency training on FASD and trauma-informed practice
  - We shifted the lens from "won't" to "can't"
  - We learned how trauma affects the brain
  - We learned the developmental implication of FASD, trauma and her other diagnosis
- We figured out her emotional-social developmental level
- We prioritized her needs, keeping development as our lens

Fetal Alcohol Syndrome

Prenatal Exposure to opiates and cocaine

Trauma (early years disorder, neglect, multiple placements)

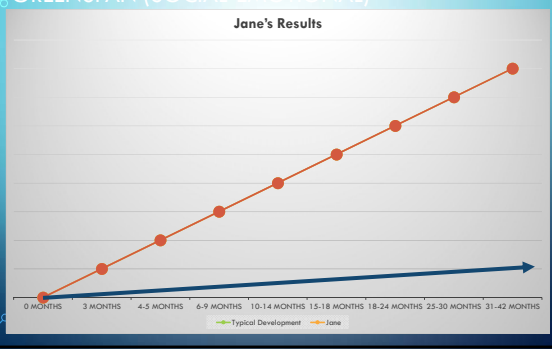
Reactive Attachment Disorder

Autism Spectrum Disorder

Anxiety Disorder-NOS

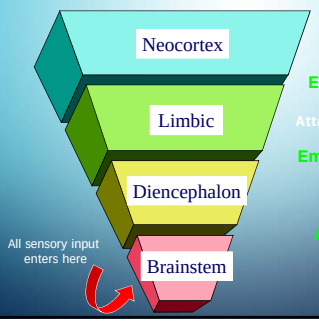
Moderate Mental Handicap

GREENSPAN (SOCIAL-EMOTIONAL)



BUILDING THE BRAIN: FROM SIMPLE TO COMPLEX

DR. BRUCE D PERRY, MD, PhD © 2004-2012,



Abstract Thought
Concrete Thought
Executive Function

Attachment / Relationships
Sexual Behavior
Emotional Regulation

Motor Regulation
Motivation
Arousal – STRESS
Sleep
BP / Heart Rate
Respiratory Drive
Body Temperature

RELATIONSHIP

- Focus was on a relationship with the primary caregivers….we supported staff to become attune to Jane's needs and state
- Paradigm shift from compliance to relational

HOW DID WE APPROACH THE RELATIONSHIP

- Created a developmental profile that was fair for all to understand the scattered development
- Reduced expectations to a developmentally appropriate level in each domain
- Emotionally: we responded as we would to an infant (<1 yr) recognizing that infants/children become upset because they need their basic needs met, they are hurt or sick or need to feel a connection with their adult (atunement)

"You are okay… I've got you…."

Reduced language = Reduced neurological pressure

Reduced neurological pressure = Less challenging behaviours

REDUCING NEUROLOGICAL PRESSURE AND EXPECTATIONS

- As we would label/decode, give understanding and problem solve for a young child, we needed to do the same for Jane.
- We needed to recognize that she was not able to access her "thinking" brain when frustrated or excited (emotional liability of FAS)
- We needed to support her understanding, as we would a much younger child.

NOW THAT WE HAVE ATTUNEMENT AND RELATIONSHIP… WE ARE READY FOR OT!

- Sensory Supports = You
- Sensory Supports = You + Jane
- Sensory Supports = Jane + Everyone
- Sensory Supports = Jane + Jane

FIVE DOMAINS OF STRESS AND SELF-REGULATION STRESSORS

- Biological
- Emotional
- Cognitive
- Social
- Pro-social

STUART SHANKER 2016

NEUROCEPTION

- Refers to the system in each of us that supports co-regulation and safety: one's own, and that of another.

SHANKER, 2016

ASSESSMENT

"Jane is not able to self-regulate effectively on her own - she needs external support to regulate her emotions and behavior. She has clear sensory sensitivities as described in this report and seems to function close to the "fight/flight/freeze" mode neurologically. It doesn't take much to push her further into this mode and away from self-regulation - her first reaction is to "fight" even

when the situation does not seem to warrant this reaction to most adults."

PERCEPTIONS DEFINE REALITY

- context of the stimulus or the situation
- past experiences
- perception and the stimulus characteristics
- individuals differences sensory processing
- psycho-social history
- motor planning capacities

SENSORY PROCESSING

- Sensory processing- (sometimes called "sensory integration") is a term that refers to the way the nervous system receives messages from the senses and turns them into appropriate motor and behavioral responses.

DEFINITION OF SENSORY PROCESSING

- Sensory processing refers to the ability to take information from our senses (touch, movement, smell, taste, vision, and hearing) and put it together with prior information, memories, and knowledge stored in the brain to make a meaningful response.

SENSORY PROCESSING ABILITIES

- The way an individual processes and responds to sensation has an impact on their daily life activities and activity choices. (Zuckerman, 1994, & Dunn, 1997)
- Atypical sensory processing refers to both hyper and hypo reactivity to sensation.
  - Poor or atypical sensory processing abilities have been associated with problems in social participation and behavioral self-regulation, as well as learning, leisure, and occupational activities. (Dunn, 2001)

SENSORY PROCESSING ABILITIES

- Other common behavioral manifestations of atypical sensory processing include distractibility, impulsiveness, abnormal activity level, disorganization, anxiety, and emotional lability.
- (Mallioux and Parham, 1995)

THE BASICS OF SENSORY PROCESSING

- Hypo-responsive → high threshold → cells do not fire easily and too little information reaches the sensory processing areas of the brain
- Hyper-responsive → low threshold → cells fire easily and too much information reaches the sensory processing areas of the brain

TYPES OF SENSORY DIFFERENCES

- Low Registration
  - Individuals with low registration tend to miss or take longer to respond to things in their environment.
  - These individuals tend to have trouble reacting to rapidly presented or low-intensity stimuli.
  - However, these individuals find it easier to focus on tasks of interest in distracting environments.
  - They tend to be more flexible and comfortable in a wide range of sensory environments.

TYPES OF SENSORY DIFFERENCES

- Sensory Sensitivity
  - Individuals with sensory sensitivity respond readily to sensory stimuli.
  - Behaviors associated with sensory sensitivity include distractibility and discomfort caused by intense stimuli.
  - These individuals have a tendency to notice each stimulus as it presents itself.
  - However, some advantages of sensory sensitivity include a high level of awareness of the environment and an ability to discriminate or attend to detail

TYPES OF SENSORY DIFFERENCES

- Sensation Avoiding
  - Individuals who engage in sensation avoiding behaviors are overwhelmed or bothered by sensory stimuli. Consequently, sensation avoiders actively engage with their environments to reduce sensory stimuli.
  - Individuals with sensation avoiding tendencies may use ritual to increase predictability of their sensory environment.
  - However, advantages of sensation avoiding include the ability to create structure and environments that provided limited sensory stimuli, as well as tolerance-even an enjoyment- of being alone.

- **D** = DEVELOPMENTAL

  FUNCTIONAL DEVELOPMENTAL CAPACITIES THAT INTEGRATE THE MOST ESSENTIAL COGNITIVE AND AFFECTIVE PROCESSES
- **I** = INDIVIDUAL DIFFERENCES

  BIOLOGICALLY BASED DIFFERENCES IN SENSORY PROCESSING, MODULATION, MUSCLE TONE, AND MOTOR PLANNING AND SEQUENCING
- **R** = RELATIONSHIPS & AFFECT

  AFFECTIVE INTERACTIONS BUILD SOCIAL AND EMOTIONAL DEVELOPMENT, INTELLIGENCE, AND MORALITY

BIOLOGICAL CHALLENGES

*Auditory Processing and Language
*Visual – Spatial Processing
* Motor Planning and Sequencing
* Sensory Modulation

Child Care- giver Interactions

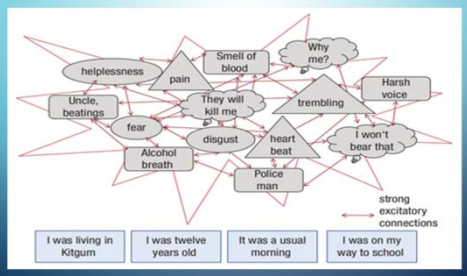
Functional Developmental Capacities
Focus and Attention
Engaging and Relating
Simple Two- way Gesturing
Complex Problem Solving
Creative Use of Ideas and Symbols
Analytic/ Logical Thinking

Diagnostic Patterns
* Deficit in affect-motor planning –symbol formation connection
* Deficit in different processing patterns

5 C'S OF DCD

- **COMMON**: Prevalence estimates range from 5 to 15% making DCD a common, although often unrecognized, disorder. In each classroom, one to two children may have DCD.
- **CLUMSY**: Although there may be differences in the presentation of children with DCD, clumsiness is the common feature. Children with DCD will appear physically awkward and uncoordinated and may bump into objects or people.
- **CHRONIC HEALTH CONDITION**: Children do not 'outgrow' DCD. DCD is a chronic health condition that persists into adolescence and adulthood.
- **CO--OCCURING CONDITIONS**: DCD is frequently associated with Specific Language Impairment (SLI) & Attention Deficit Hyperactivity Disorder (ADHD).
- **CONSEQUENCES**: Without effective management, secondary complications may occur including social isolation, physical and mental health issues and low self--esteem.

THE FORMATION OF A NEURAL FEAR NETWORK IN POSTTRAUMATIC STRESS DISORDER



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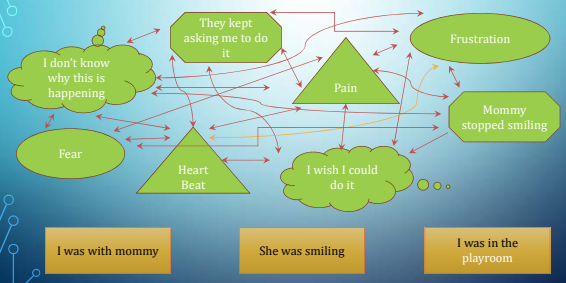

Keith Landherr, M.A.,O.T.

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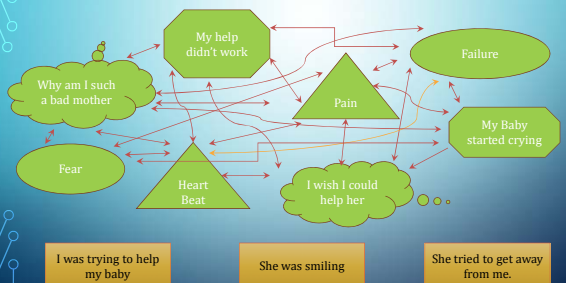

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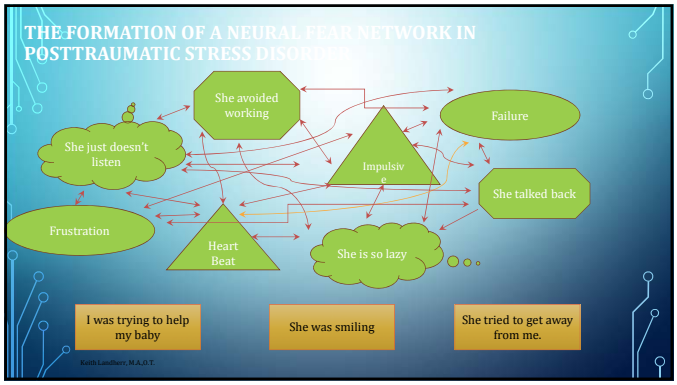
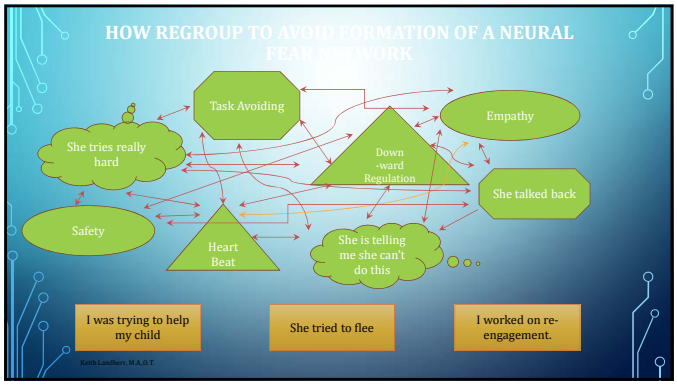

THE FORMATION OF A NEURAL FEAR NETWORK IN POSTTRAUMATIC STRESS DISORDER
She avoided working
Failure
She just doesn't listen
Impulsiv e
She talked back
Frustration
Heart Beat
She is so lazy
I was trying to help my baby
She was smiling
She tried to get away from me.
Keith Landherr, M.A.O.T.


HOW REGROUP TO AVOID FORMATION OF A NEURAL FEAR NETWORK
Task Avoiding
Empathy
She tries really hard
Down -ward Regulation
She talked back
Safety
Heart Beat
She is telling me she can't do this
I was trying to help my child
She tried to flee
I worked on re-engagement.
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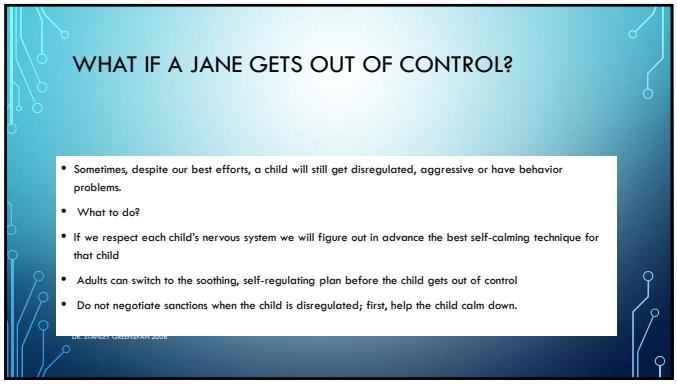
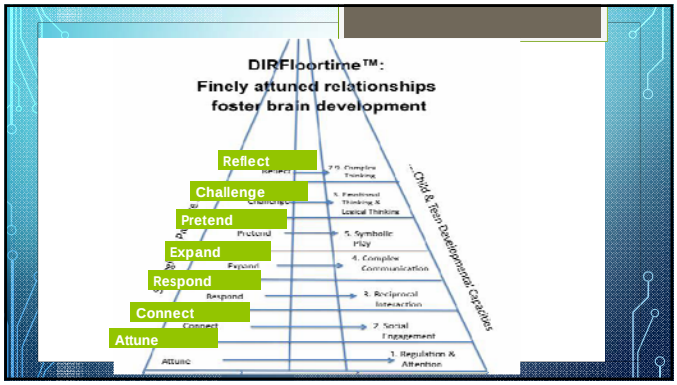

WHAT IF A JANE GETS OUT OF CONTROL?
Sometimes, despite our best efforts, a child will still get disregulated, aggressive or have behavior problems.
What to do?
If we respect each child's nervous system we will figure out in advance the best self-calming technique for that child
Adults can switch to the soothing, self-regulating plan before the child gets out of control
Do not negotiate sanctions when the child is disregulated; first, help the child calm down.



Treatment

- Staff Training
- Sensory Gym
- Team Meetings
- Desensitization/ Reappraisal

TODAY…. (2 YEARS LATER)

- PAC referral cancelled
- DDMH has discharged
- Meds reduced and some eliminated
- No longer hitting self/Low intensity hit on staff (1-2 on days when it occurs)
- School every day from 9 to 12 (staying for lunch and socializing)
- Low incidence of name-calling
- Reduction in "odd" behaviours (repetitive and non-functional)
- Responding well to redirection and humour!
- Staff are reading her emotional state with confidence

TODAY…. (2 YEARS LATER)

- Identifies classmates she likes to spend time with
- Relationship with staff at school
- Walks with staff and asking for social outings and experiences
- "Play" (Arts & Crafts, Tea parties)
- Joking and sharing laughter with staff
- OT therapy continues
- Plans are being made for transition to adult services

"WE NEED TO MAKE THE POSITIVES SO LOUD THAT THE NEGATIVE BECOMES IMPOSSIBLE TO HEAR"

G. Couvos

ANY QUESTIONS??