

**March 7, 2013**

## **Challenging Behaviours in Persons with Developmental Disabilities: The Whole Person Approach – A TUTORIAL**

---

Resource:

Canadian Consensus Guidelines for Primary Care of Adults with Developmental Disabilities and the companion Tool Kit <http://www.surreyplace.on.ca/Primary-Care/Pages/Home.aspx>

### **Case History - SALLY**

#### **Section 1: Initial Meeting**

Sally Jones is a 42 year-old woman who was brought to your clinic by her new primary support professional, Beth. According to Beth, Sally has undergone a previous psychological assessment that has confirmed that she is functioning within the mild to moderate range of intellectual disability. Approximately 5 years ago she also consulted at another clinic that is similar to yours, although Beth was unable to provide any related details or reports for review.

Sally is short with a broad square face and heavy eyebrows. She is quite overweight. Although Sally is verbal and very friendly and engaging with the examiner, it is unclear at the time of the meeting what her receptive vs. expressive language abilities are. During the first portion of the interview, you spend time focusing solely on Sally and establishing rapport. When you ask about things that she enjoys doing, she becomes very excited and tells you that later she and Beth will be going out for a Coke and a donut at Tim Horton's – her favourite activity. As she tells you this, she claps her hands and then holds onto herself tightly, rocking slightly as she does so.

Overall, Sally appears to be a poor historian, and provides limited information beyond a few word responses and is seemingly unsure of herself. As a result, Beth responds to many of the examiner's questions thereafter. You observe that when Beth is responding to your questions, Sally becomes physically restless, whines, and slaps her own face. When attention is drawn back to her, she settles somewhat. Beth sighed and tells you that Sally wants to be "the centre of attention all the time," and that at home she "acts like the Tasmanian Devil when she can't have her way."

Beth reported that they have come to your clinic owing to a worsening of Sally's self-injurious behaviours (head-banging with her fists and against hard surfaces; skin picking to the point of multiple scars and tissue damage; and, pulling off of fingernails and toenails), verbal (and, less frequently, physical) aggression towards others, and destruction of property (she throws items and has also punched holes in walls). Although she has injured herself on multiple occasions, she does not act as though she is hurt and continues with her tirade. Her sleep is very poor, with frequent nighttime awakenings, very early morning arousal, and excessive sleepiness throughout the day (most especially in the late afternoon). Sally's primary worker has recently gone off work on an extended disability leave. Beth noted that the above behavior patterns have been the trend since she started working with Sally a few weeks ago, although she is unsure if this is an historical trend or is a new difficulty.

## **QUESTIONS**

1. From the history so far, what could prove to be impediments to thorough evaluation?
2. From the information provided, does any genetic syndrome come to mind as a cause of Sally's intellectual disability?
3. Do any issues about consent come to mind?
4. What other concerns may be important to explore from information provided?

## Section 2: Medical and Health-related Information

Beth reports the following information about Sally's medical history:

- No family history of developmental disability or intellectual disability
- Hypothyroidism (stabilized), history of gout and frequent ear infections
- Her medication is prescribed by her primary care physician, and it is unknown whether she has ever consulted with a psychiatrist.
- Current medications:
  - Lithium 600 mg bid x 10 years
  - Risperidone in varying doses x 12 years – currently used as a prn: 2.5 mg per day: in the past two months, her prn use has increased four-fold vs. the trend for previous months
  - lorazepam, 2.0 mg, bid – recently prescribed
  - Fluvoxamine 100 mg x 12 years
  - Levothyroxine, allopurinol, metformin, depot provera
  - Her lithium levels were recently found to be 1.54 (an increase from 0.89 in the previous months, with no dose change)
- Previous medications:
  - Clomipramine, carbamazepine, busprione, clonidine – all unsuccessful
- You observe that she walks with a wide gait, has low muscle tone and poor posture, and she drools sporadically throughout the interview
- Height/Weight at the time of the meeting: 5'0"/185 lbs.
  - Her weight has increased by 80 lbs. in the past 10 years.
- She does not drink a lot of water, instead preferring to drink Coke
- In an effort to keep her calm and happy and to reward good behaviours, staff routinely make sweets available to her.
- She is frequently constipated.
- She has been exhibiting more frequent mood swings over the past few months. Her periods of aggression can last for hours.
- Although Sally has taken many different psychotropic medications in the past and presently, Beth reports that to the best of her knowledge she has never been formally diagnosed with any psychiatric disorders.

## QUESTIONS

1. What information from this section might shed some light on Sally's challenging behaviour?
2. What health-related factors might be relevant in Sally's life?
3. What thoughts do you have about Sally's medications?

### Section 3: Social/Environmental Information

- Sally lived with her mother and two older sisters until her early 20's, when her mother became unable to manage her challenging behaviours and she was moved to a 24/7 supported group home.
- Her mother passed away one year ago. Until the time of her death she visited Sally on a biweekly basis, and Sally enjoyed the one-on-one attention she was given.
- Her sisters live nearby and have visits with her on a monthly to bi-monthly basis. Sally seems to enjoy these visits and mainly exhibits challenging behaviours in larger family gatherings.
- Sally lives with two roommates, and she shares staff for six hours per day. Otherwise, she has one-to-one staffing. Generally, she does better when she does not share staff. She prefers to be in the company of caregivers and other people in authority.
- There have been multiple staffing changes within the home over the past two years, and most recently (four weeks ago) her primary support professional, Jillian, left after working with her for several years.
- She seems to have formed a good relationship with her new primary support professional (Beth), and they spend time together going grocery shopping, completing simple household chores, and going on outings in the community. Sally is very protective of Beth, and becomes very angry when her attention is on her roommates.
- As Beth gets to know Sally better, she has allowed for a flexible, spontaneous schedule where she can try new things each day, rather than adhering to a strict or regimented schedule.
- Sally's challenging behaviours have led to contact with the law, wherein her neighbours have called the police on numerous occasions because of property destruction and public displays of physical and verbal aggression. Although historically the police have aimed to calm her down by talking with her about what is bothering her and gently guiding her into her home, the most recent incident led to charges being filed (in part owing to the multiple occasions that police have been called to respond, without charges being laid and with the increase, rather than decrease, in her challenging behaviours).

### QUESTIONS

1. What psychosocial factors may be relevant to Sally's presentation?
2. What thoughts do you have about the strategy of involving the police?
3. What may need to be addressed in how Sally is supported?

<b>Bio (Medical)</b>	<b>Psycho(logical)</b>	<b>Social</b>
<b>Definition-medical, psychiatric, mediation reactions, syndrome, neurological state</b>	<b>Current psychological features and skill deficits</b>	<b>Environmental, interpersonal, programmatic, physical</b>