

Mental Health Issues in Autism Spectrum Disorders: Medical and psychological management

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1

Presentation Overview

- Mental health issues in ASDs
- Case Study 1
- Case Study 2
- Their medical and psychological managements

2

Common Psychiatric Comorbidities seen with ASD

- ADHD
- Aggression
- Self injurious behaviors 24 – 43%,
- Anxiety Disorders
- Depressive Disorders 9 – 44%

- Obsessive Compulsive Behaviors >40%
- Sleep disturbances
- Sexualized behaviors
- Psychosis
- Tics

3

ADHD symptoms in ASD

- > **Inattention**
 - difficulty in shifting their attention from one task to another
 - Focused on object of interest

- > **Over activity**
 - Anxiety
 - stereotypic behavior
 - agitated depression or even mania

- > **Aggression:**
 - sometimes incorrectly attributed to hyperactivity

4

> In early childhood

- hyperactivity
- stereotyped behaviors
- irritability and temper tantrums

> Later

- aggressiveness/self injurious behavior
- stereotypic behaviors

> In adolescence and adulthood:

esp. in higher functioning individuals depression or OCD may develop and interfere with functioning

5

Behavioral Issues

- Common reason for presentation to mental health services
- 20% with severe mental retardation have some form of severe behavioral disorder
- Problem behaviors: self harm/ aggression to others
- Significantly disabling/ not responding to other measures



Difficulties in diagnosis of mental illness

- Unable to express own thoughts
- Reliance on behavioral observations
- Parent reports
- Nonspecific and atypical clinical presentations
- Assumption that abnormal behavior is an inherent part of the disorder

7

Pharmacological Intervention

- No medications can cure autism
- None affects social pragmatic understanding
- Helps improve the quality of life
 1. target symptoms/behaviors of concern
 2. thereby reduce social withdrawal
- Adjunct to management so other interventions and education can be successfully implemented

8

Psychological and Educational Interventions

- Behavioral management support
- Parent and family counseling
- Speech therapy
- Sensory processing screening
- Skill building in emotions understanding and management
- Social skills training
- Special education in a highly structured environment

9

Pharmacotherapy: Neurochemical Factors

- Abnormalities of serotonin, dopamine & opioid neurotransmitter networks suspected
- This provides a rationale for the use of psycho pharmacotherapy in autism
- Medications are used by at least 30% of those with ASD



10

Pharmacotherapy: Neurochemical Factors

- Psychotropic prescribing to children with autistic disorder increased by about 50% in USA from 1993 – 2001 (better symptom identification, more drugs with less side effects)
- In 2001 antidepressant medications were the most commonly prescribed psychotropic medications for the autistic population



Epilepsy

- Most common medical disorder in mental retardation
- 20% of autistic children between the ages of 1 and 18 years suffer some kind of epileptic seizures Munoz-Yuna et al (2003)
- > Incidence
 - 8 – 18% of mild cases
 - 30 – 36% of severe cases
 - 25% of all children with mental retardation and epilepsy have autism
- In more severe cases, stereotypies and involuntary movements may be difficult to distinguish from epilepsy

12

Epilepsy

- Combination medication regimens address both seizures and behavioral emotional difficulties
- Anticonvulsants suppress seizures, aggressive behavior & impulsivity in children with PDD
- Initiated as monotherapy
- Often not sufficient
- Combination of neuroleptic & anticonvulsant preparations needed for better symptom control

13

Medications: Issues



- Adverse reactions
 - actively monitor
 - children unable to communicate these to others
- combination medications
- potential drug - drug interactions
- even conventional doses and therapeutic serum levels not tolerated

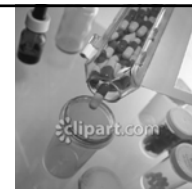
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Medications: Issues

- Medication dose increases viewed as routine may be excessive and result in unpredictable adverse reactions
- The more neurologically compromised an individual the slower the titration of medication is needed
- the medication most likely to have a positive effect not only on the chosen target symptom, but also on other behavioral disturbances is chosen
- Most studies show trials of medications on a symptomatic basis

15

Medication Classes Used



1. Psychostimulants
2. Antipsychotics
3. Antidepressants
4. Mood Stabilisers
5. Alpha Adrenergic Agonists – Catapres
6. Adrenergic Agonists - Propranolol
7. Opioid Antagonists – Naltrexone
8. Melatonin

16

Case Study 1 SAM

17

Case 1: Sam 9 yo

- Lives with single mother, home schooled
- Genetic abnormality: severe mental retardation
- Developmental Age ~1- 2 yo
- Physically: short obese boy who sat and fiddled with toys in the corner of the room, limited eye contact or facial expression, essentially nonverbal, contained through the session

18

Case 1: Sam 9 yo

- PC: increasing aggression
 - Mother had to present to emergency following minor injuries to her face following a simple request to go to bed
- Also threatened to harm self, absconded, found lying on the road
- First presentation to mental health services
- Duration of increased aggression: 8 months

19

Background

Diagnoses Case 1: Sam 9 yo

- Autistic Spectrum Disorder
- Generalized Anxiety Disorder
- ADHD
- Aggression
- High sensitivity to noise
- Medical problems: mild MR, Asthma, **Epilepsy**
- Severe allergies drugs and food, sleep apnoea
- Sleep problems+, wakes up at 2 – 3am
- Not depressed
- No obsessive features

20

Triggers of increased aggression

- attended school in a support class previously
- subject to bullying
- high expectations academically
- taken out of school, visited by HSLO, staff from DET, perceived pressure to return to school
- poor communication systems
- present when mother was sexually assaulted

21

Management/ Problems

- Family isolated
- DADHC/ DoCs/ DET/Respite Services previously involved
- No OT/ Psychologists/Speech involvement
- Mental health services/ Paediatrician/ General Practitioner

22

Management/ Problems

- DADHC: provide respite two hours/week
- attempt to provide behavior management strategies unsuccessful
- no case management

23

Other Issues

- High carer burden for mother, not coping, burn out
- Her parenting capacity
- Disconnection between services, eg. DADHC, DoCs and DET
- Engaging mother with services
- Misperception by mother that needs are being ignored and she was not being listened to

24

Management Options

- Behavior Management - psychological intervention and parent education
- Case management - individual needs, family supports and future needs
- Speech and OT assessment/Communication assessments
- Respite services
- DoCs support
- School options
- Medications
Options: Clonidine, Ritalin, Risperidone, other mood stabilizers eg Carbamazepine, Atomoxetine, Amitryptiline, Propranolol
- Medical R/v – Epilepsy
Sleep apnoea

25

Case Conference 1

Family

Community Youth and Family Team (Care coordination)

DADHC (Case management, behaviour support, communication assessment and support, sensory assessment)

DET (Disabilities Program Consultant)

NGO Respite

Paediatrician

GP

26

Case Conference 2

Aims:

1. Why previous relations have broken down
2. Assess Sam's level of function → consistent goals for everyone to work towards to prevent different levels of cognitive expectations
3. Assess mother's understanding of Sam's needs, her own needs, & support available

27

Case Conference Outcomes 1

Systemic Issues

- Isolation of family
- Minimal supports
- High needs of Sam
- Mother's perception about not being understood by services
- Lack of coordination of services
- Need for psychological support and review for the mother

28

Case Conference Outcomes 2

Individual Issues

- No formal assessment of functional/developmental level
- No understanding of communication needs
- Lack of respite services
- Complex child with multiple medical problems
- Allergies

29

Coordinating Services

- Weekly clinical communication system and monthly clinical care conferences.
- Emphasise need for staff consistency.
- Mother's perception: not supported or listened to splitting services.

30

Parent Support

- Assist mother to understand her role as carer versus therapist.
- Address burn-out, depression and trauma.
- Increase respite.
- Challenge cognitions associated with barriers to limit-setting and service use:
 - "I can't because.....
 - he won't learn."
 - I feel sorry for him."
 - no one else can understand him."

31

Developmental Assessment

- Cognitive
- Bayleys Scale for Children
 - Griffiths Developmental Scale for Children
- Adaptive Behaviour
- Vinelands Adaptive Behaviour System
 - Adaptive Behaviour Assessment System for Children

32

Communication Assessment

- No communication system
- No response to PECs training
- No consistency in signs



(Moes & Frea, 2002)

33

Functional Communication Training

- Introduction of object-symbols

Remote control = TV

Cup = drink

Spoon = food

Brush = brush hair

Pillow = sleep

Trampoline fabric = trampoline



34

Behaviour Management 1

Functional assessment of challenging behaviours

Triggers

- Lack of routines and predictability
- Boredom, frustration, and lack of self-engagement skills
- Sound sensitivity
- Communication

Maintaining factors

- No consequences for aggression
- Sleep in mother's bed during mid-night awakening

35

Behaviour Management 2

Introduce visual routines

- Snack
- Activity Box
- Trampoline
- TV
- Dinner
- Shower
- Sleep



(Dooley et al., 2001; Schmit et al., 2000)

36

Behaviour Management 3

Assess interests and develop activity schedules



(Britton et al., 2002; Patel et al., 2000; Van Camp et al., 2001)

37

Behaviour Management 4

Limit-setting and withdrawal procedures



38

Behaviour Management 5

Sleep and mid-night awakening routine

- Walk to room
- Tuck in
- Music on
- Close door
- Minimise eye contact & communication



(Weiskop, Richdale, & Matthews, 2005)

39

Sensory Assessment

Sound sensitivities

- Hyperacuity to sound increases distractibility
- Poor tolerance to specific sounds: children screaming, tyres screeching, many people talking, music



40

Sensory Intervention

- Sensory Diet
- Sound desensitisation



41

Medical Intervention

- Risperidone: 0.5mg bd
- Aggressive behaviours slowed

42

Antipsychotics

- The use of antipsychotics in AD is based on their efficacy in the treatment of other psychiatric disorders with behavioral problems similar to that seen in AD
- The possible role of dopamine in the etiology of AD
- Atypicals: lack of major adverse effects compared with the older antipsychotics

43

Atypical Anti psychotics	Benefits	Side Effects
<ul style="list-style-type: none"> ■ Risperidone <p>Others</p> <ul style="list-style-type: none"> ■ Olanzapine ■ Quetiapine ■ Aripiprazole ■ Ziprasidone 	<ul style="list-style-type: none"> ■ Aggression/self abusive behaviors/temper tantrums ■ Hyperactivity ■ Irritability/anxiety/mood lability ■ Stereotypy/repetitive behaviours <p>Ineffective in improving social or communication skills</p>	<ul style="list-style-type: none"> ■ Weight gain increased appetite ■ Hyperglycemia, hyper lipidemia ■ Fatigue, drowsiness ■ Extra pyramidal symptoms, drooling, dizziness, constipation, tremor, tachycardia, postural hypotension. ■ Hyper prolactinemia

44

Mood Stabilisers

<ul style="list-style-type: none"> ■ Valproate ■ Carbamazepine ■ Levetiracetam ■ Topiramate ■ Lamotrigine ■ Lithium 	<p><u>Effective in</u></p> <ol style="list-style-type: none"> 1. reducing aggression 2. Impulsivity 3. mood lability 4. repetitive behaviours and improved communication as a result 	<p>Side Effects</p> <p>Weight gain sedation</p>
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45

Adrenergic Medications: Propranolol

- Limited number of studies
- Reduces arousal and thus reactivity
- Beneficial effects in challenging behavior especially impulsiveness, aggression and self injury, stereotypies

46

Case Study 2

Jo

47

Case 2 - Jo 15yo

- Lives with his parents and two older siblings
- Year 10 at school
- Diagnoses
 1. Aspergers Syndrome
 2. ADHD
 3. Depressive Disorder
 4. Generalized Anxiety disorder particularly social anxiety
 5. Learning Difficulties
 6. School Refusal
 7. Eczema

48

Current Problems: School

- difficulty attending
- difficult behaviors
- learning problems
- poor organisation
- depressive and self harm thoughts
- anxiety with angry outbursts, impulsivity
- Thoughts brought on by past experiences at school, e.g. being bullied

- Unable to meet social demands at school
- Jo unable to fit in with "mainstream"
- Literal Thinking
- Perceives slights from others easily

49

History of Presenting Problems

- ADHD diagnosed at 7 years, commenced Ritalin
- Preschool ? Learning Difficulties
- First psychometrics at 10 years
- Seen by OT and Special Ed Consultant for LD

- Anxiety symptoms present since primary but marked for one year
- worse when challenged academically

- Family history of depression, ADHD

50

History of Presenting Problems

- Psychometrics: below average on perceptual and organization skills
- Verbal Comprehension Skills : Average Range

- Behavior:
 1. Tantrums major concern from 2 years
 2. Anxiety leads to anger, irrational thoughts of self harm and harm towards others
 3. Calms down with physical activity or music

- At school:
 1. somatic symptoms, urge to leave school, rapid heart rate, wide eyes, inability to concentrate, anger, impulsivity

51

Anxiety

- Social Anxiety: peers, feelings of rejection, interpersonal sensitivity, literal interpretation of meanings, low self esteem,
- Work/learning based
- Generalized Anxiety Attacks
- Nil panic Attacks: Mainly urge to leave environment

Aggression/Anger Issues

- Yelling, screaming at school
- At home flails arms around
- Impulsive threats to overdose/has made cuts on arm

52

Current Presentation

- O/E: Slim boy of average built, anxious, fidgety, talking loudly and too much
- Easily suspicious and sensitive, that he wasn't pleasing enough, had said the wrong thing
- Difficulty following conversation at times
- Variable affect: Bright and bubbly one moment, worried the next moment
- Denied perceptual abnormalities

- Living skills: age appropriate

53

Aspergers Syndrome

- Social Awkwardness
 1. makes friends/unable to keep them
 2. becomes possessive of friends/ damages friendships
 3. Low self esteem

- Perseverative: Unable to forget insults

- black and white thinking, takes offence easily, holds grudges, misinterprets others talking about him

- long term pattern of rigidity, obsessionality, difficulty with empathy, theory of mind, difficulty reading others emotions, viewpoints

54

Strategies Implemented

- Learning Support Teacher
- Strategies in Classroom: Educational Consultant
- Counseling Support: for inattention/impulsivity
- Trial of Various Medications

55

Management Plan

- School Liaison
- Medications: Optimize over time
- Psychological management
- Neuropsychological assessment
- Family work: psychoeducation, management of own anxiety, deal with literal thinking, realistic expectations, goal setting, plan for the future

56

Medications

1. Ritalin
 2. Risperidone
 3. Fluoxetine
 4. Clonidine
- On most alternate/complementary medication

57

Medications

- Ceased most alternative medications
 - Reduced antidepressant
- Monitor benefits/need for
- Antipsychotic
 - Alpha 2 adrenergic drug
 - Stimulant
-
- Management Plan
 - Medication optimization over time

58

ADHD Treatment in ASD

- Stimulants – Ritalin, dexamphetamine
- Alpha adrenergic agonists – clonidine
- Dopamine reuptake blockers – risperidone
- SSRIs
- Atomoxetine
- Opioid Antagonists

59

Stimulants

- Early studies showed that stimulants yielded negative results in ADHD in ASD (e.g. Aman, 1996; Arnold et al 1998)
- Most common adverse event was agitation (Stigler KA et al 2004)
- But recent double blind, placebo controlled studies with MPH has shown improvement in hyperactivity, impulsivity and inattention in children with ASDs (Handen et al, 2000; RUPP Autism network, 2005)
- The response rate may be lower and adverse effects could be more

60

Atomoxetine

Selective Noradrenergic Reuptake Inhibitor

- Retrospective chart review (Jou R et al 2005)
- Placebo controlled cross over trial- (L Eugene et al 2006, Arnold et al 2006)
- Effective in hyperactivity, inattention
- As effective as stimulants, with fewer side effects
- Side effects: reduced appetite, drowsiness, constipation **etc**

61

Clonidine

Alpha 2 Adrenergic Agonist
in ASD

Controlled trials for both oral (Jaselkis et al 1992) and transdermal clonidine (Frankhauser et al 1992) reported.

Used in hyperactivity

Adverse effects: sedation, fatigue and decrease in blood pressure.

Guanfacine

Longer acting

Mildly sedating

In hyperactivity, inattention

Not available in Australia

62

Conclusions

- Evidence from RCTs suggest that methylphenidate is effective in individuals with AD,
- RCT evidence: Clonidine may have a role in hyperactivity
- One adequately powered RCT found that risperidone produced a robust reduction in hyperactive behaviors
- Present evidence favors MPH as the first line treatment for hyperactivity and inattention in the context of AD.
- Stimulants can exacerbate epilepsy, tics, anxiety and obsessive or psychotic features in some
- In such circumstances atomoxetine may be an alternative as it less likely to exacerbate tics and other abnormal movements that may occur in association with AD

63

Naltrexone

(Willemsen-Swinkels et al 1996, Kolmen et al 1997, Feldman et al 1999)

most consistent in ameliorating self injurious behaviours

Used in children as young as 2.8years
The dose ranges from 0.5mg/kg/day to 2mg/kg/day once daily

Other possible improvements

- Hyperactivity
- Agitation
- Aggression
- Irritability
- Temper tantrums
- social withdrawal
- Attention
- eye contact
- stereotyped behaviors

Drowsiness may be a side effect

Equivocal evidence with opioid antagonists

64

SSRIs

(McDougle et al 1996,2000, Sugie et al 2005, Hollander et al 2005)

Anxiety

SSRIs

Alpha adrenergic agonists

Atypical antipsychotics

Bupirone

Atomoxetine

Antidepressants

Fluoxetine (Prozac) Fluvoxamine (Luvox)

Sertraline (Zoloft) Citalopram (Celexa) L Namerov et al

Escitalopram (Lexapro)

Repetitive behaviour:

SSRI Fluvoxamine McDougle et al 2000

Fukuda T et al 2001 looked at Fluvoxamine in Children

Advantages of SSRIs

- low incidence of side effects
- compared to other agents
- safer in cases of overdose
- no food restrictions

Side Effects

Agitation

Anorexia, weight loss or weight gain

Gastrointestinal disturbance, nausea

Headache

Insomnia or sedation

Serotonin syndrome when used with MAOIs

Sexual dysfunction

65

SSRI in Autism

Kolevzon A et al 2006- Journal of Clinical Psychiatry

- Pubmed database 1966 – July 2005
- 3 RCTs, 10 OLS/Ret studies identified
- Equivocal evidence based on prospective and retrospective studies
- The most pronounced effect was in the presence of anxiety or OCD symptoms
- Concern regarding side effects making behaviour worse

66

Drugs with both Adrenergic and Serotenergic Activity: Use for ADHD symptoms in AD

- Clomipramine (Remington et al 2001)
- Desimipramine
- Amitryptiline

67

Sleep

- The cause of sleep problems in autistic children is unknown
- Social cues may be important in addition to the light dark cycle
- A perseveration of thoughts and anxieties at bedtime or during night awakenings may be important
- There is some evidence that melatonin levels are lower in autistic children

68

Sleep

- Melatonin
- Clonidine
- Atypical antipsychotics
- Short acting benzodiazepenes e.g clonazepam
- Chloral hydrate
- Mirtazapine
- Anticonvulsants

69

Sexualised Behaviors

In extreme cases

- Antiandrogens: Cyproterone acetate
- Mirtazapine
- Antianxiety agents : Buspirone (Realmutto et al 1989, McCormick 1997) Unclear if buspirone tends to work in children having uncomplicated hyperactivity or whether high anxious behavior must be present to achieve efficacy
- Benzodiazepenes: Marrosu et al 1987
- Six of the seven children showed elevations in hyperactivity and all seven in aggressive behaviour with diazepam treatment

70

Conclusions

- Despite uncertainty about validity of current psychiatric classification in people with learning disability when criteria for a particular mental disorder are met the diagnosis should be made
- Pharmacological intervention is only one component of the therapeutic package
- Often not enough information about the safety and efficacy of psychotropic medications in children especially with intellectual disabilities
- Use is often based on extrapolation of knowledge about the effects of psychotropic drugs on people who do not have intellectual disabilities

71

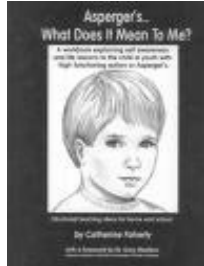
Psychological & Educational Interventions

- Neuropsychological assessment
- Psychoeducation about diagnosis
- Self-esteem building
- CBT: anxiety & depression
- Social skills training: perspective taking & theory of mind
- Organisational skills
- School support and reintegration

72

Psychoeducation about Diagnosis

Faherty, C. (2000).
Asperger's...What
Does it Mean to Me?
Future Horizons Inc.
Arlington, TX.



73

Aspergers Syndrome is invisible. No one can see Aspergers Syndrome (AS). It is one of the things that make me who I am and so special.

AS affects the way my brain works. The brain is like a computer which is always on and keeps people living and learning.

AS causes my brain to sometimes work differently than other people's brains.

Having a brain with AS is like having a computer with an Aspergers Syndrome Operating System (ASOS), while most other people have a Plain Operating System (POS).

AS makes me experience the world in a certain way.

Sometimes it's the same as most people, but sometimes I experience the world differently.

Aspergers is another way of thinking and being.

74

Why do I Have AS?

No one knows why I have AS. Scientists are not sure what causes AS in particular people. They are trying to find out why some children have AS and others do not. AS is still a mystery. But they do know some things about it.

Scientists know that:


- AS is not a disease, and it does not mean that I am sick.
- It does not mean that I am bad or wrong, or that I am better than other children.
- It is nobody's fault that I have AS.
- AS is called *neurological* because it involves my brain.
- Sometimes it appears to be genetic. Cousins, uncles, aunts, brothers, sisters, or other family members might also have AS.

It is not wrong or bad to have AS, it is just different.

AS is another way of thinking and being.

75

I Might Have Questions

I will  the questions that I have:

What does it mean?

Is then something wrong with me?

Am I the only one like this?

Isn't everyone like me?

Are there other people like me?

Who should I tell about this?

76

Special Interests

Everyone has interests, things they like. **One of the important things about having AS is that it helps me be very focused on my interests.** I usually feel good when I am focused on my special interests. I might have just one special interest or I might have more than one.

My favourite special interests are:

1. _____
2. _____
3. _____

There are many ways to enjoy special interests. **I will mark the ways I like to enjoy my special interests.**

- I like to **think** about my special interests.
- I like to **read** about my special interests.
- I like to **talk** about my special interests.
- I like to **draw** pictures about my special interests.
- I like to **write** about my special interests.
- I like to **do something** with my special interests.

Some people with AS have the same special interests for a long time. Sometimes special interests change after a few months. On the next page is a list of my special interests over the last few years.

77

Self-esteem Building

■ Strengths and weaknesses

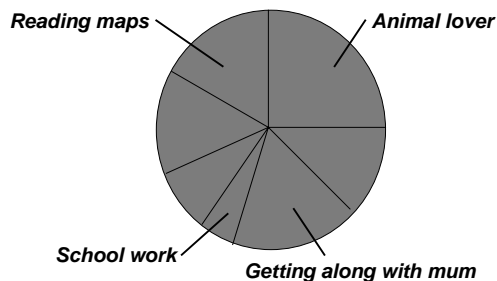
My Strengths (S) and Weakness (W) are:

- | | |
|---------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> reading | <input type="checkbox"/> memory |
| <input type="checkbox"/> spelling | <input type="checkbox"/> remembering how things look |
| <input type="checkbox"/> putting things in alphabetical order | <input type="checkbox"/> writing stories or poetry |
| <input type="checkbox"/> handwriting or calligraphy | <input type="checkbox"/> photography |
| <input type="checkbox"/> foreign languages | <input type="checkbox"/> sports |
| <input type="checkbox"/> drawing or painting | <input type="checkbox"/> cooking or baking |
| <input type="checkbox"/> computers | <input type="checkbox"/> cleaning |
| <input type="checkbox"/> Maths | <input type="checkbox"/> straightening up |
| <input type="checkbox"/> matching | <input type="checkbox"/> putting things in order |
| <input type="checkbox"/> dates | <input type="checkbox"/> drama |
| | <input type="checkbox"/> mechanical things |

78

Self-esteem Building

Sense of self



79

Social Skills Training: Perspective training & ToM

video

Wong, Lopes & Heriot (in preparation)

80

Social Skills Training: Perspective training & ToM

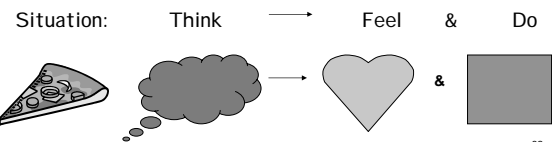
Emotion-based Social Skills Training
(Wong, Lopes & Heriot, in preparation)



81

Social Skills Training: Perspective training & ToM

In the same situation, different people can have different thoughts about it. This means they might feel and behave differently.



82

Cognitive Behaviour Therapy

Exploring Feelings: Cognitive Behaviour Therapy to Manage Anxiety/Anger, Tony Attwood (2001)

The Friends Program: Prevention of Anxiety and Depression, Paula Barrett, Hayley Webster & Cynthia Turner (2000)

Attwood, T. (2004). Cognitive behaviour therapy for children and adults with Asperger's Syndrome. *Behaviour Change*, 21(3), 147-161.

83

Cognitive Behaviour Therapy 1

Psychoeducation about thoughts and feelings.

Identify and challenge unhelpful thoughts.

- "I'm retarded" Correct distorted conceptualisations and dysfunctional beliefs.
- "Everyone's assualting me." Address false assumptions of the intentions of others, especially in terms of an action being deliberate or accidental.
- "I'm going to kill you." Address tendency to make literal interpretations.

84

Cognitive Behaviour Therapy 2

Challenging unhelpful thought:
"I'm retarded"

Socratic questioning

- If someone is retarded what does that mean?
- What evidence is there that you are retarded?
- What evidence is there that you are not retarded?

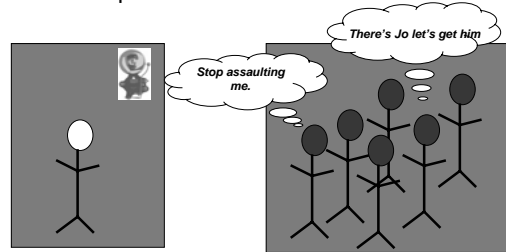
Are you really "retarded"? If not, what is a more realistic thought to have?

(White, 2004)

85

Cognitive Behaviour Therapy 3

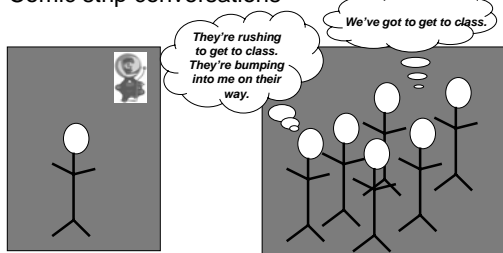
Comic strip conversations



86

Cognitive Behaviour Therapy 4

Comic strip conversations



Kerr & Durkin (2004), Wellman et al. (2002)

87

Cognitive Behaviour Therapy 5

Metaphor Dictionary

"I'm going to kill you."

He's going to murder me.

He's really angry at me and wants to scare me.

"Bob's your uncle."

I don't have any uncles. He's bullying me.

Everything's fine, there you go.

"Teacher just dropped his guts!"

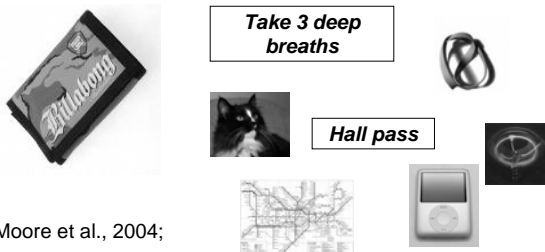
What's wrong with the teacher? I can't see his guts.

Teacher just farted.

88

Cognitive Behaviour Therapy 6

- Emotional Toolbox



(Moore et al., 2004;
Richman et al., 1998)

89

Organisational Skills

- Mentor to scribe, record, submit.
- Assignment and study schedule
- Homework diary
- Materials colour-coded according to subject.
- Spare pens, pencils, etc kept in locker.

90

School Support and Reintegration

- Introduce increasing amounts of schooltime based on interest and success.
- Computer room and library available during lunchtime.
- Laptop for most lessons and exams (60wpm).
- Homework flexibility.
- Provide as much information about changes or novelty, e.g. video school camp.

91

Questions

92

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- Judy Longworth, Snr Pharmacist, CHW

93