



Sydney Children's Hospitals Network

MENTAL HEALTH AND INTELLECTUAL DISABILITY HUB

Developmental Models: Lorna Wing's Influence

The clinical assessment of development: the implications for understanding Social and Communication Disorders.

A tribute to Lorna Wing (1928-2014)

Development, behaviour, emotional and social competence, Autism and Lorna Wing

1. HBS and Why assess development?
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Development, behaviour, emotional and social competence, Autism and Lorna Wing

- Developmental assessment is a central skill in Dev Psych
- Often lapsed in senior trainees esp psychiatrists
- Overlooked in adult psych but not ID psychiatrists
- The Handicaps Behaviour Skills Schedule as a semi structured interview teaches these skills from usage
- Lorna Wing met at Maudsley Hospital 1980, trained in HBS 1985 for my MD thesis research into family adjustment to a teen with severe ID
- Lorna and HBS influenced my thinking and in turn those I teach.

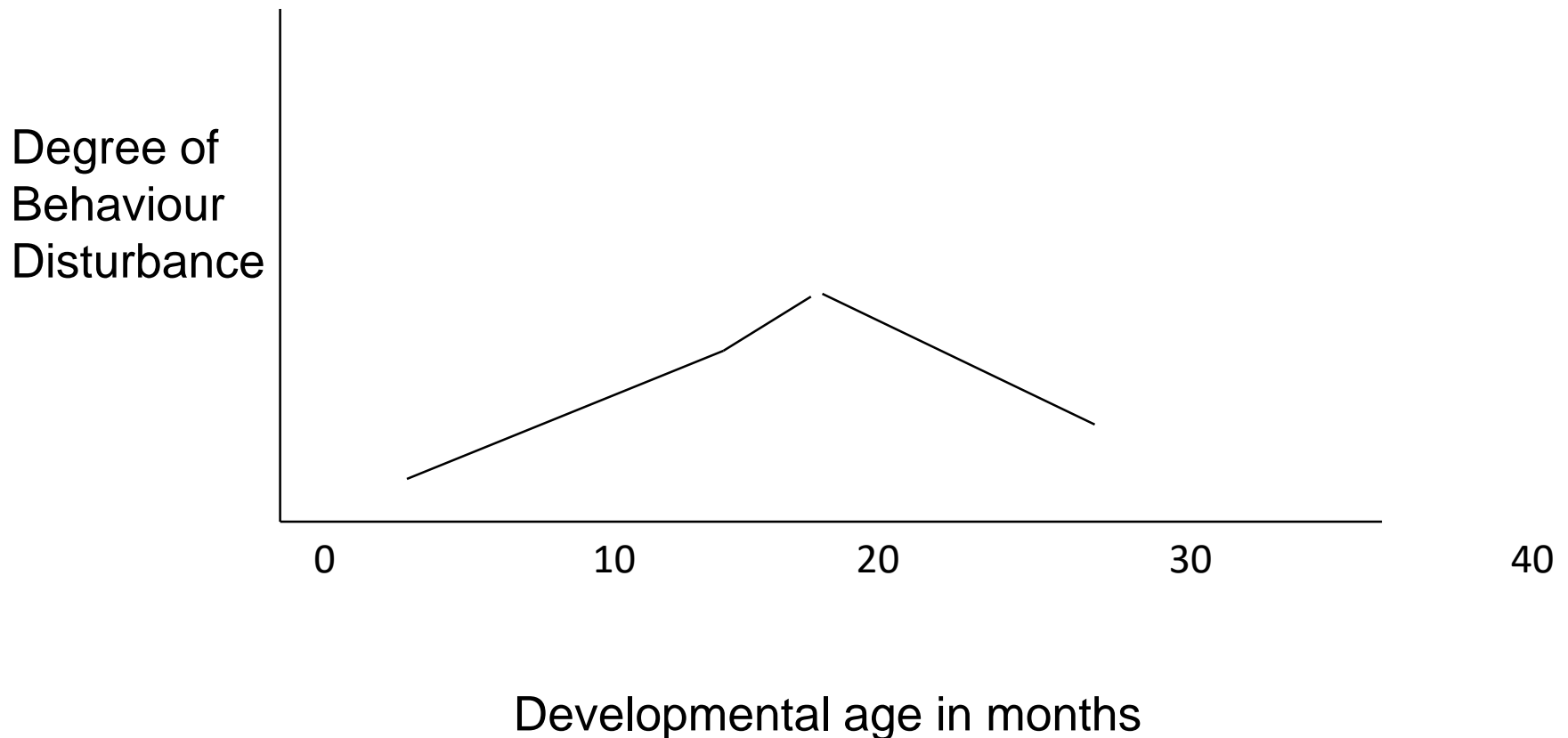
Lorna Wing (1928–2014) & Maudsley

- Mother of a girl with autism, founder member of National Autistic Society, UK, 1962
- The Centre for Social and Communication Disorders, in Bromley, Kent, was founded in 1991 and was renamed the [Lorna Wing Centre for Autism](#) in 2008, the first place in UK to provide a complete assessment and advice service for children, adolescents and adults.
- Was passionate about understanding and helping young people with autism.
- Judith Gould's described as "non-competitive excellence".
- Developed the concept of an Autism Spectrum Disorder and translated Asperger's syndrome and therefore brought it to the English-speaking world.
- Hb: John Wing: PSE; Expressed Emotion, with George Brown and Julian Leff; Translated Asperger's paper
- Her favourite phrase was: "Nature never draws a line without smudging it." ie. it is very difficult to draw neat boundaries between those who have and who do not have an autism spectrum disorder.
- was pragmatic, thoughtful, experienced, scientific and enquiring, and incisive when you asked her opinion

ON MY TOMBSTONE it will be writ:

“Developmental age is a greater determinant of
behaviour than chronological age”

Behaviour measures came out as a single dimension.



Autism, the Maudsley & the Battle of the clumpers and the splitters

- Mike Rutter brought epidemiology and science to child psych
- 'ASD is the nearest we have to a mental disease, with its predictive validity'
- Predicted 6 genes maximum would explain Autism and the ADI-R would define it (Jonathan Green personal communication 2021).
- The HBS is the precursor of the DISCO, which is as well reputed as the ADI-R but also too long to be practicable in clinical practice.
- Eric Taylor (PC 2021) observed that nature and EB disorders work in dimensions or degrees, and regretted DSM5 did not reflect this
- Edward Zigler observed development shows sequential progress with time and age regardless of aetiology.
- HBS implied Autism is a specific delay in emotional competence and therefore social development.
- Poor Peer Relationships, the capacity to make new affectional bonds in primary school is factor most predictive of adult MH (Rutter)

Handicaps Behaviour Skills Schedule: HBS

- The HBS semi-structured interview; derived from hours of clinical and research interviewing;
- takes less than an hour to complete.
- completing the interview (re-)trains you in developmental sequence
- Its questions of atypical behaviours sensitises you to symptoms characteristic of autism.
- Experience with the HBS gives
 - an awareness of the sequence of skill development that should be inherent to all clinicians that work with these children.
 - Internalising this developmental metric teaches you to adapt your questioning to any presenting individual
 - also provides an in-depth sensitivity to differences in each domain of skill.
- An ADI-R is designed to the presence or absence of autism, whereas the HBS (or DISCO) provides the information for a developmental assessment (and therefore a diagnosis of autism) and an individual psychiatric assessment.
- (Familiarity with the DISCO or ADI-R enables you to cross check a threshold of clinical diagnosis against their algorithms.)
- A few areas of the interview are less central and were designed for collecting data on issues that were teasing Lorna (such as Autism associated neuropsychiatric syndromes, such as catatonia)

HBS

- The HBS was derived from interviews of 150 young people with intellectual disability and autism (Wing, 1980).
- Through semi-structured interviewing, it assesses the reliability of the interviewee by eliciting examples of behaviours that the clinician can evaluate.
- But no single source of information is adequate for a comprehensive, reliable diagnosis and over-reliance on any one informant has inherent risks.
- Although the golden rule is that developmental stages generally happen in sequence, neurodevelopmental kids tend to have unequal skills across different domains;
- Sometimes have apparent islands of developed skills (savant skills). One example might be an ability to multiply numbers, but not be able to give two objects (ie the absence of object number concept).
- Generally, for adaptive behaviour and ability, the base level skill is more important than the island of advanced skill.
- Once you have an impression of what level of skill the YP has, one can check this out against the next level of skill above and/or below that identified.
- When you are aware of the general level of skill, one can use questions at a similar developmental level in a different domain.

HBS semi structured interviewing

I: focuses on ability and skills

II: on abnormal or problematic behaviours; rated absent, present or severe, based on both frequency and severity (ie total impairment).

(A copy of HBS interview is downloadable via www.schoollink.chw.edu.au);).

Each question has an open-ended introductory question

- Eg. ‘how much help does (child’s name) need for dressing’.
- Such an opening question can be adapted according to the level of ability of the child.
- After the open question, clarification with stage-related prompts to elicit examples.
- Self-care skills are the best measure of IQ in those who lack educational skills,
- But the establishment of skills can be influenced by other factors, eg coordination disorder or other problem of motor development such as hemiplegia.
- Can also be influenced by parenting style eg where a parent ‘does everything’ for their child.
- Many parents declare ‘oh he understands everything’ and therefore tie the receptive language question down to ‘what instructions can you give that (child’s name) responds to’ and ask for an example, before defining what developmental age skills are present.
- For mental health evaluation it is the current functioning that is most important, although HO skill developed can be of interest in understanding factors influencing developmental progression, such as the development and control of seizures.

HBS 2 types of Abnormal Behaviour

- 1. that are **characteristic of autism**
 - eg approached openly, eg 'does (name) tend to have certain phrases or words, that he repeats, which he may have heard others say in the past?' (delayed echolalia).
 - Such abnormal use of words is rated on the frequency and degree of repetitiveness or duration (eg how much of the day is taken up with repetitive behaviour?).
 - Eg (2) the abnormal response to visual stimuli eg unusual interest in shiny objects or the things that spin (an example of abnormal response to visual stimuli).
- 2. that are indicative of abnormal or **maladaptive emotions or behaviours.**
 - like wandering, destructiveness, tantrums, noisiness, aggression, pestering, rebellious, lying or stealing.
 - These can be subdivided into disruptive behaviours with and without social awareness. Ie. whether a disruptive act such as violence is with insight or intent or a wild lashing-out-of-emotion without awareness of the impact
 - important in terms of community and professional response and responsibility. The implication is that adults hold a special responsibility for supporting young people with Autism who lack insight into their maladaptive behaviours.

Other thoughtful items

- often not considered in similar interviews,
 - eg ability to recognise and communicate facial emotional communication,
 - awareness of time,
 - how they respond to their image in a mirror or photograph.
 - what do they watch on a screen and what is it that interests them, such as movement or music or simple characters or a story.
 - Others incl practical skills and avoidance of danger, according to skills of competence.

Such questions guide you to appreciating the qualities and individuality of even the most disabled children. Parents so appreciate the skill of ‘tuning’ into small but critical differences of ability in the severe and profoundly disabled.

- **The main domains of development of the HBS.**

- **1. Mobility/Gross Motor Skills,**

- Walking on level surfaces
- Up and down stairs

- **2. Skilled Movements**

- Riding a tricycle/bicycle
- Manual dexterity
- Hand/eye coordination
- Problems with coordination/clumsiness

- **Self-Care**

- **3. Feeding**
 - Utensils used
- Ability to chew
- Drinking
- **4. Hygiene**
 - Washing
- **5. Dressing: how much help does A need**
 - Brushing and combing
 - Buttons,
 - Laces
 - undressing
- **6. Toilet training**
 - Wee; day/night
 - Poo: no supervision needed 3y10m

- **5. Communication (object, visual, sign language, speech, or writing)**

- **7A** Receptive: general level of understanding
 - Understanding preposition
 - Understanding concepts re future events
 - Appreciation of humour
- **8A.** Expressive: ability to use speech
- **8B.** Asking questions
- Curiosity
- **8C.** Intelligibility

- **Non-verbal**

- 9.** Gestures and miming
- 10.** Use of sign language
- 12.** Comprehension of non-verbal communication
 - Shows what (s)he wants
 - Joint referencing, sharing interests
 - Nodding/shaking
 - Communication to affect others
 - Describes objects
 - Emotionally expressive gestures
 - Facial expression
 - Body language in social interaction/non-verbal communication

- **15. Educational Achievement**

- Visuo-spatial with puzzles or building blocks
- Use of scissors
- 3 d modelling
- Drawing
- Painting
- Colouring in lines
- Response to picture books,
- Understanding pictures
- Response to mirror image
- Response to photographs
- Money
- Days, weeks months
- Telling the time by a clock
- Understanding of time
- Reading
- Writing
- Numbers

- **16. Entertainment**

- TV, screentime; Stories read aloud

17. Imaginative play

18. Abnormal imaginative activities

19. Eye contact

Social use of eye contact

20. Social responsiveness

Show of affection

21. Response to age-related peers, ability to make friends.

22. 'Social Awareness and Interaction' (rating see page 4 above)

23-30. Moves on to abnormal responses to stimuli

Practical skills

31. Tidying Cleaning

31B. Cookery woodwork

31.C Special skills (above general level)

32. Initiative and perseverance: 32A. Acquisition of objects ie reaching or managing doors/locks

32B. Spontaneous initiation of activities to do things for self

32.C Nature of chosen activities ie varied and constructive or just repetitive

32D. Attention span for chosen activities

32E. Attention span for tasks given by others

33. Level of independence

33A. Understanding of danger in the home

33B. Need for supervision: how far can he go?

33C. Staying at home alone

33D. Shopping

33E. Telephone calls

I: Examples of skills and developmental age progression on HBS

Details of all other items is in the interview

- **Gross Motor Skills “how much can he move around?”**

- Lift head 4 months
- Turns on back 6 months
- Sits with support 6 months
- Sits without support 7 months
- Shuffles or crawls 9months
- Walks without support indoors 1yr2months
- Walks without support outdoors 1yr5m
- Runs more than 45m 2yr 11m

- Walks up and down stairs alternate feet 4yr4m
- Push a tricycle with feet 2yr 6m
- Rides well 4yr

- **Feeding “What instruments does he use for eating, how much do you need to help?”**

- Always fed
- Feeds self with fingers 9m
- Feeds self with spoon messily 1yr
- Feeds self with spoon or fork no help 1yr6m
- Feeds self with spoon and fork together 3yrs
- Feeds self with knife and fork 5-8yrs
- Manage boiled eggs/fish bones 9yr

- **Dressing “How much help does he need for dressing?” (“and for undressing?”)**

- Holds arms/legs out 1yr
- Puts shoes on 2yr
- Pants down and up and arranges clothes 3yr
- Big buttons 3yr6m
- Dresses completely but needs clothes arranged in sequence 4yr
- Clothes right way round and do all buttons 5yr
- Tie shoelaces 5-6yr
- Choose clothes appropriate for occasion/weather 12yr5m

- **Washing “Can he wash himself, or does he need help?”**

- Dries own hands without help 2yr7m
- Gets hands acceptably clean and dry without help 3yr 7m
- Washes and dries hands and face without help 4-5yr
- Baths self without help but with supervision 6yr3m
- Can wash and dry hair, cut nails, shave without help 12yr5m
-

I: Examples of skills and developmental age progression on HBS

- **Practical skills eg Tidying Cleaning "Can he give you any help with tidying or cleaning?"**

- Helps a little eg carry cup to kitchen 1yr9mo
- Simple immediate tasks eg putting something on shelf 2yr
- Fetches or carries to other room or takes message 3yr
- Gives help for sequence of actions eg clearing or laying table, dusting, 3yr7mo
- Helps regularly without supervision 8yr 6mo
- Does some tasks in own initiative for payment 10 yr 11mo
- Is responsible for a domestic task et weeding garden or car washing 14yr 8mo

- **Tidying and cleaning: cooking, woodwork**

- Help carry cup to kitchen, help with cooking eg stir cake mix 1yr9m
- Help with sequence of actions eg laying/clearing the table 3yr7m
- Sew hem, sandpaper wood 3yr6m-4yr
- Helps without supervision 8yr6m
- Complex task, cook eggs and bacon, simple woodwork 11yr3m

- **Avoidance of danger/independence in or out of home**

- Avoids falling from heights 2yr
- Avoid danger of traffic 5 yr
- Go to local shop without traffic 8-9yr
- Left alone at home for 1 hr 10yr
- Crossing road safely 10-11yr
- Left at home for half day 11-12yr
- Left home all day 15yr
- Go around nearby town 15yr
- Go alone to remote place 18yr

22. 'Social Awareness and Interaction' is different

- The item is based on a clinician judgement
 - both the interview but also on the clinician observations.
 - Social awareness and Interaction is therefore the most challenging and most interesting domain.

Wing and Gould (1979) divided social interaction into categories based on their own subdivision of types of social-relating of children with Autism & Aspergers Syndrome:

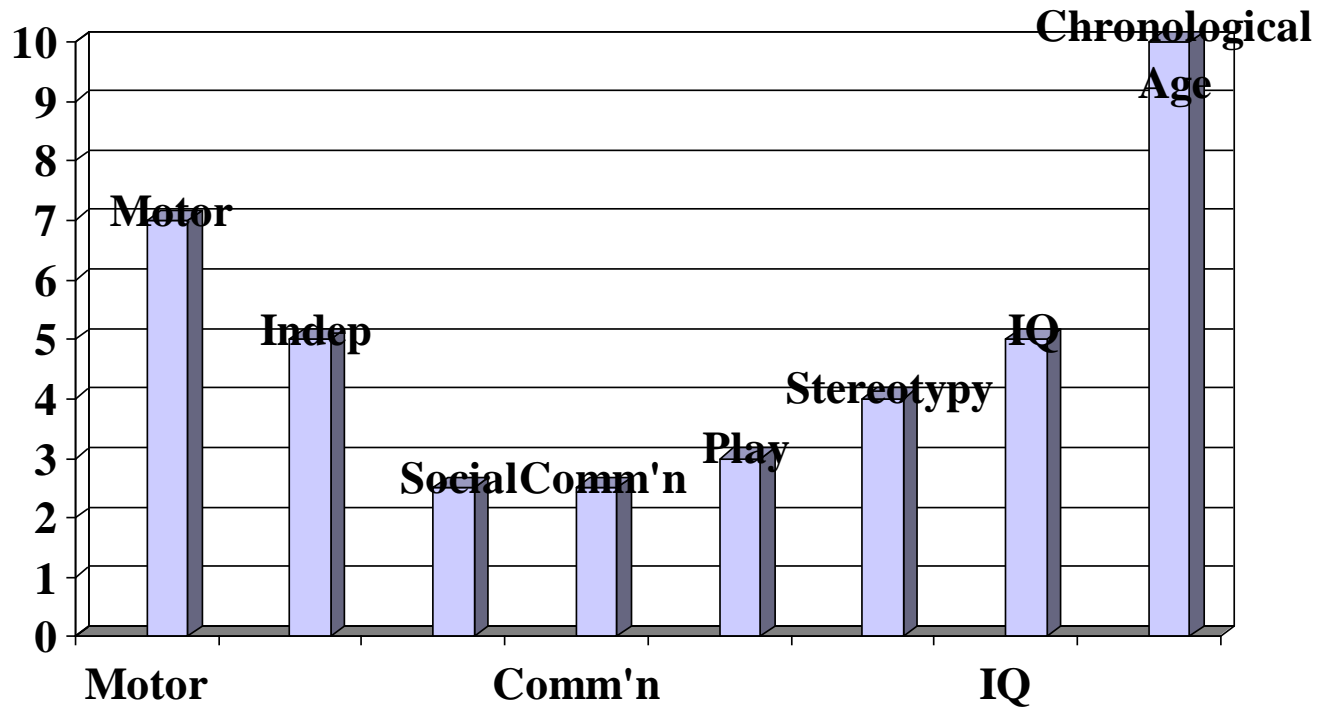
- **Alloof:** which includes categories
 - **0)** 'does not interact, aloof and indifferent'
 - **1)** interacts to obtain needs and otherwise indifferent and
 - **2)** responds to (or may initiate) only physical contact only including rough and tumble, chasing, cuddles.
- **Passive:**
 - **3)** generally, does not initiate but responds to social contact; joins in passively eg as a baby in a game of mothers and fathers or for adults. Tries to copy but with little understanding. Shows some pleasure in passive role.
- **Active but odd:**
 - **4)** makes social engagement actively but it is inappropriate, naive, peculiar, bizarre or one-sided; behaviour is not modified according to needs, interests or the approaches of the person approached.
- **Shy:**
 - **5)** but social approaches appropriate for mental age with well-known people. This may be found in selective mutism, where the subject still communicates with peers, or the withdrawal associated with other psychiatric disorder.
- Lastly **6) Social interaction appropriate for mental age** in both children and adults. (ie developmentally appropriate).

Clinical Usage and scoring

IBS Schedule - Developmental profile (Edition 2)

Col	Card 1	Motor	Self care	Language	NVC	School wo	Imag./social	Practical
1b 11	MOB							
2a 12	BIKE							
2c 14	HAIR-EYE							
3a 16	FEED							
4a 20	WASH							
5a 22	DRESS							
6a 27	CONT							
7a 31	COMP SP							
8a 33,34	USE SP							
8b 35	QUEST							
8c 36	INTELL							
12a 51	CCIP NVC							
13a 55	COPY							
15a 56	USE NVC							
14c 59	SHARE INT							
15a 60,61	VIS-SPAT							
15a 64	DRAW							
15L 72	READ							
15a 74	NUMBER							
15c 75	MONEY							
15c 77	TIME							
16a 79	TV							
	<u>CARD 2</u>							
17a 9	IMAG							
21a 17	SOCIAL							
	<u>CARD 3</u>							
31a 9	CLEAN							
31b 10	COOK							
33a 19	SUPERV							
33a 21	SIOP							

Gringras' Graphic Equaliser Alternative



Clinical Usage and scoring

HBS Schedule - Abnormalities of behaviour (Edition 2)

Quality of:

22 Social interact.

19 Eye contact

18 Imag. activ.

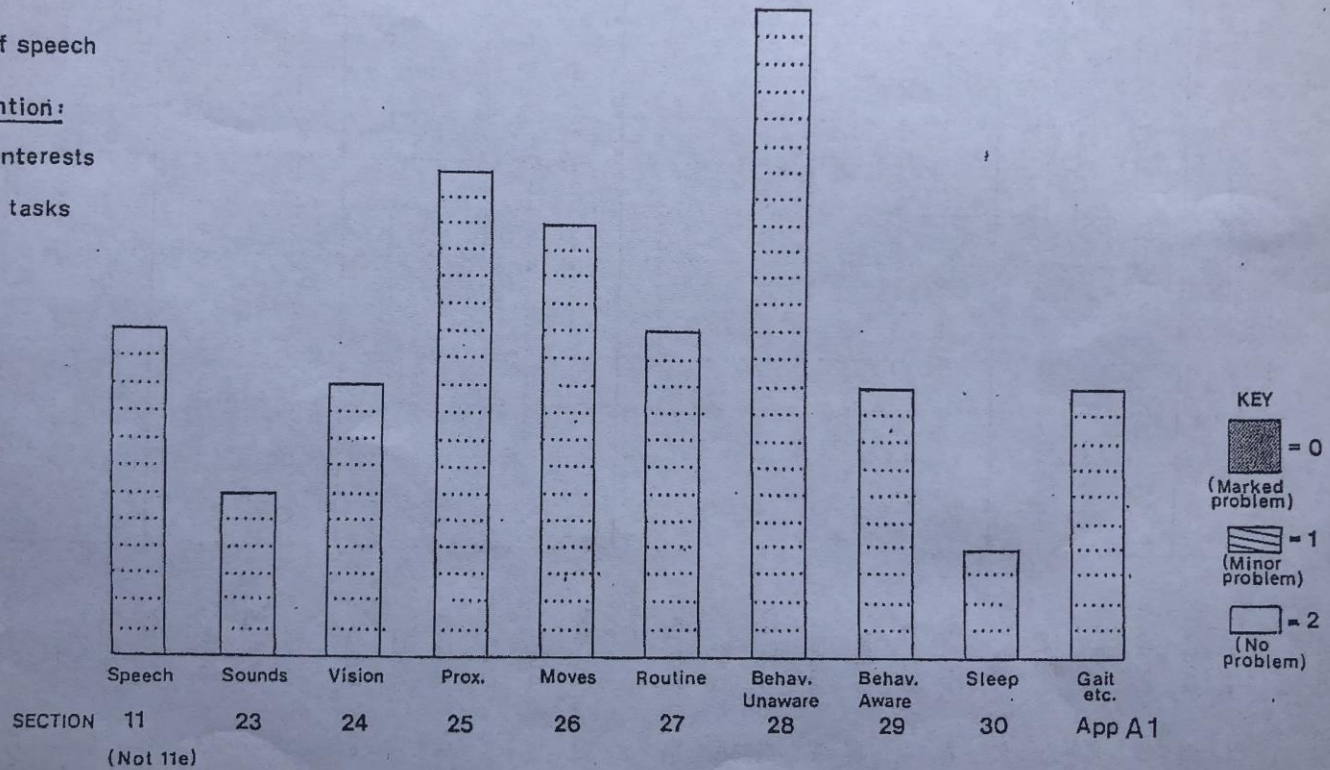
11e Use of speech

Attention:

32d Own interests

32e Given tasks

Other problems
(Appendices A2,3,4)



II Abnormal (ASD) Behaviours on the HBS

The abnormal or problematic behaviours are rated absent, present or severe, based on both frequency/duration and severity (ie total impairment).

- **Abnormal imaginative activities**

- Stereotyped play or other symbolic activities
- Fantasies (preoccupation with)

- **Abnormal response to sounds**

- Distress caused by sounds
- Fascination with sounds
- Other: ignoring loud or overreacting to almost inaudible sounds

- **Abnormal response to visual stimuli**

- Unusual interest in bright lights and shiny objects
- Interest in watching things spin
- Twisting/flicking his hands or objects near his eyes
- Interest in looking at objects from different angles
- Other response to visual stimuli

- **Abnormal response to peripheral stimulation**

- Mouthing of objects
- Smelling of objects or people
- Touching objects for its feel
- Scratching or tapping surfaces
- Repetitive destructive activities eg paper or bits of wall paper or toys
- Repetitive aimless manipulation of objects (not near eyes)
- Self-Injury
- Self-Stimulation without injury, eg pushing eye, regurgitating food, self induced vomiting, tapping chin, grinding teeth.
- Other repetitive sensory activity

- **Abnormal response to bodily movements**

- Tip-toe walking
- Aimless movement

- Other abnormal bodily movement

- **Routines and resistance to change**

- Dislike of change in normal routine
- Routines invented by the child
- Food fads
- Clinging to objects

- Interest in special objects or part of objects (eg light switches, church steeples, people's teeth)
- Special fear: eg dark, big dogs, trains

Maladaptive behaviour

- **Behaviour problems involving limited or no social awareness**
- Wandering
- Destructiveness
- Noisiness
- Temper Tantrums
- Aggressive behaviour incl spitting
- Hyperactivity
- Behaviour in public places
- Lack of cooperation
- Crying and moaning
- Difficult or objectionable personal habits, eg spit, smear, make vomit, hoard rubbish, inappropriate swearing, inappropriate sexual beh without social awareness.
- Scatters or throws objects around (creates chaos aimlessly)
- Other beh prob with limited or no social awareness
- **Behaviour problems with social awareness**
- Difficulties with other people eg tease, bully refuse to take turns, make trouble
- Rebellious awkward or cheeky behaviour
- Pestering for attention
- Lying, cheating, stealing
- Other behaviour probs
- **Sleeping problems.**
- Needs night sedation
- Other disturbance of sleep, eg late to sleep, waking in night, restlessness, noisiness, waking early
-
- **Sexual problems:** Includes: masturbation in public, inappropriate hetero or homosexual behaviour, sexual interest in much younger children, indecent exposure, other inappropriate sexual behaviour.
-
-
- **Summary of Other psychiatric problems**
- Includes items on: depression, mania/hypomania, anxiety, hypochondriasis, obsessional neurosis eg hand washing, other neurosis, schizophrenia, other psychosis, personality disorder, other psychiatric disorder, abnormalities of mood, organic dementia or confusional state.
- **Legal problems or status**

Implications and Discussion

- Wing and Gould were the first to describe a sequence and severity of skills of social interaction that links a progression of severity of autism in this scale to mental age appropriate emotional and social awareness.
- Constantino (Constantino and Todd, 2000) confirmed that Autism is a dimension of severity and that all severities are all equally genetic.
- From these observations I have proposed that Autism is not just category of loss of reciprocity but is related to a delay in the emotional understanding and consequent social skills (Dosssetor, 2004).

Evidence of a developmental framework: Social communication: the primary variable for ASD

- factor analysis of social communication items of ADI-R resulted in
- a 3-factor solution of symptoms:
 - Affective reciprocity, (?1st year)
 - Joint attention and (?2nd year)
 - Theory of mind. (?3rd year)
 - AR was the behavioural propensity to use facial, gestural, vocal and body language in 2-way communication.
 - TOM represented social knowledge in the broadest sense.
- The most severely affected autistic children had impairments on all three domains
- Asp and PDDnos had better affective reciprocity scores than Joint Att, or TOM.
- The least impaired scores were most impaired in theory of mind.

Shows a developmental progression of Autistic Features

Tanguay, Robertson Derrick 1998 JAACAP 37:271-277

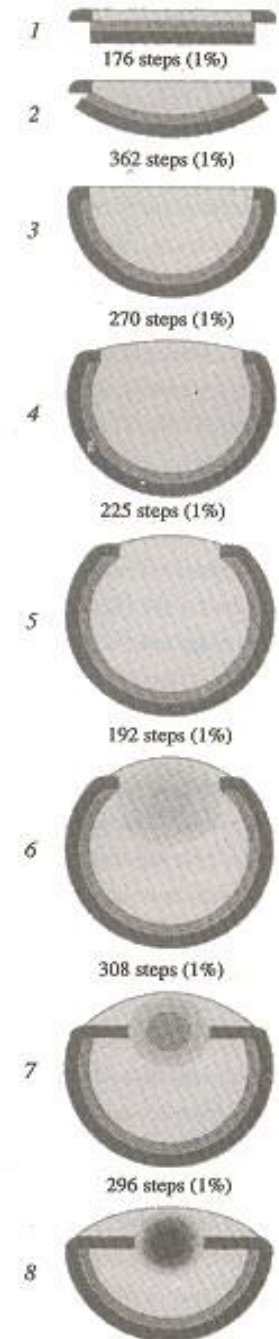
Stages of social development

Age	Stage	Features
0-1 year	Parent oriented	Development of primary attachment and wariness of strangers. Develop preverbal babble, enjoy rough and tumble. Affective reciprocity
1-2 years	Adult oriented	Develop capacity for short lived separations; widens range of adult attachments, develop sense of play and humour with adults, such as 'peekaboo'. Develop capacity for joint attention. Respond to gross non-verbal emotional communication
2-2.5 years	Toddler independence	Copy adults, develop pretend and creative play, become aware of peer play in parallel. Sensitive to subtle non-verbal communication and shame
2.5-4 years	Peer skill development	Move progressively towards skills of reciprocity with single age-related peer; develop skills of sharing and turn-taking. Initially can turn take if in charge or organised by another. Becoming less ego-centric; popularity comes from organising positive initiatives. Develop First order of Theory of mind
4-8 years	Peer group association	Understand reciprocity to maintain friendship and the practical needs a friend fulfils, eg a friend helps you feel happy. Learn to cope with group relations and social organisation by rules. Second order theory of mind
9-13 years	Pre-adolescent	Learn to challenge and create group rules. Clear gender split, friendships based on similarity, emotional support, and how they might be viewed by others. Capacity for guilt/sense of object constancy.
13 and older	Adolescence	Based on trust and self-disclosure and mutual or admired aspects of personality. Abstract cognitive capacity

Nilsson & Pelger's (1994) Computer Generated Theoretical Series, Leading to a Fish Eye.

Shows the mathematical **evolution of a 'photon catcher'** developing from 3 layers of transparent, light sensitive and light impermeable cells. Simple mathematic rules determine the shaping of this computer generated eye, which match evolution in the full spectrum of creation's species: light sensitive, direction sensitive, box camera to finally a lens focusing of an image.

From Climbing Mount Improbable, Richard Dawkins, Penguin 1996

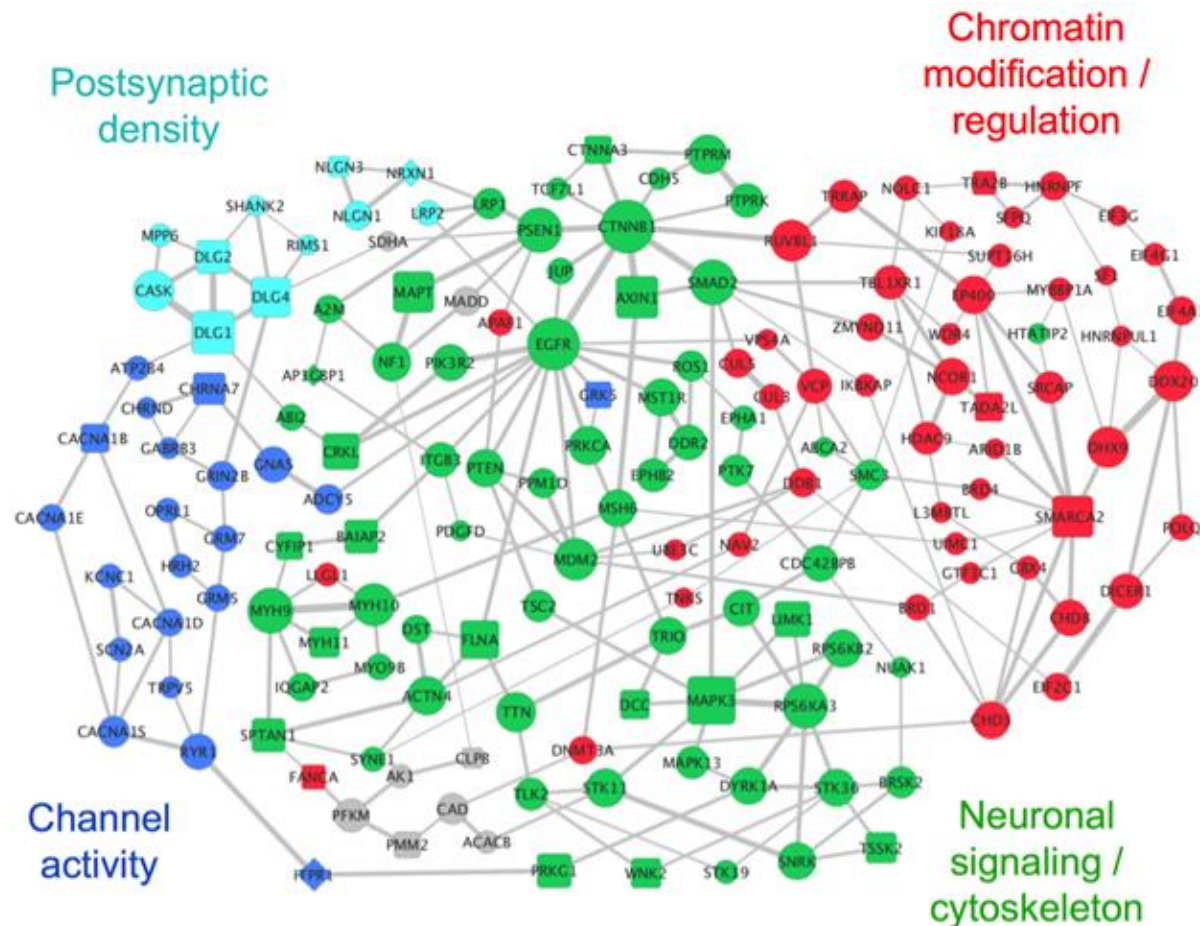


ASD: the specific disorders of social development

- A specific delay in socio-emotional development (social intelligence) behind general intellectual development
- Autism is social development skills < 2 years
- Aspergers is social development skills < 4.5 years
- A normative view of the biological causes of delays in developing peer relationships
 - help young people, families understand and accept:
 - specific strengths and weaknesses;
 - increased need for social support and guidance
 - Still make and need attachments, love and care like one of younger social age
 - but difficulties making friends with age related peer
- Social development: due to increasing mathematical complexity of networks/mechanisms, no single cause. (human connectome)
- Developmental Models simplify complexity and make understandable,
 - Vs biological models deconstruct brain function but are seldom clinically useful, but provide small increments of knowledge

Autism is a complex genetic disorder!

- With over a 1000 genes
- Genetic show the overlap with Schizophrenia, Bipolar, ASD & ID
- Is more likely to explain the development of the brain



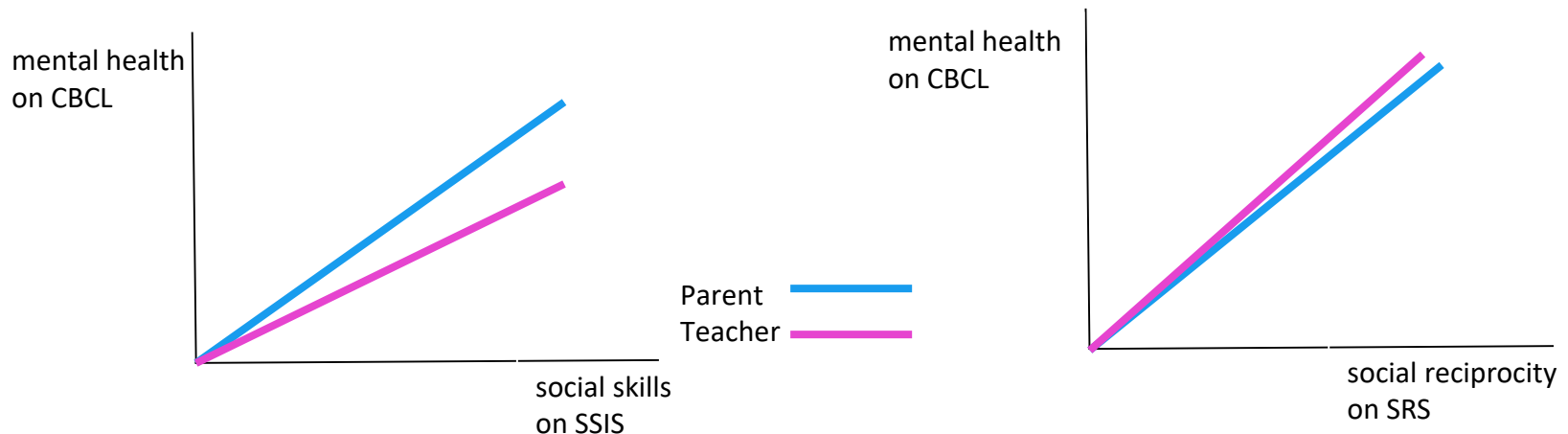
“Genotype to phenotype relationships in autism spectrum disorders.” J Chang, [SR Gilman](#), AH Chiang, [SJ Sanders](#)... - Nature ..., 2015 - nature.com
<https://scholar.google.com.au/citations?user=O1EuSPYAAAAJ&hl=en&oi=sra>

Why do YP with ASD have highest rates of Psych Disorder?

Emotional developmental determines adjustment

- Dosen et al demonstrated this sequence of emotional development correlates highly with age in normally developing children and with the level of intellectual disability in adults with the Scale of Emotional Development (Vandeveldel et al, 2014).
- Sappock et al (2013) demonstrated that adults of average age of 36 years with Autism and ID have a lower average emotional age of 1.5-3 yrs than ID alone, and emotional age was predictive of emotional disturbance.
- Emotional beh disturbance is correlated to social skills in ASD.

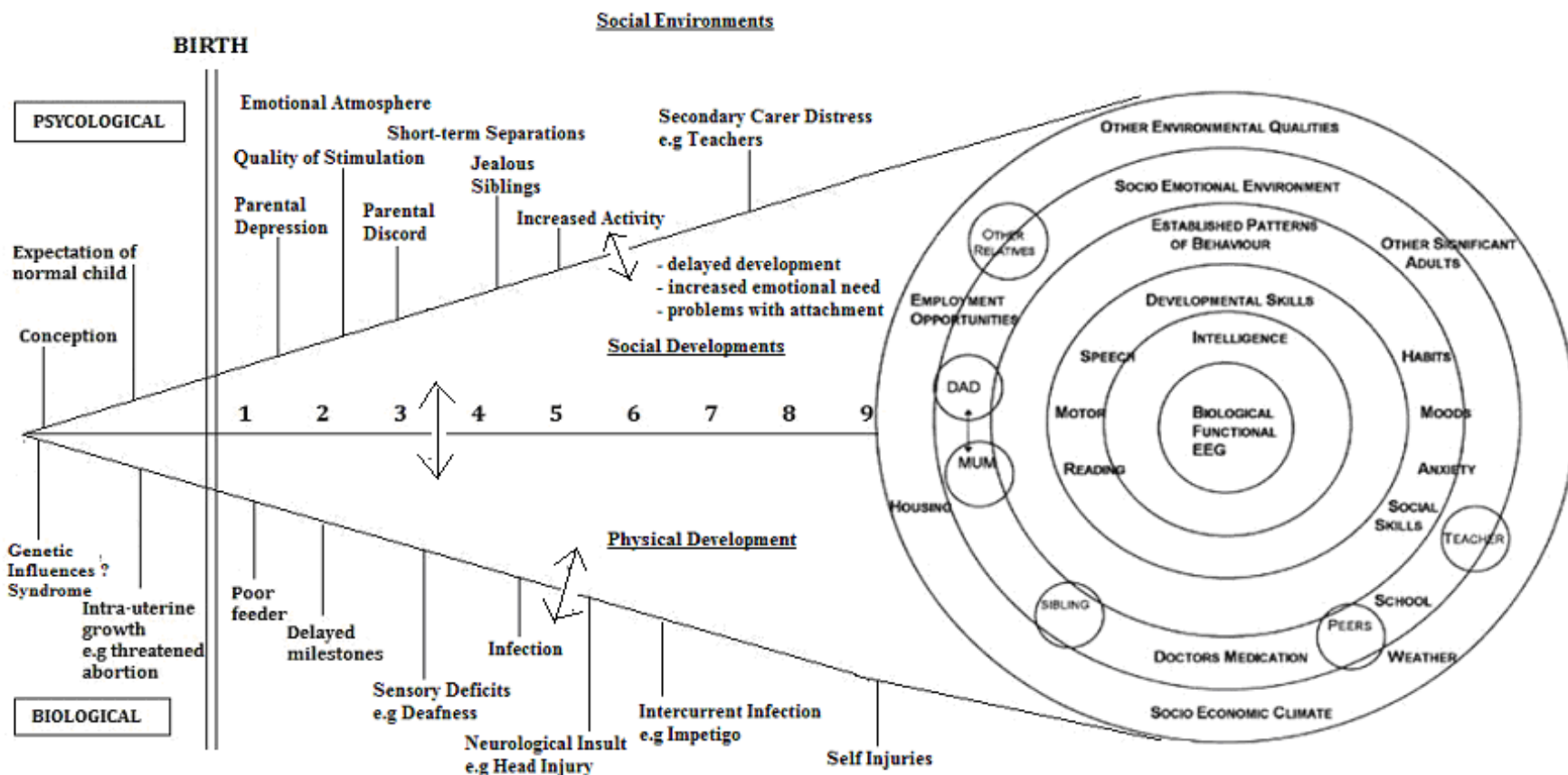
Better social skills and social reciprocity is associated with better mental health in children with ASD. (n=292) (Ratcliffe, Wong, Dossetor, Hayes, 2013)



The bio developmental psycho social cultural multi-aetiological framework for child disorder.

After Brofenbrenner, 1979

Lorna Wing put the **Developmental** in the bio developmental psycho social cultural framework of child development



Theories of Mind

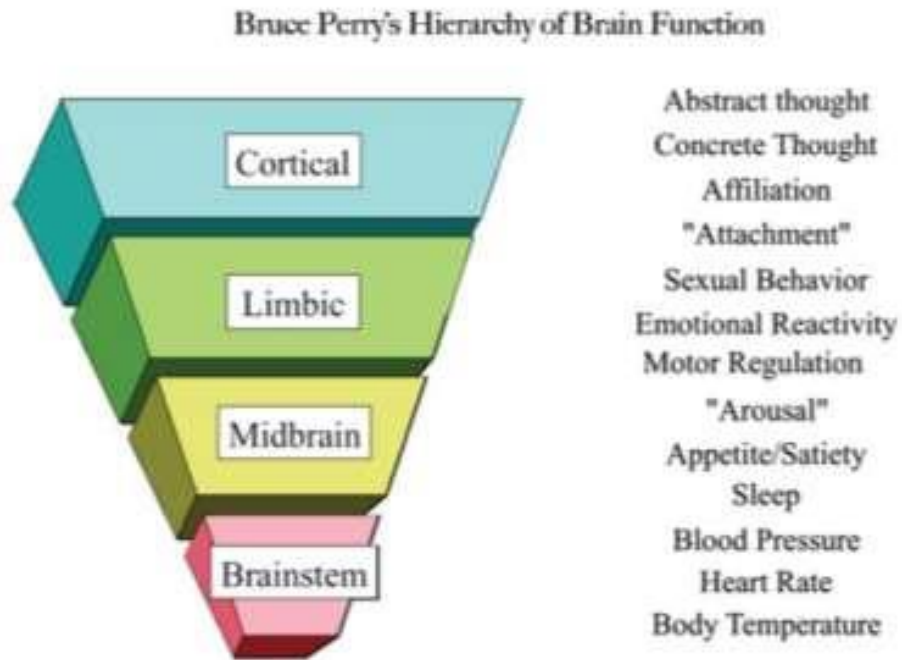
- Religion: Education, altruism and the power of belief
 - Father, Son and holy ghost
- Freud: Id, Ego, Superego
- Object relations and the importance of early attachment the psyche
- Kraepelin: descriptive abnormal phenomenology,
- Popper: Conjectures and refutations: scientific thinking had to be testable, as best evidence of truth
- Thomas Kuhn in 'the structure of scientific revolutions' described that theoretical models are overthrown with paradigm shifts
- When Ken and I arrived at CHW we insisted that all theoretical models were equal in the inclusive biopsychosocial model

Other models of psychological development

- Erikson (psychological development through the lifespan),
- Skinner/Watson (Behavioural learning)
- Bowlby (attachment as a contribution to childhood social adjustment),
- Piaget (cognitive conceptual development),
- Bandura (social learning),
- Beck (CBT, linking emotions to thoughts and actions and whether they are adaptive or not)
- Kohlberg (sequence of moral development),
- Gardiner (multiple intelligences, not just verbal and VS, but maths, music, motor, nature connection)
- Perry/Segal's (neurodevelopmental sequence of the impact of trauma), which are also linked to a model of increasing evolution of the function of the brain and its anatomical substrate, or midbrain/basal nuclear, limbic system, hemispheric specialisation of skills, and the development of frontal lobe executive skills (Perry, 2014).
- Porges: Vagal Nerve Theory, provides an evolutionary explanation of brain development: of Animal/Instinctive, Mammal/Affectional and Human Brain/Learning and Insight
- Meditation an awareness of the evolved self?

Evidence of developmental age determining behaviour

- Siegel described neurodevelopmental sequence of the brain and mind, equating developmental awareness of: 1. arousal to brain stem , 2. sensation/movement to midbrain/cerebellum 3. emotions to limbic system and 4. higher skills or executive functions to frontal lobes respectively (Siegal & Szalavitz, 2017).



Development of the Mind & Mental Competencies

Mental Competencies may be subjective experience, but developmental concepts are critical to understanding children

help identify reasons for not coping & showing maladaptive behaviour

- Identification of self and non-self
- Motor regulation and coordination, sensory modulation
- Selective attention and attention switching
- Communication skills and theory of mind
- Mood regulation and empathy
- Self-concept and self-esteem
- Reciprocal social interaction and relationship building
- Reality testing, perspective taking, creativity and other executive function skills

Best evidenced by the capacity of a young person to make new good quality peer attachments.

Most important skills:

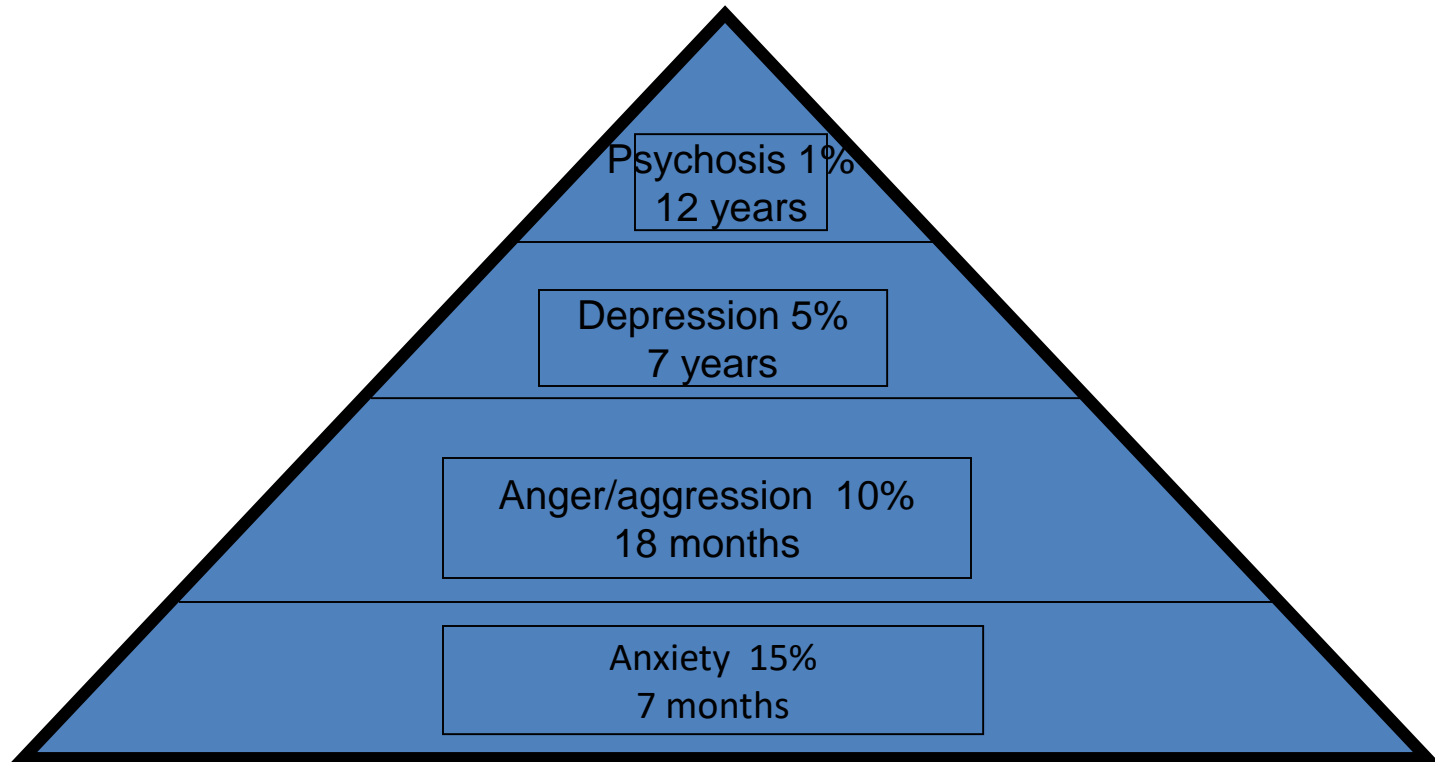
development of **attention and concentration**, a pre-requisite for learning,

development of **theory of mind**: the capacity to appreciate that others have separate thoughts and feelings to your own

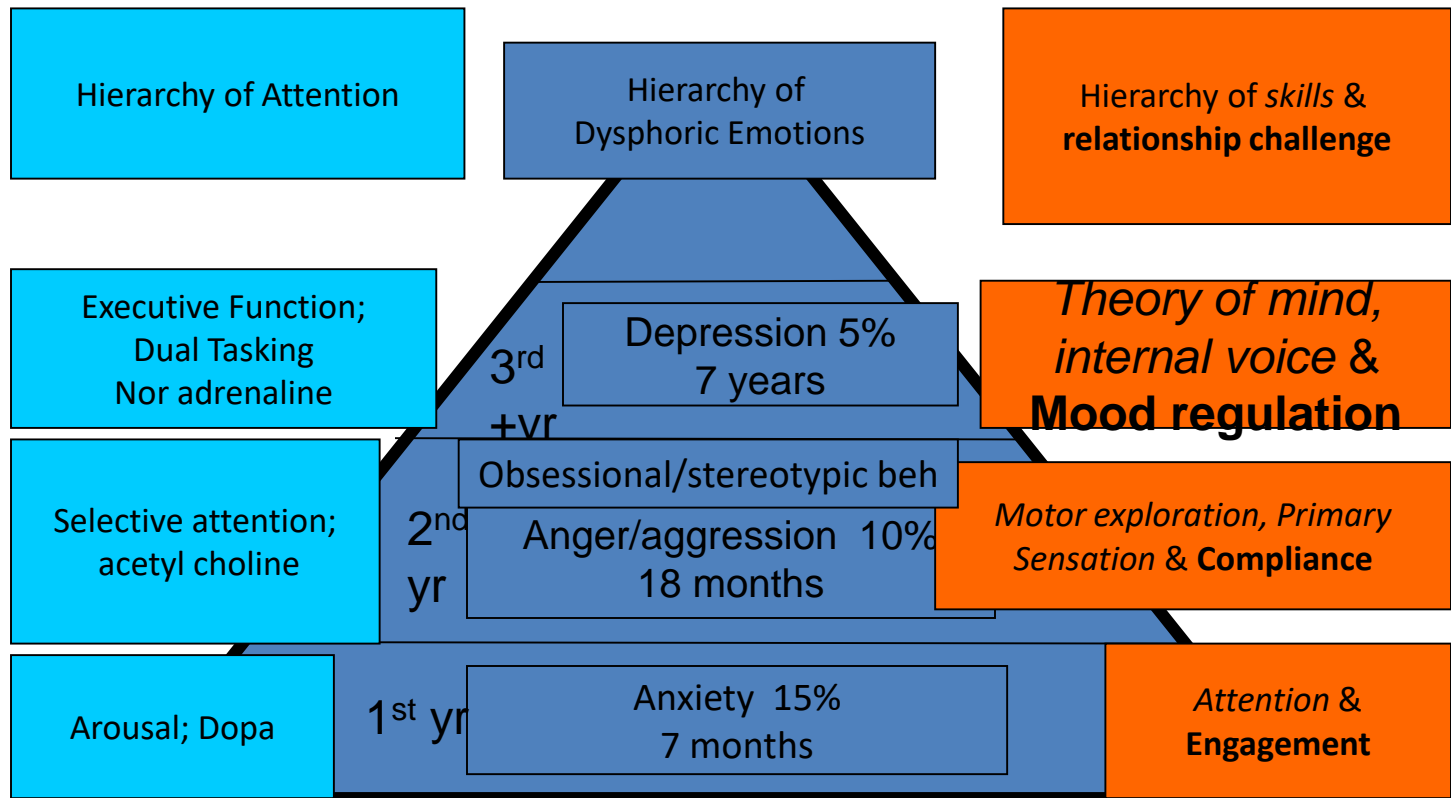
Alternative contributing concepts: DEVELOPMENTAL HIERARCHY OF EMOTIONAL DISORDERS

The Hierarchy of Disorders was originally described by Foulds (1976). The hierarchy has parallels in cognitive, language, conceptual and social development. The pyramid illustrates the general frequency of symptoms of psychological/emotional dysphoria and the developmental age at which this symptom is first recognized

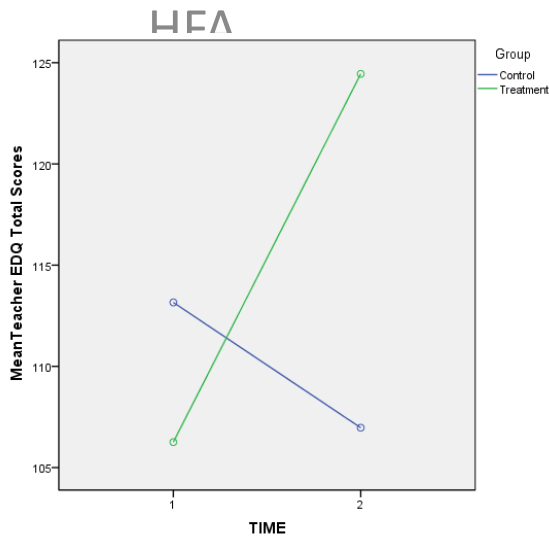
Dossetor D, 2004 *Clinical Child Psychology & Psychiatry*. 9(3), 443-451.



Developmental Sequences:
 DEVELOPMENTAL HIERARCHY OF EMOTIONS, ATTENTION, INDEPENDENCE AND
 RECIPROCAL SKILLS

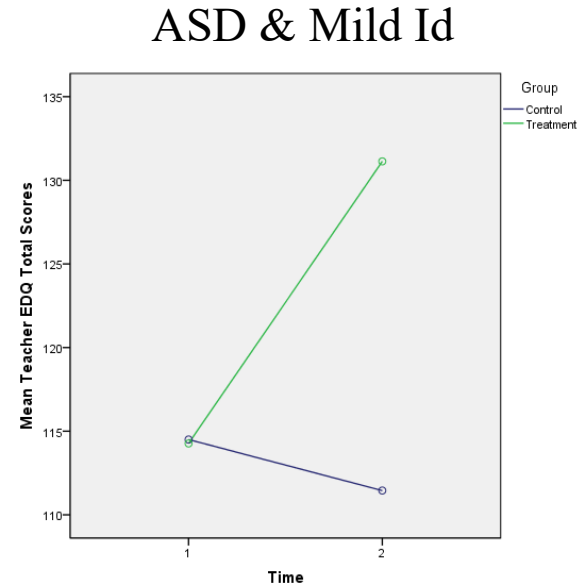


RESULTS –EDQ (Emotions Developmental Questionnaire) (Wong, Lopes & Heriot, 2009)



Time x Group – Significant
Time –Significant
Group –Significant

High scores = Better skills.



Time x Group – Significant
Time –Not Significant
Group –Not significant

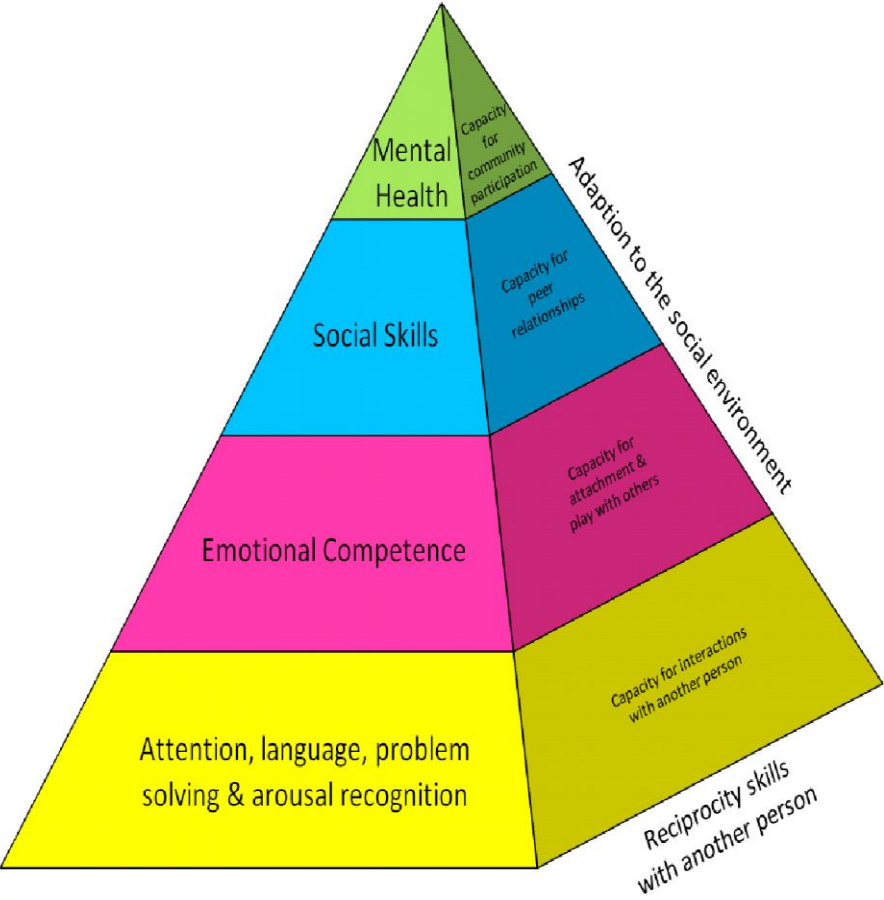
Pyramid of Social Competence, Reciprocity and Mental Wellbeing

Adolescence
is preparation for adult role of
contributing to community;
the basis of MH resilience?

Primary school age
Social Skills:
Best predictor of well-being

Emotional competence skills (2-5)
The **Westmead Feelings Program**
develops these skills
Necessary for attachment

Behavioural regulation &
management (0-4yrs)
Basis of adaptability

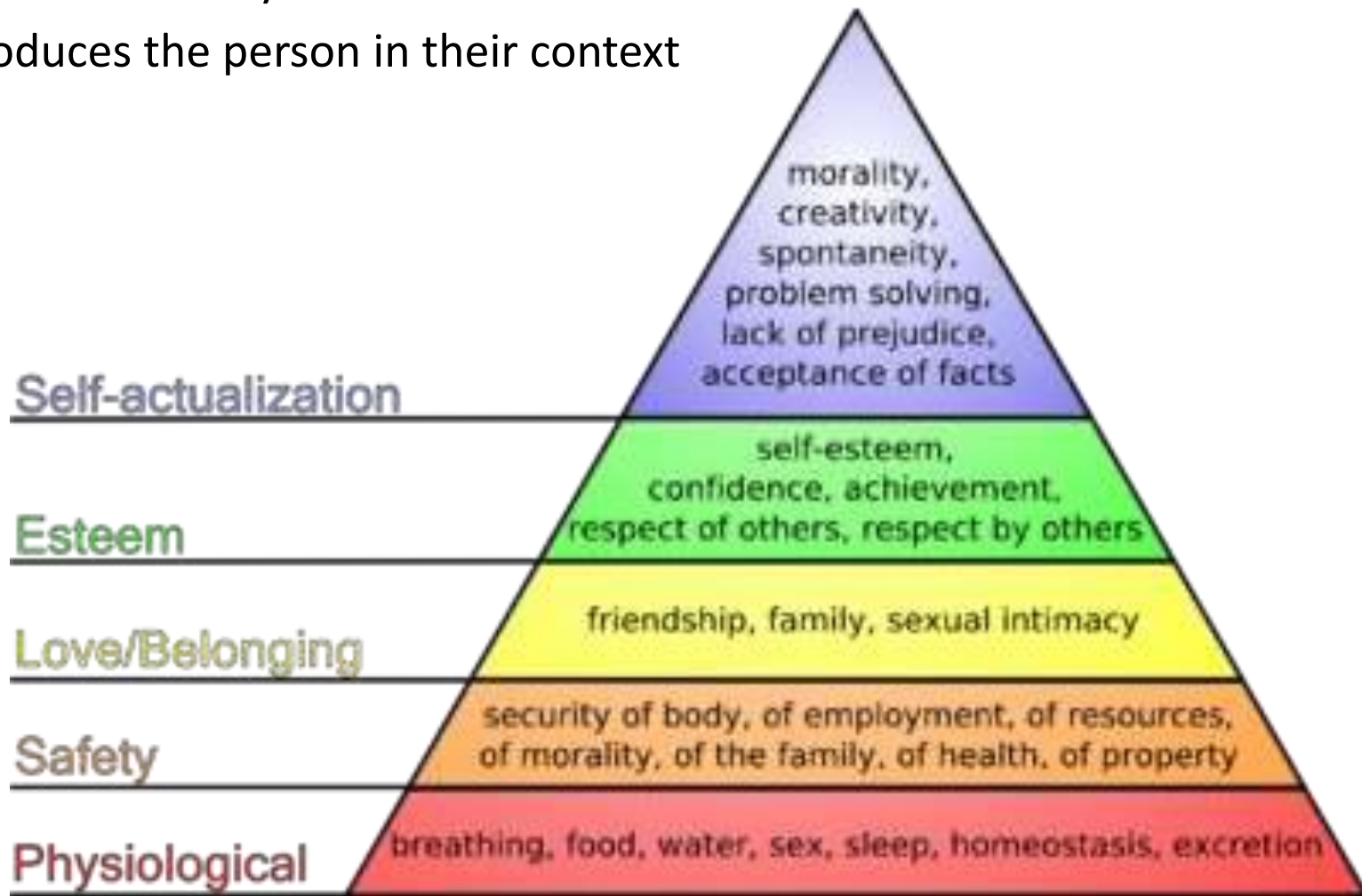


Autism and the importance of Emotional and Social Development

- Evolution is the most valuable idea mankind has had (Dawkins)
- Emotional & social development and attachment has led to the success of mankind (Porges).
- Social success depends more on emotional intelligence than IQ (Goteman)
- Theory of mind is a skill to be aware of other's thoughts and feelings and is impaired in Autism (Baron Cohen).
- 1st degree ToM develops in third year of life (when the human spirit enters, Graeme Watts, PhD)
- Autism is a delay in emotional and social development and grows up slowly, affecting emotional attunement, the development of self awareness and peer relationships.
- In Autism, theory of mind is delayed but as applied to emotional learning by Michelle Wong in the Westmead Feelings Program can be taught and follows a normative path. Such emotional competence enables attachment, improves social relationships and in consequence mental health (Wong M).
- Emotional competence determines behaviour and insight more than intelligence, regardless of intellectual ability.

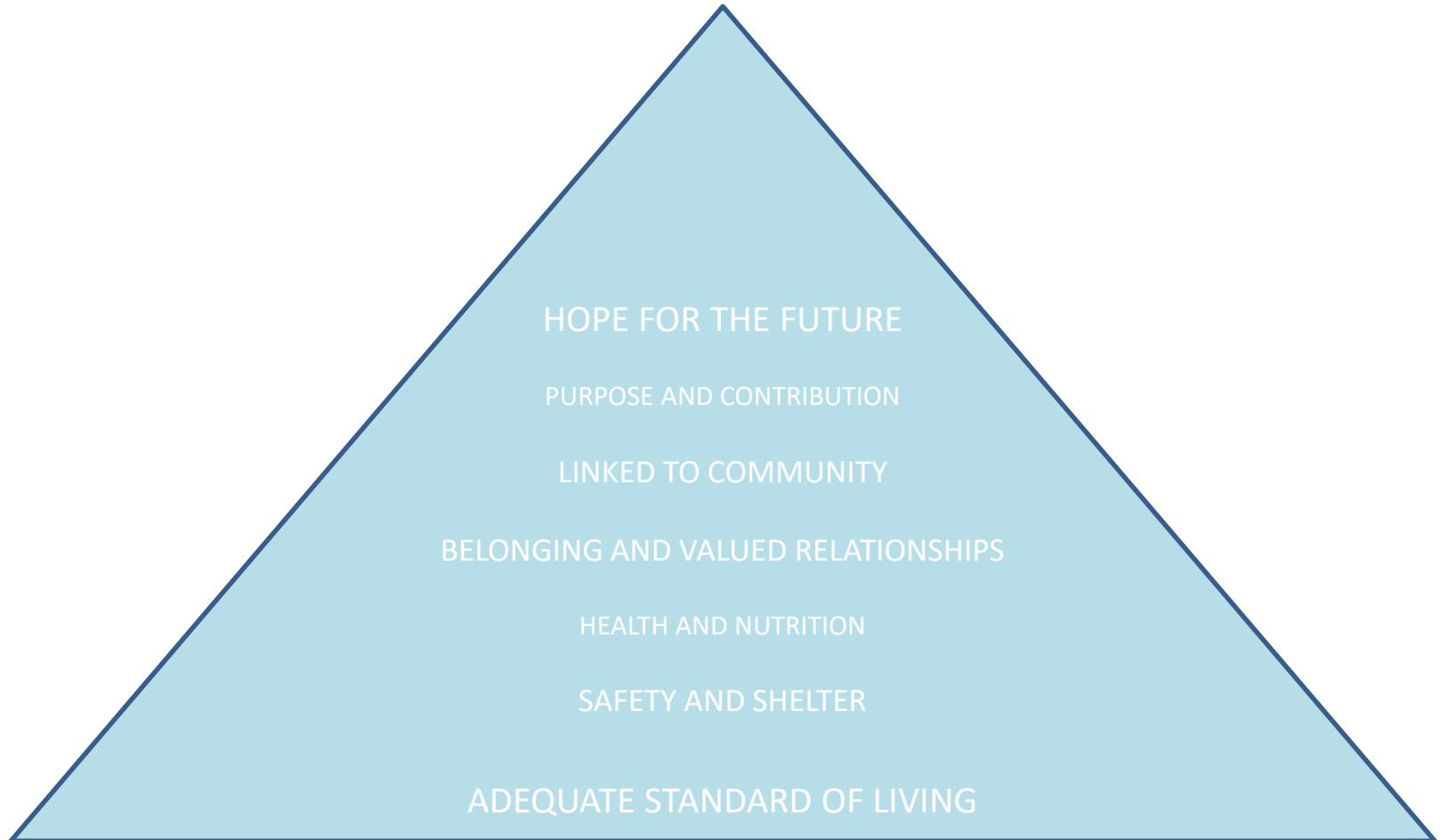
Psychology and psychiatry started by examining the abnormal and now studies the components of health and wellbeing

- Maslow Hierarchy
- Introduces the person in their context



The importance of Quality of life in treating patients. (Cummins, 2012)

QOL depends on human values & is achievable for anyone regardless of ability or affluence



The quality of life of populations

depends on

- Flourishment: is feeling you creatively contribute (Seligman)
 - by 2051, 51 percent of the world could be "flourishing."
- Freedom from discrimination and valuing of human rights: "Enlightenment Now" (Pinker S)
 - should value the internal worlds of all 8 billion people
 - suggests that there is no better time to have lived:
 - the progressive rise of democracy,
 - separation of law making from policing and enforcement (courts)
 - economic competition, independent banking, and Innovation, leads to posterity
 - Associated with reduction in starvation, plagues and epidemics, and violence
 - Improved well-being

Current Challenges

- Problems of relative inequity:
- Problems of Climate Change

Developmental models of understanding others evolve and impact on our capacity to act, help others and contribute to community.

- Popper, Karl (1962). *Conjectures and Refutations: The Growth of Scientific Knowledge*. London and New York: Basic Books, Publishers.
- Kuhn, Thomas S. *The Structure of Scientific Revolutions*. 3rd ed. Chicago, IL: University of Chicago Press, 1996.
- Seligman, M. E. P. (2011). *Flourish: A visionary new understanding of happiness and well-being*. Free Press.
-

J for MH of C&A with IDD: an educational resource

Partnership between Health/MH, Education and Disability
10th year, 25th edition; readership of >2000; still the only one
Continues the themes from the textbook:
Sample of Other Topics include:

- A developmental psychiatry assessment & process
- Other emerging frameworks
 - e.g. Practice Improvement Framework, IDMH Core Competencies
- *Behavioural Phenotypes, Fetal Alcohol Spectrum Disorder*
- Rights and Responsibilities to access health services
- *Health economics of preventative MH intervention in ID*
- Models of support eg. shared care
- Promoting resilience
- Parent training e.g. Stepping Stones Triple P
- Sibling Australia resources
- A Special Olympian: the benefits of exercise
- Positive Behaviour Support for Learning (PBL/PBS)
- Managing violence and the importance of safety
- *Grief/loss intervention*
- *Creative therapies* e.g., Play Therapy, Music Therapy
- Communication and visual strategies
- Sensory modulation and self regulation
- Animal Therapy
- *Trauma and attachment informed practice framework*
- Getting students ready for life after school
- *Personalised learning & support in schools*
- Diagnosis, Medication and Outcome
- Personal guidelines on prescribing
- Strugglers and Copers: Psychosis in VCFS
- ASD implications of DSM-5
- Catatonia; Psychosis in ID
- Autism in girls
- Refugee mental health and intellectual disability
- Updates on Pharmacological Interventions
 - *The medicine cabinet series number 18*
- State and National forums on better health and MH
- Implications NDIS on services for complex emotional behavioural disturbance
- Insight into a mental health review tribunal
- Restrictive practices: Policy and practice
- Complex case reviews systems
- Practice leadership e.g. “A day in the life of...”
- Conference reports

References/reading

- **Mental Health of Children and Adolescents with intellectual Disability: A framework for professional practice.** Dossetor D, White D, Watson L. (Eds) August 2011. IP Communications: Melbourne.
- **Young People with Learning Disabilities.** Dossetor D. 2017 May. Chapter: in *Child Psychology and Psychiatry - Frameworks for Practice*. Skuse D, & Dowdney L. (Eds). 2017. Wiley-Blackwell: London.
- **Teaching social–emotional skills to school-aged children with Autism Spectrum Disorder: A treatment versus control trial in 41 mainstream schools.** Ratcliffe B, Wong M, Dossetor D, Hayes S. *Research in Autism Spectrum Disorders (Impact Factor: 2.96)*. 12/2014; 8(12):1722–1733.
- **Westmead Feelings Program I: Emotion-based Learning for Autism.** An intervention Manual for children with verbal but not literacy skills, or mild intellectual disability. Radcliffe B, Wong M, Dossetor D, Carroll L, Brice L, Graeme V. 2017. Australian Council for Educational Research. <https://www.acer.org/westmead-feelings-program>.
- **The Evolution of the 'Photon Catcher': Implications for Social Development and Autism.** Dossetor D. *Clinical Child Psychology & Psychiatry*. Vol 9(3) Jul 2004, 443-451. Sage Publications, US.
- **Psychopathology in young people with intellectual disability.** Einfeld, S.L., et al. (2006). *JAMA*, 296(16), 1981-1989.
- **Mental health of children and adolescents with intellectual disabilities in Britain.** Emerson, C Hatton 2007. *BJPsych* 191 (6), 493-499
- **Why do families relinquish care? An investigation of the factors that lead to relinquishment into out-of-home respite care.** Nankervis, K., Rosewarne, A. Vassos, M. (2011) *Journal of Intellectual Disability Research*, 55 4: 422-433.

References in JMHCADD downloadable at www.schoollink.chw.edu.au

- **Some personal guidelines for prescribing for the mental health needs of children and adolescents with intellectual disability and/or autism.** Dossetor D. Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability. 2019, (1): 4-16.
- **Violence in children and adolescents with an intellectual disability and the importance of safety.** Dossetor D. Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability. 2016. 7(1): 4-13.
- **Diagnosis, Psychotropic Medication and Outcome in an audit of 150 children and adolescent neuropsychiatric patients.** Dossetor D. Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability. 2014; 5(1): 4-9.
- **The Developmental Psychiatry Clinic.** Dossetor D. Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability. 2015. 6(2): 4-13.
- **Catatonia: an under-recognised, acutely treatable condition in young people with intellectual disability/ASD.** Dossetor D. Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability. 8(1): 4-10.
- **Ewan's story: Psychosis in Intellectual Disability and Autism** by Ewan's parents and David Dossetor
- Dossetor D. **Mental Health Problems: Disorders of Social Development caused by Maladaptation's of Theory of Mind? A Developmental Psychiatry View.** CHW School-Link Newsletter 3(1). 2012.
- **www.schoollink.chw.edu.au: resources include all past editions of Journal of Mental Health for Children and Adolescents with Intellectual and Developmental Disability.**
- **Evaluation report on the Developmental Psychiatry Clinic: A Partnership between The Children's Hospital at Westmead and Statewide Behaviour Intervention Service (ADHC) by CDC 2014.**
- Promotion, Prevention and Early Intervention resources.
- **Webinars:**
 1. Curiosity, collaboration and action: Understanding & Responding to Behaviour in the Classroom;
 2. Cool, Calm, Collected & Connected in the Classroom: Supporting Students with Self-Regulation;
 3. The Mental Health of Young People with Intellectual Disability: What you need to know and what you can do.

– Other titles are to follow.

References/Podcasts

Partnership Projects with The Department of Developmental Disability Neuropsychiatry (3DN) UNSW (<https://3dn.unsw.edu.au>).

E-learning for IDMH for MH professionals, disability professionals and carers

Intellectual Disability Mental Health Core Competency Framework: A Manual for Mental Health Professionals and Toolkit. Committee Member and presentation.

<https://youtu.be/h15Y3yWfrxc>

Accessible Mental Health Services for People with an Intellectual Disability: A Guide for Providers.

https://3dn.unsw.edu.au/sites/default/files/ddn/page/Accessible%20Mental%20Health%20Services%20for%20People%20with%20an%20ID%20-%20A%20Guide%20for%20Providers_current.pdf

July 2016. CardioMetabolic Syndrome in Adolescents with Intellectual Disability. Presenter

<https://youtu.be/rqS20Sy7Uy8>

Responsible Prescribing of Psychotropic Medication Podcast 2017. incl: Prescribing in children and adolescents with intellectual disability. <https://3dn.unsw.edu.au/content/responsible-psychotropic-prescribing-people-intellectual-disability-podcasts>

[Episode 1: Recognising symptoms of mental illness in children and adolescents with an intellectual disability :](#)

[Episode 2: Deciding if, when and what to prescribe](#)

[Episode 3: Instituting, monitoring and discontinuing psychotropic treatment](#)

[Handout: Guidelines for an assessment summary](#)

[www.schoolink.chw.edu.au/webinar-series;](http://www.schoolink.chw.edu.au/webinar-series)

1. Understanding and responding to behaviours
2. Self Regulation
3. Mental Health for young people with intellectual disability and autism: what you need to know and what you can do.