Management Plan Notes for Billy Baxter

A real management plan constructed by Peter Trask, psychologist. All names changed to protect the client's confidentiality.

Background

These notes are prepared to provide some guidance to the staff of the [Named_School] College regarding the day-to-day management of student Billy Baxter. Suggestions and recommendations contained here are provisional only and ought to be reviewed and adapted as further information about Billy's condition is provided, from other medical and allied health sources. In the next several weeks, Billy has appointments scheduled with a psychologist and a paediatrician. It is anticipated that these individuals can clarify Billy's condition and hopefully, provide further guidance, in due course. In the meantime, these notes are provided in lieu of this new information.

Family Background

Biological father unknown. Mother died of an epileptic seizure when Billy was about 4 years old. He witnessed this event and the accompanying medical attention. At the time of the death of his mother, Billy was very briefly cared for by his then step-father and that man's extended family. That step-father is also the biological father of Billy's younger sister Alice. Soon after this traumatic period, Billy and his sister were in the full-time care of their maternal grandmother Evonne, although Alice continues to see her father, from time to time. It is alleged that the step-father grudgingly applied for access to Billy so he could also assure his access to his daughter, although Billy no longer sees that man who lives in [the city]. Further, it is alleged that Billy's step-father had been physically and psychologically abusive toward Billy both before and after his mother's death.

Billy's grandmother Evonne is now the official guardian of both Billy and Alice. Evonne remains committed to the care of Billy but has her own challenges including some relationship difficulties with her husband (and Billy's maternal grandfather) as well as coping with Billy's erratic behaviour.

While it is hard for Evonne to manage her own arousal levels and be calm around Billy, it is true that living in a volatile, emotion-charged environment does not bode well for Billy's prognosis. This needs to be considered in light of management plan suggestions noted below. Effectively, Evonne has a very central role in assisting Billy's on-going medical and psychological treatment, and so she needs to be supported so she in turn can support Billy's treatment. Effective treatment for Billy will not be short term and so will require Evonne in particular to be resilient, persistent, patient and able to modify some of her own emotional inclinations.

Provisional Diagnosis

Post traumatic stress disorder. Trauma as multi-faceted and cumulative. Very strong defense mechanisms, and so works to keep them intact. Deprive him of his defences and he becomes emotionally disregulated (erratic, unpredictable, aggressive) and vulnerable. He will fight that.

Disorganised attachment. Lack of cohesive, continuous, predictable, safe and nurturing environment from his primary care-givers in his infant and young childhood years. Critical period consequences in terms of the compromised neurological development in the first 5 years or so of his life, resulting in poor emotional regulation and minimal capacity to self-soothe (calm) himself when aroused (triggered). Also consequences for intellectual development and social skills.

Need to rule out (or confirm) **medical conditions** given mother's epilepsy. Refer paediatrician.

Some **learning difficulties**. Likely to be mainly developmental in origin (i.e. lack of appropriate stimulation in early critical period years).

Some **visual acuity** difficulties. Encourage use of prescription spectacles.

Provisional Management Plan

- ✓ Educate teachers and staff in trauma (causes and consequences - behavioural, emotional, other). Refer Peter Trask presentation - planned, date to be confirmed.
- ✓ Aim to adopt the Do's and Dont's from below.
- ✓ Guide family in achieving appropriate and competent external medical and psychological care for Billy. In progress but needs to be monitored, and if successful, treatment approaches integrated across school and family environment.

Don'ts / Things to Avoid

a. Do not talk about his mother. Maybe not his step-father either.
b. Avoid any comparisons with his sister. She "has a real father" while Billy does not, and that is the source of some angst and considerable discomfort.
c. Do not talk to Billy about anything (other than mainstream school content or behavioural expectations) that is known to cause a *negative* emotional (heightened physiological / arousal) response. Once Billy becomes disregulated, his behavioural responses are highly unpredictable and potentially dangerous to either self or others.
d. Avoid setting up therapeutic or caring relationships with Billy unless continuity and regular availability is practical and likely. That is, avoid further rejection or abandonment scenarios (or even potential for perception of same) in advance. Where people are only caring for him temporarily (eg. a mentor or remedial teacher), it is important that this temporary aspect is explained to Billy in advance so he understands. Termination of these relationships need to be managed sensitively and not abruptly.
e. Do not avoid disciplining Billy. However, avoid doing so, or talking to him about inappropriate behaviour at times of disregulation. If disciplining him, do so calmly, focusing on his behaviour and not his persona (i.e. what you **did** was naughty, not you are a naughty boy....).
f. Avoid punishing Billy for some of his mindless behaviour. Until his emotional regulation can be improved, some of his behavioural responses are instinctive (habitual, maladaptive defence mechanisms), and so we must avoid compounding his trauma by 'abusing' him further.
g. Avoid play therapy with Billy unless a skilled child therapist experienced in trauma treatment. Play therapy can connect a child with their unconscious thoughts and emotions and related and often suppressed emotions. This is a subtle yet profound consideration for Billy at school, as children will 'play' often. The intent is to avoid role-playing scenarios inadvertently with Billy, in the classroom or elsewhere, and aim to keep his play simple and free of emotive triggers.

h. Avoid escalating Billy's emotional outbursts by mirroring his emotional state. Instead, aim to provide him a safe environment ASAP, keeping others safe in the meantime. Be firm without being provocative.
i. Billy should not be handling firearms or be using any equipment that can be used as a weapon.

Do's

1. Be structured, concrete and simple in all daily interactions and instructions.
2. Provide him with a safe place or refuge he can withdraw to if he is becoming disregulated. This will need to be explained and negotiated with Billy and require on-going coaching and reinforcement.
3. Introduce a scoring system to label his level of distress (eg. use of green, yellow or red cards, or the 0-10 subjective units of distress scale - SUDS). This is to help him become more **mindful** of his emerging emotional distress before he 'loses it'.
4. Aim to 'ground' him at times of disregulation, using concrete methods to engage his perceptual systems ('can you see that', 'can you hear that'), while perhaps avoiding 'what can you feel' (emotive connotations) questions but rather give him something to play with and touch, such as a 'stress' ball. Neurologically, we are aiming to re-engage 'frontal lobe processing' rather than 'mid-brain processing' (emotional state in ascendancy with sympathetic nervous system activation) whereby a more 'mindful' state helps to activate self soothing responses (and thus activating the calming aspects of the parasympathetic nervous system).
5. At every (appropriate) opportunity, help him to acknowledge his emotions (name them) and as he maintains this awareness (and so is maintaining some aspects of cognitive / mindful executive control rather than emotional 'fight / flight / freeze' response), encourage him to activate a self soothing response, including deep breathing and exhalation with a sigh, helpful self talk, or use of positive and affirming imagery).
6. Show empathy and be so, as often Billy cannot control or help his outbursts.
7. Encourage positive emotions including gratitude, joy, laughter etc. Encourage affinity with nature or family pets.
8. Focus on what he can do, not on what he cannot. Build his confidence (and potentially, increasing trust and self worth within himself) by allowing him to complete tasks at his level of competence (and so he succeeds).
9. Funding to achieve a teacher's aide would be helpful but that person also needs to comply with that above. Mentoring might be worthwhile but only if the mentor is hardy, not egocentric and willing to commit for the long term.
10. Aim to establish a whole of school approach for Billy, at least for staff. Consistent with above. Interactions with peer students and others is more problematic but perhaps can be addressed via routine wellbeing, pastoral care and welfare initiatives throughout the school.

Review the above in several months, modify and integrate routinely as certain methods are proven, and take into account feedback from external medical and health professionals treating Billy, with consent of and via his guardians.