



## **Approach to challenging behaviour: A family affair**

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Approach To Challenging Behaviour:  
A Family Affair

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## **Abstract**

Over the past 30 years, research in the area of applied behaviour analysis has led to a rich knowledge and understanding of the variables that influence human behaviour. This understanding and knowledge has given rise to a range of assessment and intervention techniques that have been applied to individuals with challenging behaviour. Interventions have produced changes in the severity and frequency of behaviours such as self-injury, aggression, and property destruction, and have also led to the acquisition of desired behaviours. While behaviour change has been achieved, families have expressed a desire for positive behaviour support approaches that adopt a family focus. Research and development of support frameworks that emphasize the interrelatedness of family members, and the child with a disability as part of his or her family, have gained prominence in the family systems literature. The present paper reviews some of the behaviourally based research in this area. Through the use of a case illustration, the authors discuss the links between behavioural support and family-centred support systems for children with developmental disabilities. Theoretical and practical implications are considered and areas for future research are highlighted.

Approaches to children and young people with intellectual and developmental disabilities presenting challenging behaviours have changed dramatically over the past 2 decades. Awareness of the communicative intent of these behaviours and the importance of a quality lifestyle has influenced intervention options (Koegel & Koegel & Dunlap, 1996; Kincaid & Fox, 2002). Concurrent with these developments, family support initiatives have been incorporated into programs that see the child as a part of a family system, that the family is the “client”. However, there is little research that focuses on incorporating a family systems approach to achieve meaningful outcomes for individuals with challenging behaviour and their families.

Over the past decade, there has been a significant expansion in the understanding of, and knowledge about, the importance of contextual factors in the assessment and treatment of challenging behaviours. Early applied behaviour analysis (ABA) approaches focused on reducing challenging behaviours through the use of assessment and intervention strategies that were generally carried out by ‘experts’, often in controlled settings (Carr, 1997). Developments in the way of conceptualising assessments and interventions and where they take place has led to a more ecological approach to ABA sometimes referred to positive behaviour support (Koegel, Koegel, & Dunlap, 1996). As can be seen in Table 1, many of the changes that have taken place have required interventions to occur in natural settings and involved family members and others in the design and selection of intervention strategies. This has been accompanied by a shift in focus, away from the specific problem behaviour and more toward lifestyle issues of the individual with the challenging behaviour.

**<Insert Table 1 about here>**

Positive behaviour support has also stressed the importance of multicomponent approaches that combine teaching new skills, making changes to the environment, and modifying the consequences for positive and negative behaviours (Carr & Carlson, 1993). Families have indicated a desire for this kind of approach, that emphasizes structuring home routines, enhancing communication, expanding relationships, increasing choice-making, and de-escalating stress (Turnbull & Ruef, 1996; Turnbull & Turnbull, 1996; 2001a). However, there have been only limited examples of approaches that adopt a family focus in the literature. Detailed below are two examples of such studies.

Lucyshyn, Albin, & Nixon (1997) collaborated with the family of a 14-year-old girl with multiple disabilities named Helen, to develop and implement a behavioural intervention. Helen's parents were involved in the selection and definition of four family routines in the home and community that were used as settings for intervention. Helen's parents were interviewed and information about the family's goals, strengths, resources, social supports, and stressors were considered in the development of the intervention plan. The plan was developed by the authors, who held meetings with the family to gain feedback and finalise the plan. Helen's parents were then supported to implement the final plan. In addition to measuring changes in challenging behaviour and completion of family routines, the authors also used a tool developed by Albin, Lucyshyn, Horner, & Flannery (1996) to evaluate the contextual fit of the behaviour support plan with the family's ecology. The intervention resulted in durable improvements in the child's behaviour and in the completion of valued

family routines, with parent indices indicating high social value and contextual fit with the family ecology.

In a study conducted by Vaughn, Dunlap, Fox, Clarke, & Bucy (1997), the mother of a 9-year-old boy with severe disabilities and challenging behaviours served as a member of the research team, to design and implement both research and behavioural support strategies. As in the Lucyshyn et al. (1997) study, the family chose the intervention settings and the boy's mother was explicitly involved in assessment and hypothesis development, formulation of appropriate intervention plans, implementation of the intervention, and the selection of measures and designs. The intervention led to significant reductions in challenging behaviours that were maintained over time and judged by family members to be important and feasible. In a companion article, Fox, Vaughn, Dunlap, & Bucy (1997) provided a qualitative analysis of the family's experiences during the assessment and intervention process. The authors discussed some of the factors associated with the ecological approach that may have influenced the success of the intervention and the outcomes achieved, particularly the development of a relationship between the interventionist and family members. The establishment of this relationship hinged on the interventionist developing an understanding of the family structure, routines, needs, and capacities.

The studies by Fox et al. (1997), Lucyshyn et al. (1997) and Vaughn et al. (1997) provide examples of how positive behaviour support approaches have taken an ecological view of challenging behaviour. They have attempted to work in collaboration with families although the focus has remained on the individual with challenging behaviour within home and community settings. Thus while successful

outcomes of intervention using this approach may refer to positive lifestyle changes for the whole family, generally this has occurred as a result of decreased challenging behaviour leading to greater community participation and completion of family routines. In general, individual goals for family members and the family unit, aside from those related to the challenging behaviour, have not been identified or targeted in any way.

There may, however, be a need at times to conceptualise the focus of intervention in terms of the family unit as a whole, rather than just the individual with challenging behaviour within the family context. It has been suggested, for example, that while the principles of behaviour analysis have usually been applied to individuals, they can be applied equally well to ‘communities’ such as schools (Horner, 2000). For example, Sugai and Horner (1999) have argued that when a school serves as the unit of intervention, effects can be achieved that benefit the entire student body and improve the school’s capacity to work intensively with students requiring higher levels of support. In a similar way, families may benefit from being the ‘unit of intervention’, thereby strengthening the family unit in a way that may help provide ongoing support for the family member with challenging behaviour but also to enhance the lifestyle quality of all family members. While not commonly found in the positive behaviour support literature, shifting the focus from the individual to the family unit has been explored in the family systems approach literature.

Paralleling the developments in positive behaviour support described above, significant effort has also focused on providing quality support to families who have a child with a disability. These family support initiatives are premised on the critical

role played by the family in the child's life (Bricker & Widerstrom, 1996; Carpenter, 1997; Covert, 1992; Dunst, Trivette & Deal, 1994; Turnbull & Turnbull, 1990; 2001a). This emphasis has led to support frameworks that see the child as part of his or her family and recognises the interrelatedness of all family members. That is to say, the family is the "client" or the focus of the intervention rather than simply the child. Indeed, the shift towards a family focus has been incorporated into much government policy within Australia and overseas (e.g., the Commonwealth and States Disability Services Acts in Australia and IDEA in the USA). Building cohesive and reciprocal family relationships for children with challenging behaviour from the earliest years may make an important contribution to an inclusive lifestyle for that child and his or her family (Turnbull & Ruef, 1997). The focus on maintaining the family integrity is acknowledged as time and effort well-spent.

A theoretical position that takes into account the interrelatedness of family members is that of family systems theory (Begun, 1996; Carter & McGoldrick, 1980; Seligman & Darling, 1989; Turnbull & Turnbull, 1986). From this perspective, the family is a societal system with unique characteristics and needs comprised of individual members who also have unique characteristics and needs. Like all systems, the family is not a static entity, but is continually changing and adapting to meet the needs of individual members and the demands of the society in which the family is embedded. All parts of the family are interrelated and phenomena affecting any one member of the family must inevitably impact on all members of the family. Turnbull & Turnbull (1986, 1990, 2001a) suggest that the family system can be viewed from three dimensions. The structural dimension focuses on the major components of the family structure such as membership characteristics, cultural style and ideological style. The

functional dimension focuses on the responsibilities or tasks assumed by family members that contribute to the adaptation of the individual family members, e.g. economic, domestic, identity, and socialisation functions. Finally, the family life cycle dimension focuses on the dynamic aspects of the family system. The needs and characteristics of the family do not remain static but rather change over its life cycle, described as members grow older and pass through a succession of roles. The key aspects of the life cycle stages are seen as changes in the function of the family over time.

It is therefore apparent that families are complex and dynamic entities, and that there are many factors that impinge on family lifestyle. The family does not remain static but changes and adapts according to the demands placed on the family system. All factors (structure, function and lifecycle) must be taken into account in supporting a family who has a child with a disability, including children with challenging behaviours. Moreover, it is not sufficient to focus only on the child or the child within the family; it is also necessary to consider the family within the context of the larger social, economic and political realities. The child is but one part of an intricately woven system. He or she on the one hand is part of a family system of interacting units, and on the other, part of a social system of interacting families, individuals and social institutions. A critical aspect of this wider system is, of course, the service provision structure.

However, as Mitchell and Winslade (1997) have argued, while systems theory has broadened the view of service providers from a narrow focus on the individual it is timely to extend the systems approach. They contend that the systems approach

should be expanded to include an understanding of the lived experiences of families, to an approach that considers families as experts on their experiences and see as critical the understanding of the meanings or stories underpinning the interaction of the various systems around and within families.

Understanding lived experience as part of a system operating within a more extensive systemic framework represents a challenge to service providers to conceptualise working with families in a manner that not only respects, but also empowers and strengthens them. Such a consideration endorses Bowman and Virtue's (1993) contention that services must do more than act as a prop to keep families going in an effort to avoid out-of-home placement. Services must work with families in a manner that enhances family integrity and their sense of control over their lives (Wheeler, 1996), in effect to work with families to enhance not only the quality of life of the individual child but also that of the family (Turnbull & Turnbull, 2001a).

Mitchell & Winslade (1997) also point out that voice and agency are central notions to conceptualisations of the quality of life construct. Borrowing from Bach (1994), they argue that a critical aspect of the pursuit for quality of life may be thought of as the pursuit to establish agency in one's own life, in the face of powerful discourses that are marginalising in their effects – as is often the case for many families with a child exhibiting challenging behaviours. Services dedicated to enhancing quality of life for people with disabilities and their families therefore need to design and deliver services that are responsive to such agency and voice. Moreover, as Turnbull & Turnbull (2001a) maintain, the inclusion of agency and voice in family quality of life conceptualisation is paramount. From this perspective, not only is the focus on the family as the “client”, but also families are viewed as key decision-makers in a partnership with service providers rather than simply consumers or clients of a service

(Brown, Nolan & Davies, 2001; Knox, Parmenter, Atkinson & Yazbeck, 2000; Murray 2000). Their expertise is valued and used, and they play an active, rather than passive, role in their support planning and implementation efforts.

In summary, key elements of family systems theory and positive behaviour support have been reviewed. Examples of these elements include a contextual and ecological approach to behavioural assessment and intervention, shifting the focus from the individual with challenging behaviour to the family, incorporating the interactional dynamics of the family, and encompassing a family/professional partnership approach. It is suggested that an important outcome of drawing from both these theoretical perspectives, could be a more effective means of supporting families with a member with challenging behaviour.

To help explore these elements, the authors sought the assistance of a family, referred to as the Crisps. The Crisps agreed to collaborate with the authors to demonstrate how elements of family systems and family partnership approaches can be incorporated with intervention efforts aimed at addressing challenging behaviour issues raised by the family itself. To ensure confidentiality for the family, the authors have altered any individual personal details that may identify any of the family members.

### **Case Illustration** *The Family*

The Crisp family consisted of Ms Crisp and her three daughters Amelia, Bridget and Caroline. Each of the girls had significant challenging and disruptive behaviours associated with diagnoses of autism spectrum disorder or attention deficit hyperactivity disorder (ADHD), although Amelia was the family member referred for assistance with challenging behaviour. Amelia was the eldest child, and planned to

graduate to high school at the end of the year. Challenging behaviours ranged from self-injury to physical and verbal aggression that had led to injuries requiring medical attention and at times, hospitalisation. Problems of school refusal for all three children had resulted in high rates of absenteeism. Social security payments were the sole source of income for the family. Ms Crisp performed voluntary work for a local church group and members of this church group were a significant but sole source of support for her. Amelia was the oldest child, had a diagnosis of autism, ADHD, and seriously challenging behaviour, including physical aggression toward her mother and siblings. Activities organised for Amelia and her sisters by a disability support group were not enjoyed by Amelia and poorly attended. Amelia's younger sisters, Bridget and Caroline, also exhibited challenging behaviours that included verbal and physical aggression. Bridget was diagnosed with autism and both Bridget and Caroline had a diagnosis of ADHD. All three girls were prescribed medication to assist with behaviours associated with their diagnoses.

### ***Issues and Strategies***

Following agreement by the Crisp family to participate in the study, the authors met with the family, to discuss the nature and extent of their involvement. Following the initial meeting, time was spent with each member of the family and with the family as a whole to enable them to identify and articulate issues and goals, both individually, and as a family. The authors used their extensive experience in communicating with individuals with autism to involve each of the children in this process. Three meetings were held and the issues and goals identified by family members as most important are presented in Table 2.

**<Insert Table 2 about here>**

With the authors acting as facilitators, and drawing on the family's strengths and knowledge, the family then considered how their goals could be achieved. As described above, family interactional dynamics are a critical aspect of family systems theory. It was therefore a critical role of the authors to support family members to identify both individual and family goals that recognized the effects of these dynamics. The family played an active role in identifying strategies and how these would be incorporated into the family lifestyle (see Table 2). For example, levels of aggression appeared to escalate in the periods just before and after school and one goal identified by the family was to reduce the level of aggression during these time periods. A functional assessment was conducted by an independent observer on four separate occasions, before and after school. Several hypotheses resulted from this assessment. First, Amelia's aggression appeared to be motivated by task avoidance. When asked to undertake a task by Ms Crisp, she would scream, turn up the television volume, or hit out at her mother. If asked again, she would often turn her aggression toward one of her siblings. It was also observed that these incidents tended to occur when Amelia was watching television. Second, Bridget's behaviour appeared to serve the function of avoiding school. She would often refuse to get up, dress, or carry out other self-care tasks and when requested to do so, would scream and hit her mother. She spent much of the morning watching television. On many occasions, she would not go to school, and this often led to all the children staying home.

Ms Crisp was keen to modify the family routine in the periods before and after school to encourage the children to carry out necessary self-care tasks. She considered the children's favourite television shows and the impact of their viewing times on their ability to undertake these tasks. Ms Crisp then discussed this with the children and

together they planned a time before and after school when the television would be turned off and tasks would be completed. In addition, one of the authors visited Bridget's school to identify any factors that may have been contributing to Bridget's reluctance to attend. This process resulted in a collaborative approach between Ms Crisp and the school, where knowledge of Bridget's interests was used to encourage school attendance. Specifically, Bridget was given the task of feeding some fish kept at the school and an opportunity to work on a tapestry if she arrived 30 minutes before school commenced.

While functional assessment data were collected to inform intervention, members of the Crisp family were reluctant to participate in follow-up data collection due to the intrusion this would cause. Thus it was the reports of the family members themselves on changes that had occurred and their satisfaction with these changes that were used as indicators of goal achievement/non-achievement. While use of such measures can be problematic in terms of validating a particular intervention approach, the use of these qualitative measures is consistent with the tenets of social validity as espoused by Baer et al. (1987). Issues related to measurement and evaluation will be considered further in the discussion. Overall, however, the Crisp family indicated that the goals they set had been achieved and had impacted in a positive way on their life. For example, both Ms Crisp and the school reported that Bridget consistently arrived at school before the morning bell and school attendance for all three girls had improved. Levels of aggression within the family decreased, particularly before and after school, with the children undertaking self-care tasks as requested. Amelia participated in regular outings to the movies and other locations of her choosing, independent of her mother and siblings. This provided needed respite for members of her family and

opportunities for Ms Crisp to spend time with each of her daughters separately. It also enabled Amelia to participate in activities that reflected her particular interests. Ms Crisp was able to attend a weekend retreat while the children stayed with members of the church congregation. Additionally, the family shared time together doing things they all enjoyed, such as making decorations for the house and planting a vegetable garden.

While these outcomes were achieved, several issues concerning the authors' experiences of working within the family support and behaviour intervention frameworks arose and are discussed below. The authors do not pretend to have unequivocal answers to these issues, but merely present these reflections as issues for consideration.

### **Implications**

This paper has explored the use of a family-centred approach and positive behaviour support principles to support the Crisp family - a family consisting of a mother and 3 daughters each of whom displayed a range of challenging behaviours. The use of this amalgam of intervention strategies resulted not only in an improved lifestyle for all members of the Crisp family, but also one in which the family were the primary decision makers with the interventionists adopting a facilitative rather than a directive role. This relationship is depicted in Table 1.

### ***The Family as the "Client"***

The framework used by the authors in supporting the Crisp family was underpinned by an amalgamation of a family-centred approach and positive behaviour support

principles. As such, it has identified and pointed to the critical nature of an ecological approach to behaviour support and intervention efforts. The person with challenging behaviour is seen as a member of an interconnected family system, and the family considered the client, rather than simply the person or persons with challenging behaviour. In short, with the focus on the family as the client, the focus of the intervention efforts is on maximising *family* quality of life rather than, or as well as, *individual* quality of life.

Dowling & Dolan (2001) point out, without a family-centred approach, the carer's quality of life may well be compromised in their caring for a family member with a disability. A consequence of the carer role can often be exclusion from public or community life. This issue has been addressed to some extent in this study by paying attention to the issues around all family members, not simply the child presenting the challenging behaviours. For example, for the Crisp family, the role of the church was significant in helping Ms Crisp achieve her goals of retreat and participation in community activities of her choosing with the assurance of satisfactory childcare for her daughters. Additionally, when the attention is on the child and his or her challenging behaviour, the boundaries for intervention are clear. However, when the focus extends to the family, the boundaries become blurred. The authors were confronted with questions of where the boundaries lay between having sufficient information to be able to facilitate family goals and a sense of invading the family's privacy. Questions of where the limits lay and how far they should go continually confronted the authors. These were not clear-cut issues and it was, at times, difficult to know the parameters. An important aspect of this partnership approach is the need

to determine from the family, throughout the process, what the boundaries of the partnership will be.

### ***Multiple Partnerships***

The approach used by the authors was also predicated on working in partnership with families, where roles and respective expertises are acknowledged and valued; a framework where the family are key decision-makers about what is needed to enhance their quality of life, with the substantial role of the interventionist being to facilitate the achievement of these goals (Lehr & Brinckerhoff, 1996; Nelson, Zoelleck & Dillon, 2000). The need for superior interpersonal skills in the interventionist to carry out the facilitative role involved in this kind of partnership is patent. It is critical that attention is paid to the “matching” of the family with an appropriate interventionist who values this relationship.

However, partnerships extend beyond the family, to include associated agencies, and the family’s informal supports. In relation to the Crisp family, the interventionists were required to work collaboratively with personnel from other agencies involved in the implementation of the family’s support initiatives. Thus, it was necessary to not only find the resources that might be appropriate for the family, but also work with these agencies in coordinating the support to address the family’s goal. At times, this involved working as part of a multi-disciplinary or in some cases a transdisciplinary team. Thus teamwork was an essential requirement of the interventionist’s role within this framework. Further research is needed concerning relational skills required by interventionists to operate within a family centred approach (Brown, Nolan & Davies, 2001).

### *How is Success Determined*

In this paper, we have traced the changes in focus and methodology associated with supporting families that have a member with challenging behaviour. Table 1 described a shift in focus from assessing behavioural change in a controlled environment to considering changes to the quality of life for the individual and his/her family within an ecological framework. As the focus of intervention has moved away from controlled environments and measurable behaviours toward a family-centred approach, the means to measure success have become less clearly defined. Recent research has furthered our understanding and knowledge of the components and intricacies of the quality of life concept (for example, Brown, 1997; Brown, 1999; Schalock, 1990, 1996, 1997; Wallander, Schmitt & Koot, 2001)

However, much of this research has also highlighted the difficulties of empirically validating the efficacy of an intervention. That is, what should be measured, how, and by whom? One way in which this issue may be addressed is to consider working collaboratively with the family to identify their own measures. When specifying intervention goals, for example, family members could be supported to indicate how they would know whether each goal had been achieved. In this way, the family would determine the effectiveness or success of the intervention, thereby ensuring socially valid outcomes. Measures may relate to goal achievement or family quality of life and may be quantitative, qualitative, or a mixture of both. This process may help to avoid some of the issues that arise from researcher-driven data collection, such as intrusion on family privacy. Further research is needed to explore the efficacy of such an approach .

This paper has raised a number of issues involved in adopting an ecological approach embedded in family systems theory or embedded in a family-centred approach and has argued that, inter alia, a focus on family-centred practice needs to address the issues of the individual family member in a way that respects and upholds the integrity and lifestyle quality of the family as a whole.. It has used a case illustration to show that such an approach can have a significant effect on families maintaining control over their lives and on the quality of the family's life – not just that of the individual with challenging behaviour. However, the issue around collaboration with families is critical as is the wider focus of intervention, and family centred evaluation. It would seem the issues identified in the current paper are just some of the issues needing consideration as intervention efforts increasingly take place in more ecologically valid and family-centred contexts. Indeed, as Allen & Petr (1998) point out there are clearly many issues associated with family-centred practice that are not yet well understood and require attention. It is far from a simplistic and clearly understood approach. The need for broader cross-disciplinary approaches (e.g. between family therapy and behaviour therapy) as suggested by Rhodes (2003), amongst others, offer potentially fruitful opportunities to foster greater understanding of the complexities of family centred practice. The challenge lies ahead.

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**Table 1. Changes In The Focus And Methodology Of Family Behaviour Interventions From Applied Behaviour Analysis (ABA) To Positive Behavioural Support**

<b>Factors</b>	<b>Traditional ABA</b>	<b>Positive behavioural support</b>	<b>Family Support Model</b>
Focus	Problem behaviour	Problem behaviour + environment	Family members/caregivers Individual as part of a family unit
Assessment	Frequency, duration and intensity of behaviour	Behaviour change + quality of life for the individual, linked to person-centred planning	Behaviour change + quality of life for individual family members and the family unit.
Role of interventionist/professional	Define problem, select and design interventions	Collaborates with others to define, select and design interventions	Collaborates with the family who has significant input in defining, selecting and designing intervention
Relationship between interventionist and family	Interventionist decision maker and expert	Interventionist collaborates as part of a team. Joint decision making	Family and interventionist are equal but with different expertise. Joint decision making
Focus of intervention strategies	To modify problem behaviour	To modify environments	Interrelatedness of family members' environments
Intervention settings	Experimental and segregated	Home and community Embedded in family routines	Interrelatedness of family routines/ activities
Outcomes measured	Behaviour change	Individual lifestyle change	Family lifestyle change. Enhancement of family quality of life

**Table 2. Issues Goals and Strategies Identified by the Crisp Family**

<b>Issue</b>	<b>Family member</b>	<b>Associated behaviours/ Consequences</b>	<b>Goal</b>	<b>Strategies/Outcomes</b>
Each family member had very limited time to spend on her own, or to pursue her own interests.	Ms Crisp	Ms Crisp was isolated and spent large amounts of time at home with the children. Ms Crisp reported high levels of stress and depression.	For Ms Crisp to have opportunities to engage in her own interests and preferred activities.	Ms Crisp began voluntary work in a shop and attended a weekend church-run retreat while the church provided child care.
	Amelia	Amelia engaged in aggressive behaviour when required to attend most activities and often refused to go out unless with her mother.	For Amelia to engage in activities, independent of other family members.	Amelia was supported to go on outings of her own choosing independent of her sisters and mother.
Ms Crisp identified the periods just prior to and after school as being the most challenging times, with high levels of aggression and stress for the family	All	Physical aggression and injury to family members and high rates of school absenteeism.	To develop a family routine to reduce conflict and encourage school attendance.	Functional assessment undertaken before and after school in relation to Amelia's aggressive behaviour and Bridget's refusal to go to school.
	Bridget	Bridget refused to undertake personal care tasks and often refused to go to school.	To make attendance at school more appealing.	Liaison with school to arrange preferred activities to be made available to Bridget 30m prior to school commencement.

**Table 2. Issues Goals and Strategies Identified by the Crisp Family (Cont).**

<b>Issue</b>	<b>Family member</b>	<b>Associated behaviours/ Consequences</b>	<b>Goal</b>	<b>Strategies/Outcomes</b>
	Amelia	Amelia engaged in physically aggressive behaviour toward her mother and siblings	To decrease levels of aggressive behaviour	Functions of behaviour identified as ‘task avoidance’ and ‘tangibles’. Routine established by family to undertake tasks during periods of ‘no TV’.
Time spent together as a family was often stressful and centred around conflict and violence.	All	Frequent physical aggression between family members	For the family to engage in enjoyable activities together.	Family support worker facilitated family-based craft and gardening activities.
Unresolved issues for Ms Crisp and Amelia, related to past physical and verbal abuse.	Ms Crisp and Amelia	Unknown, although Ms Crisp felt that this may have contributed to her depression and Amelia’s behaviour at times.	To receive appropriate counselling related to past abuse.	Appropriate counselling services identified.
Lack of clarity with respect to current diagnoses and management of medication for the 3 girls.	All	Medication given inconsistently thereby reducing its effectiveness. School programming affected by unclear diagnosis.	To clarify diagnoses and maximise the benefits of medication.	Referral of family to a specialist developmental diagnostic clinic for children with ADHD and autism.

