

# Clinical Case Rounds in Child and Adolescent Psychiatry:

## Separation, Autism, and Residential Treatment

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### Introduction

We present the case of an 11-year-old boy with autistic disorder who developed a marked escalation in psychiatric symptoms after being removed from his family's home and placed in a residential setting. Psychiatric sequelae of separating children from their parents have long been recognized (Bowlby, 1951). Children with developmental challenges are often unable to express their feelings with regards to separation due to communicative and cognitive limitations. In addition, it is well appreciated that autistic children are highly reactive to changes in their environment. We hypothesize that autistic children may experience separation in a powerfully traumatic fashion yet may be unable to describe, understand and interpret the feelings of loss and abandonment. There are some case reports in the literature that address the traumatic impact of sexual and physical abuse on children with autistic disorder (Cook et al, 1993). Our case adds to the literature by focusing on the impact of separation and the subsequent development of profound psychiatric symptoms in a child with pervasive developmental disorder sub-type autistic disorder. Some aspects of the case have been changed in order to protect confidentiality.

### Case History

J.D. is an 11-year-old boy with a diagnosis of autistic disorder, based on DSM-IV criteria of language delay, poor social interaction and the presence of repetitive behaviours (American Psychiatric Association, 2000). Nonverbal cognitive functioning is in the normal range. He lived

in a family with two parents and a younger brother. At 18 months of age behavioral challenges increased with extensive tantrums and aggressive behaviour. Upon entering school behavioral difficulties continued, resulting in frequent periods of explosive anger towards others. He was often suspended from his classroom. At age 7, J.D. was diagnosed with oppositional defiant disorder as well as autistic disorder. He was also found to have severe disturbance of attention, concentration and impulse control. Psychiatric evaluation revealed obsessional thinking with agitation and dysphoric mood particularly during periods of transition and change.

At age 10, J.D. was admitted, via the emergency room, to a community hospital for the first time. He remained on a psychiatric inpatient unit for approximately one month. He was found to display impulsive and noncompliant behaviour, and was aggressive, particularly toward his mother. He was treated with risperidone and methylphenidate as well as with behavioral interventions. There was mild to moderate improvement in his symptoms, but at the time of discharge, his parents decided to not have him return home. He was subsequently placed in a community group home with 7 other children, visiting his parents on weekends. After a short time in the group home, his presentation changed markedly. He appeared fatigued, withdrawn, depressed and less communicative. Methylphenidate was discontinued, resulting in some improvement in his mood and energy level, but soon afterwards he became distressed and agitated. He began counting repeatedly to 21. At times, he would approach staff saying, "Please help me". He displayed symptoms of anxiety with repetitive thoughts and dysphoric mood, leading to the addition of fluoxetine to the risperidone.

Five months after his first admission, J.D. was readmitted to the inpatient psychiatric unit in an attempt to stabilize his symptoms and ameliorate his distress. While in hospital, he was generally sad and withdrawn, but at times

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became explosive and agitated. He responded positively to behavioral interventions and after 3 weeks, was discharged back to the group home.

Two days after returning to the group home J.D. became physically aggressive and injured one of his counselors. Again, he was brought to the Emergency room and was readmitted to the hospital.

A case conference was convened with representatives from the group home, child welfare, family and the inpatient team. It was decided that J.D. should return to his family and that assistance would be provided to support the transition. This decision was strongly encouraged by the treating psychiatrist in the community as well as by the inpatient psychiatrist.

J.D.'s mood and behaviour improved after moving back home to live with his family, although his parents reported that he continued to be aggressive at times, for example pinching them if he didn't get what he wanted. They reported that his mood was generally happy, and he did not engage in repetitive behaviours or express repetitive thoughts as he had done previously. His medications were gradually discontinued.

## Discussion

This case demonstrates how mental health professionals were unable to identify that escalation of symptoms in a child with autistic disorder was influenced by the impact of separation from his primary attachment figures. J.D. had a long history of oppositional behaviour but his behaviour worsened markedly when he was anxious. Failure to identify that his deterioration was associated with anxiety secondary to separation from his primary attachment figures resulted in unnecessary use of medication, costly inpatient hospitalization and prolonged distress for J.D. and his family.

It is of fundamental importance that practitioners recognize that children with autistic disorder can be very attached to their primary caregivers (Rutgers et al, 2004). Consequently, they may be highly sensitive to separation from a primary attachment figure. Separation may be experienced as emotionally traumatic, with accompanying feelings of fear and helplessness, resulting in an increase in symptoms of anxiety and agitation (Bowlby, 1960).

It is also important to recognize that the expression of trauma in all children is influenced by developmental factors (Salmon and Bryant, 2002). Recently, Scheeringa and colleagues (2006) have suggested that the diagnosis of Post Traumatic Stress Disorder (PTSD) in children be based on criteria that are more sensitive to developmental level. Children with Pervasive Developmental Disorders (PDD), especially those with intellectual disabilities, are even more limited than other children in their ability to understand, interpret and respond appropriately to trauma (Howlin and Clements, 1995). A child with intellectual disability may interpret a move to a residential setting as severe punishment. The child may lack an appreciation of time and be incapable of processing the concept of "temporary". Cognitive limitations have been shown to be a significant risk factor for the onset of PTSD after traumatic events, for children and adolescents with a diagnosis of PDD. (Turk et al, 2005)

Autistic children have a limited capacity to express affect verbally and may do so behaviorally (Howlin and Clements, 1995). When highly anxious, aggressive behaviors can increase, resulting in a "spiral effect" whereby additional medications are prescribed with little if any benefit. Side effects, such as akathisia and dysphoria, cannot easily be described by the patient but may be interpreted as agitation and mood disturbance, leading to further increases in the dosage of the patient's medications in an attempt to control symptoms.

Autistic children are overrepresented in residential settings. They often present with major behavioral challenges. Symptoms of aggression, agitation and poor impulse control may lead to psychiatric evaluation, hospitalization and/or treatment with medications. This case clearly illustrates how symptoms in this vulnerable population may escalate after being placed in a residential setting. Reaction to trauma, including the trauma of separation, should be considered in assessing such children.

## Acknowledgements/Conflict of Interest

The authors have no financial relationships to disclose.

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## Commentary on Separation, Autism, and Residential Treatment: Tapping the Strengths of the ASD Parent

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Our understanding of autism and PDD's ("ASD") has leapt forward over the last two decades, but it still confounds the most experienced clinicians. Research is beginning to provide *some* scientific data on ASD, but much remains unknown.

There is solid research to refute Bettelheim's "*Refrigerator Mother*" hypothesis. Studies also report that most ASD children do not differ in early attachment behaviours from their typical counterparts. Although a subset may display "disorganized attachment", even this may be more attributable to associated intellectual disabilities. The literature on the interactions between ASD and co-morbid mental health conditions is scarce. We know these children suffer a markedly higher risk for

psychiatric disorders (often presenting in atypical patterns). Yet, the manifestation and impact of a psychiatric syndrome in a child with ASD remains largely speculative.

The best clinical research into improving the outcomes for children with ASD remains flawed, but points to the importance of early and *meaningful* support for child *and* parent development. Though informed pharmacological treatment can sometimes be very helpful, it does not replace adequate attention to the support needs of families. The case history of *J.D.* reflects the remarkable resilience of parents in spite of daunting childhood disorders, and how appropriate supports promote better outcomes for all.

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