

Trauma and Violence in Autism

Alexander Westphal, MD, PhD

Comorbidities of autism spectrum disorder are discussed as an introduction to the argument that, although ASD may modify presentation, it does not confer any protection against other disorder, including the negative effects of trauma (e.g., posttraumatic stress disorder). Dr. Im's hypotheses are discussed, and a case example of childhood disintegrative disorder (CDD) is raised to give clinical support to his hypotheses. CDD is a rare form of ASD that is defined by late onset, a traumatic prodrome, onset of behaviors including some with similarities to PTSD, and aggression.

J Am Acad Psychiatry Law 44:198–99, 2016

Autism spectrum disorder (ASD) encompasses a variety of presentations, differing from one another along several spectra, including intellectual and language ability. ASD is more often than not associated with psychiatric comorbidities, including anxiety disorders, mood disorders, and psychotic disorders. From a clinical perspective, managing autism can be challenging. The core symptoms that define ASD, social disability, and restrictive patterns of behavior are thought to be the consequences of a distinct developmental trajectory rather than a reversible psychiatric illness, thus not easily treatable. On the other hand, many of the problematic behaviors associated with ASD, including aggression, are treatable. Untangling the contributing factors to define treatment targets must be done with an understanding that ASD itself can distort the way in which psychiatric disorders present themselves.

For example, when a child with ASD is inattentive in a school setting, it raises the question of comorbid attention-deficit/hyperactivity disorder. ASD can also be associated with hyperfocus on details in the environment, which may present as inattention, and in fact reflects attention focused on aspects of the

environment that are not salient to others. If an inappropriate focus were driving inattention, rather than true attention-deficit/hyperactivity disorder, a standard treatment such as a stimulant, may exacerbate the problem.

In some cases, ASD can mimic other disorders. Consider repetitive behaviors, for example, one of the hallmark symptoms of ASD. Repetitive behaviors can be conceptualized as representing an aspect of the primary diagnosis, or, on the other hand, comorbid obsessive-compulsive disorder. Selective serotonin reuptake inhibitors, which can be effective for obsessive-compulsive disorder, rarely have any impact on primary repetitive behaviors rooted in ASD. Another example of the way in which ASD can mimic another disorder is depression. The social disability in ASD can manifest as flat affect, social withdrawal, and reluctance to engage in group activities, all things that could also be attributable to depression.

These examples highlight the importance of a careful clinical examination as fundamental to any attempt to determine the source of problematic behavior. They also illustrate that ASD should be thought of as a pervasive disorder, with broad effects on all domains of behavior. Furthermore, they illustrate that psychiatric behaviors that co-occur with ASD should be assessed through the lens of ASD and that ASD can alter or distort them. Above all, it is important to recognize that people with ASD experience the full array of psychiatric disorders that typ-

Dr. Westphal is Assistant Professor, Division of Law and Psychiatry, Department of Psychiatry, Yale School of Medicine and Yale Child Study Center, Yale University, New Haven, CT. Address correspondence to: Alexander R. N. Westphal, MD, Division of Law and Psychiatry, 34 Park Street, New Haven, CT 06519. E-mail: alexander.westphal@yale.edu.

Disclosures of financial or other potential conflicts of interest: None.

ical people experience and that having ASD does not confer protection against any other disorder.

“Trauma as a Contributor to Violence in Autism Spectrum Disorder”¹ is interesting from the start as a consideration of the effects that traumatic experiences may have on ASD. Dr. Im suggests the possibility that people with ASD are particularly vulnerable to the negative effects of trauma. He bases this suggestion on similarities in the neuropathophysiology of ASD and the long-term neurobiological effects of trauma exposure. He then describes what links trauma histories with violence. Combining these, he theorizes that trauma may heighten the risk of aggressive behavior in ASD. Although the hypothesis is interesting for scientific reasons, discussed below, it also draws attention to the fact that, even in severely disabled children who sustain trauma, although they may not be able to describe it, the traumatic experience may have negative outcomes.

Our experience at the Yale Child Study with Childhood Disintegrative Disorder (CDD), a form of ASD, supports the idea that there is an interesting clinical overlap between ASD and trauma. CDD is a late-onset variant of ASD that is defined by dramatic regression and subsequent severe impairment, including, for the most part, profound intellectual disability (IQ <20). In most cases of CDD, the onset is associated with a prodromal phase of extreme anxiety in 70 percent of cases. Several descriptions from parents illustrate the prodrome: “appearing terrified and confused,” “constantly fearful,” “scream[ing] and cry[ing] that she was scared for no apparent reason.” Although this prodromal period does not involve classic trauma, in that there is no external agent, it is clearly a very traumatic experience.

Subsequent to the prodromal period, there is a steep decline in adaptive function, including social withdrawal and speech loss. Most of the children become hypervigilant but also have a flat, withdrawn affect, similar to the presentation of post-traumatic

stress disorder. In addition, almost half of the children become aggressive. Parents described several aggressive behaviors including scratching, biting, and hitting. In some cases the behavior was self-directed. One child began to hit himself in the head so violently that he had to be fitted with a helmet. In other cases, the aggression was directed toward others, in particular siblings and parents.

At its core, ASD is a disorder of social relatedness. Descriptions associating ASD with aggression date back to Hans Asperger’s early description of autism, which he termed “autistic psychopathy,” and his description of what he termed “autistic acts of malice.” He concluded that “the nature of these children is revealed most clearly in their behavior toward other people. Indeed, their behavior in the social group is the clearest sign of their disorder” (Ref. 1, p 77).

The relationship between violence and ASD is at the forefront of the mind of anyone who works with people who have ASD. Although the type of planned, predatory violence that has been associated with ASD in high-profile news stories is very rare and there is no indication that rates of it are higher in people with ASD, affective violence and lashing out at caretakers and family members is a very common problem, particularly in the group with ASD and comorbid intellectual disability. If Im’s hypothesis that trauma confers a particular risk of aggression and the mechanism that he posits are correct, and it is something that can be tested in an epidemiological and neuroimaging study, it would provide significant progress in a field in desperate need of information.

References

1. Im DS: Trauma as a contributor to violence in autism spectrum disorder. *J Am Acad Psychiatry Law* 44:184–92, 2016
2. Asperger H: Die “autistischen psychopathen” im kindesalter [Autism psychopathy in childhood]. *Arch Psychiatr Nervenkr [Archives of Psychiatry and Neurological Sciences]* 117:76–136, 1944