# Trauma and Compassion in the context of Autism Spectrum Disorders

**Dr Fionnuala Larkin** - Clinical Psychologist
**Dr Stephanie Petty** - Clinical Psychologist
North Yorkshire Autism and ADHD service

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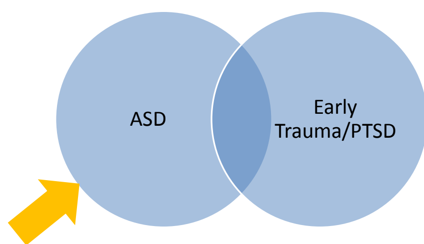
# Aims

- What are the clinical features that most clearly distinguish trauma and ASD during the diagnostic process?
- What factors render people with ASD vulnerable to interpersonal abuse?
- What might be experienced as traumatic for people with ASD?
- What areas of overlap exist in the symptomatology of ASD and trauma that clinicians need to be aware of?
- Adaptations and modifications to therapeutic interventions



# 1) Autism and Trauma






# What is ASD?

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V):

**A. Persistent difficulties in social communication and social interaction across contexts and manifested by all three of the following:**

- Difficulties in social-emotional reciprocity

*sharing topics, knowing what to say, thinking on the spot, understanding humour/gist, taking turns in conversation, taking the view of other people, sharing the interaction, being present in the interaction, enjoying a range of topics, chit-chat*

- Difficulties in nonverbal communicative behaviours used for social interaction

*reading other people, sharing eye contact, using facial expressions and gestures to tell a story*

- Difficulties in developing and maintaining relationships and friendships

*having realistic expectations of other people, having motivation to be around other people, enjoying company*



# What is ASD?

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V):

**B. Restricted, repetitive patterns of behaviour, interests or activities as manifested by the following:**

- Excessive adherence to routines, ritualised patterns of verbal or nonverbal behaviour, or excessive resistances to change

*thinking flexibly, problem-solving in the moment, understanding the benefits and limitations of rules, tolerating feeling anxious when things change*

- Highly restricted, fixated interest that are atypical in intensity or focus

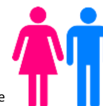
*enjoying a range of interests, moving in and out of different hobbies for enjoyment and relaxation*

- Hyper or hypo reactivity to sensory input or unusual interest in sensory aspects of the environment

*being able to tune in and out of incoming sensory information, getting the right balance of incoming sensory information*

# What is ASD?

- UK prevalence estimate 9.8 per 1,000 (Brugha et al., 2011)
- Female Presentations
  - Under-estimated prevalence
  - Masking; Imitation
  - Associated with affective disorders
  - High likelihood of being victims of interpersonal abuse



- Clinical observations beyond the listed diagnostic criteria:
  - Epilepsy
  - Non-epileptic seizures
  - Dyslexia
  - Dyspraxia

# Comorbid diagnoses

- **Anxiety disorders**
- **ADHD**
- **Depression**
- **Medically unexplained symptoms**
- **Personality disorders – Emotionally Unstable**
- **Psychotic episodes**
- **Gender identity disorders**

"Imitation: an intelligent and constructive compensatory mechanism" which can cause problems based on who is imitated. The seemingly artificial or less spontaneous behaviour can be misperceived by some clinicians as **multiple personality disorder**. Also discussed in relation to **gender identity** linked with seeking social acceptance or wanting to identify with other females/males (Attwood, 2006).



# Aetiology

- Best current understanding is that ASD is **a group of neurodevelopmental conditions** that arise from gene-environment interactions, e.g. Tordjman et al., 2014.
- Subclinical autistic traits and associated conditions (e.g. anxiety, depression, OCD) are common in family members – the Broad Autism Phenotype.



# Attachment

- Early postulated links between parenting and autism are not substantiated
- 53% of children with ASD form secure attachments (60% in TD)
- Slightly more insecure / disorganised attachment in ASD, but:

"Autism challenges the validity of attachment theory"
(van Ijzendoorn et al. 2007)

- Parents are just as sensitive as parents of TD children, but correlation with attachment security is not seen
- Attachment security is lower where ASD symptoms are higher



# Attachment

- Constitutional differences in ASD mean children are not as tuned in to cues from parents or may misinterpret typical parenting behaviour as threatening
- Attachment relationship may take longer to develop
- Our measurements are problematic
  - Parenting sensitivity looks different in ASD
  - Attachment security looks different in ASD children



# Overlapping symptoms

| • ASD | • Trauma |
|---|---|
| Low eye contact | Withdrawal |
| Low response to name | Low social interaction |
| Reduced sharing of interests | Issues with trust |
| Reduced sharing of emotion | Anxiety / Depression |
| Difficulty with relationships, understanding others | Effects on empathy, trust, turn-taking |
| Tantrums, meltdowns | Tantrums, anger |
| Eating problems | Poor appetite |
| Sleep problems | Sleep problems |
| Hypo/hyper sensitivity to sensory input | Hypersensitivity to sensory input |
| "Lives in own world" | Dissociation |
| Difficulties with pragmatic language | Difficulties with language development |
| Insistence on routine, restricted interests | Difficulty with changes, repetitive play themes |

From Weir 2017



# Overlapping symptoms

| • ASD | • Trauma |
|---|---|
| Low eye contact | Withdrawal |
| Low response to name | Low social interaction |
| **Inherent problems with reciprocity** | **Due to mistrust** |
| Reduced sharing of interests | Issues with trust |
| **Inherent problems with reciprocity** | **Due to trust being violated** |
| Reduced sharing of emotion | Anxiety / Depression |
| **Inherent problems with reciprocity** | **Due to internalised trauma** |
| Difficulty with relationships, understanding others | Effects on empathy, trust, turn-taking |
| **Deficits in theory of mind skills** | **Due to violation of trust in relationships** |
| Tantrums, meltdowns | Tantrums, anger |
| **Due to communication problems, rigidity** | **Due to emotional dysregulation** |
| Eating problems | Poor appetite |
| **Due to sensory processing, need for sameness** | **Due to mood dysregulation** |

From Weir 2017

# Overlapping symptoms

- ASD

Sleep problems
**Due to poor sleep-wake cycle**
Hypo/hyper sensitivity to sensory input
**Inherent sensory sensitivity**
"Lives in own world"
**Inherent difficulties with reciprocity**
Difficulties with pragmatic language
**Due to language delay and social understanding**

Insistence on routine, restricted interests
**Due to inherent symptoms of ASD**

- Trauma

Sleep problems
**Due to fear, nightmares**
Hypersensitivity to sensory input
**Due to hyperarousal, reminders of trauma**
Dissociation
**Maladaptive coping mechanism**
Difficulties with language development
**Due to early trauma and developmental impact**
Difficulty with changes, repetitive play themes
**Due to anxious reaction to uncontrollable events**

From Weir 2017



# Distinct symptoms

- ASD

Symptoms present from before age 3
Symptoms are consistent
Scripted speech
Repetitive or stereotypical motor movements
Fascination with moving parts of objects
Strong cognitive style
Sensory processing
Lack of awareness of mental states and emotions rather than avoidance of them

- Trauma

Follows a traumatic event
Re-experiencing
Flashbacks
Hypervigilance
Disorganised attachment style
Sensory based trauma associations

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# Distinct symptoms

- Asking about early relationships

"They seem to lack a sense of a world in which there are people with minds who could both be interesting and interested in them… an impairment of the normal sense of emotionally based curiosity about, and desire for, interpersonal relationships." (Alvarez & Reid, 2013, p. 1-2)

- A response to being different

"children who use their intellect rather than their intuition to succeed in some social situations… may be in an almost constant state of alertness and anxiety" (Attwood, 2006, pp. 29)

- The feel in the room

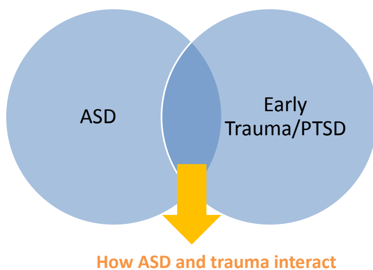


# Distinct symptoms

- Differential diagnosis

Avoidant attachment style or early emotional neglect
"Boarding school syndrome"
https://www.brightontherapypartnership.org.uk/impact-of-boarding-school/

# 2) Autism and Trauma




**How ASD and trauma interact**



# Autism and Trauma

- Increased risk of victimisation, e.g. interpersonal trauma, bullying
- Limited coping skills to respond
- Confusing social situations and sensory sensitivity can render 'ordinary' experiences highly stressful
- Experiences others might find traumatic may not be so for people with ASD

From Bargiela et al, 2016; Earl et al 2017

## Dual diagnosis

- Difficulties may manifest in atypical ways
  - Non-epileptic seizures
  - Mutism
  - Extreme avoidance
  - 'Meltdowns'
- Need for awareness of diagnostic overshadowing and mis-diagnosis



## What do you think?

- Two case examples
  - What questions would you explore?
  - ASD, trauma, neither, both?

## Assessment

- Screeners

NHS
National Institute for Health Research

**AQ-10**

**Autism Spectrum Quotient (AQ)**

*A quick referral guide for adults with suspected autism who do not have a learning disability.*

| | *Please tick one option per question only:* | Definitely Agree | Slightly Agree | Slightly Disagree | Definitely Disagree |
|---|---|---|---|---|---|
| 1 | I often notice small sounds when others do not | | | | |
| 2 | I usually concentrate more on the whole picture, rather than the small details | | | | |
| 3 | I find it easy to do more than one thing at once | | | | |
| 4 | If there is an interruption, I can switch back to what I was doing very quickly | | | | |
| 5 | I find it easy to 'read between the lines' when someone is talking to me | | | | |
| 6 | I know how to tell if someone listening to me is getting bored | | | | |
| 7 | When I'm reading a story I find it difficult to work out the characters' intentions | | | | |
| 8 | I like to collect information about categories of things (e.g. types of car, types of bird, types of train, types of plant etc) | | | | |
| 9 | I find it easy to work out what someone is thinking or feeling just by looking at their face | | | | |
| 10 | I find it difficult to work out people's intentions | | | | |



## Assessment

- The Coventry Grid
- Coventry Grid Interview

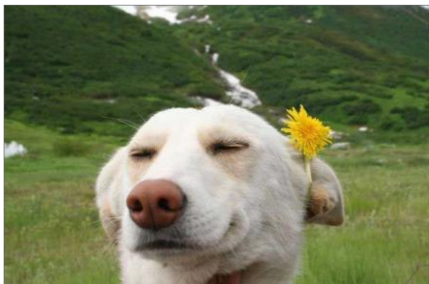
The Coventry ASD vs Attachment Problems Grid

Differences between Autistic Spectrum Disorder (ASD) and attachment problems based upon clinical experience and observations

Heather.Moran@covwarkpt.nhs.uk
heatherjmoran@yahoo.co.uk



## BREAK



## Compassion in assessment and therapy

- Reasons why people get assessed
  - To better understand themselves and increase their self compassion
  - So others can understand them and adapt to them
  - To advocate for themselves and others (e.g. autistic children, grandchildren)
- Can be healing
  - Compassion for younger self struggling without support
  - Forgiveness for social gaffs, explanation for times of difficulty
- Can be empowering
  - Enabling the person to request adjustments at work, understanding from others.
- For a minority, it feels stigmatising, depending on their defences (e.g. "It *was* me all along")

# Therapy

- Affective disorders higher in children and adults with ASD
  - Buck et al. (2014) prevalence study in Utah, n=129, 69% had lifetime psychiatric disorder.
  - Anxiety disorders in 'high-functioning' adults at 50 - 56%, compared to 3 – 12% in typical population.
  - Mood disorders in 'high-functioning' adults at 53 – 70% compared to 5 – 17% in typical population (Bruggink et al., 2016).
  - Suicide rate very high in ASD (Hedley & Uljarevic, 2018).
- Shame and self-attack:
  - Perception of ASD having made family's life harder; feeling at fault for various perceived failings in life, e.g. losing jobs; dropping out of education. Depression a cost of realising their social difficulties.
- Subject to criticism by teachers, students, family – stigmatised



# Difficulties with therapy

- Recognising and describing own emotion
  - Alexithymia higher in ASD
  - Reading and labelling emotions more difficult in ASD (Hill, Berthoz, & Frith, 2004), as are rates of depression (75% in mild or above range on BDI in Hill study).
  - Can create difficulties for emotional regulation

"I get so mad when people say 'got no feelings, can't relate to me.' I have feelings— [I'm] told [I'm] very deep . . . Trouble is wires crossed so show all this in perhaps odd bizarre fashion or in misplaced way" (a 34-year-old woman with Asperger syndrome; Hill et al., 2004)



# Difficulties with therapy

- Interoception – people with ASD less likely to be accurately tuned to body signals (Shah et al., 2016)
- Concrete thinking, focus on events rather than inner experiences, autobiographical memory differences
- Imaginal exposure
- Delayed processing of information and slower emotional response, hit after session
- Change can be scary, even positive changes
- Open-ended questions; lack of dialogue; and tangential high detail
- Check the room (sensory sensitivities; order; twiddle items)



# What do you think?

Groups – EMDR / Trauma-focused CBT etc.

- What modifications have you made in therapy?

- What modifications might you want to make?

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# Modifications of therapy

- NICE Guidelines CG142: 1.6
- Staff delivering interventions have awareness of ASD and how core symptoms may impact on treatment (which you now have)
- Consult with specialist ASD teams where needed (please do!)

https://www.nice.org.uk/guidance/cg142/chapter/1-guidance#interventions-for-coexisting-mental-disorders



# Modifications of therapy: NICE CG142: 1.6

- Modifications:
  - Concrete and structured approach with written and visual information
  - Emphasis on behaviour change as starting point to cognitive change
  - Making rules explicit and explaining their context
  - Plain English, avoiding ambiguity (metaphor can still be helpful)
  - Involving family or carers to support implementation if agreed by client
  - Offer breaks
  - Maintain interest through incorporating interests

## Trauma-focused CBT

- Possible adjustments
  - Reminder: increased risk of victimization and limited coping skills
  - When assessing, people with ASD may not generalise your questions to other scenarios and contexts
  - Psychoeducation: could use a Visual Activity Schedules (VAS)/social stories to describe the planned sessions; find optimal ways of giving information before starting
  - Individualise ways of recording SUDs
  - Coping skills: you may need to teach emotional states and physiological cues
  - Ensure coping strategies are in place outside of sessions (including basic sleep hygiene and ways to manage distress)
  - Exposure: you may need to offer an example trauma narrative because of difficulty imagining or recalling autobiographical events. Consider images/cartoons/technology
  - Discuss who to share the content of the discussions with (Earl et al. 2017)



## EMDR

- Possible adjustments
  - Difficulty visualising; intellectual descriptions and high detail
  - Communicating emotion and regulating emotion might need more attention
  - Core beliefs can be difficult to change
  - Slower information processing
  - Difficulty maintaining conversation
  - Interweaves: “Can you feel that anywhere else in your body?”
  - EMDRIA training, protocols for various age groups; “story telling method” of Lovett?
  - Ending the session
  - TAKES TIME



## Outcomes of therapy

- Can be ‘black and white’ and logical about therapy: if advised not to engage in a habit will do this perfectly, e.g. following one session using a handout.



## Resources

- Sharon McGilvery - The Identification & Treatment of Trauma in Individuals with Developmental Disabilities.
- https://netforum.avectra.com/eweb/shopping/shopping.aspx?site=nadd&webcode=shopping&prd_key=a49f76c8-c199-49b4-8274-b28462ffce9f
- University of Washington Guide on Trauma and ASD:
- https://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/1%20Therapist%20Resources/Bernier-Lab-UW-Trauma-and-ASD-Reference-Guide-2017.pdf

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## 10 questions

**What is our current evidence-based understanding of the aetiology of autism spectrum disorders?**

1. ASD stems from inadequate parenting by overly involved but emotionally aloof caregivers.
2. ASD arises from a range of environmental influences and insults, including toxins and childhood immunisations.
3. ASD is largely a genetically-based neurodevelopmental disorder arising from a complex range of gene-environment interactions.
4. ASD arises from children experiencing theory-of-mind deficits.

**According to the DSM-5, the following symptoms of ASD are classified as B. Restricted, repetitive patterns of behaviour, interests or activities:**

1. Persistent difficulties in social communication and social interaction and Hyper- or hypo-reactivity to sensory input
2. Excessive adherence to routines, Highly restricted, fixated interest and Hyper- or hypo-reactivity to sensory input
3. Excessive adherence to routines, Highly restricted, fixated interest and Difficulties in social-emotional reciprocity
4. Difficulties in nonverbal communicative behaviours and Hyper- or hypo-reactivity to sensory input

**Assessment for ASD at the Tuke Centre typically entails which of the following:**

1. Psychometric testing of personality traits
2. Observations of the client in a naturalistic environment such as at home or at work
3. Clinical interview, structured observation and, where possible, a parent interview
4. Review by a consultant psychiatrist

**People with ASD can be vulnerable to abuse because of:**

1. Unrealistic expectations of social relationships or lack of awareness around appropriate social behaviour
2. Enjoying a range of interests for enjoyment and relaxation
3. Strengths with thinking flexibly and problem-solving
4. Heightened sensory perception

**The most likely factors that influence what is perceived to be traumatic for people with ASD are:**

1. The age of onset of abuse or other trauma
2. Strengths with thinking flexibly and problem-solving
3. Enjoying a range of interests for enjoyment and relaxation
4. Sensory sensitivities and intolerance of imperfection

## 10 questions

**Succeeding in social interactions through intellectually analysing others and imitating others can be misperceived by others to be:**

1. Depression
2. ADHD
3. Personality disorder
4. Dyslexia

**Which of the following is not true of emotions in ASD?**

1. People with ASD are incapable of understanding others' thoughts and feelings
2. Alexithymia is relatively common in people with ASD
3. People with ASD can become emotionally overwhelmed by others' emotions
4. Understanding of one's own emotions can be more difficult for people with ASD

**Which of these conditions are frequently co-morbid with ASD?**

1. Attention Deficit Hyperactivity Disorder
2. Anxiety and Depression
3. Obsessive Compulsive Disorder
4. All of the above

**NICE Guidelines make which recommendation around psychological therapy for mental health conditions in people with ASD?**

1. Use the clinical guidelines for the mental health condition as usual
2. Psychological therapy is not deemed useful for people with ASD
3. There are no specific recommendations from NICE
4. Use the clinical guidelines for the mental health condition with adaptations

**Within EMDR therapy, clinicians have found it helpful to:**

1. Use brighter lights in the therapy room
2. Find ways for the client to signal their progress without conversation
3. Offer fewer therapy sessions
4. Maintain constant conversation throughout exposure