Consultation to a Group Home for a Young Autistic Woman with a History of Severe Trauma

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Abstract

A young autistic woman presented to a treatment centre following a diagnosis of Post-Traumatic Stress Disorder. Her severely disrupted behaviour was threatening her group home placement. It appeared that the sources of this behaviour stemmed, in part from an early history of severe abuse. The consequences of the abuse were evident in this client's anger, aggression, high levels of arousal and tendency to repeat the trauma in various ways. A consultation addressed to these issues resulted in improvement in the presenting problems and maintenance of her group home placement. Comorbid Autistic Disorder and Post-Traumatic Stress Disorder (PTSD) have received little attention in the literature. This is surprising given the well-documented higher frequency of abuse in individuals with developmental disabilities (Sobsey, 1994, pp.67-73). A notable exception is the description of a 12 year old autistic boy who met criteria for PTSD after experiencing physical abuse by a teacher at his school, a specialized residential school for autistic children (Cook, Kieffer, Charak & Leventhal, 1993). Cook et al. (1993) noted the potential for parents and caretakers of autistic children to perceive the impairments of the child as a blow to their self-esteem, a narcissistic injury that calls up feelings of inadequacy in the parent or caretaker. These powerful negative feelings may find expression in the punishment or abuse of the child to compensate for the painful feelings that the child has precipitated in them. In the case study presented by Cook et al. (1993), individual therapy with support for the boy's parents was undertaken with a successful outcome.

Case History

In a centre dedicated to working with developmentally handicapped individuals, our team has been providing consultation for autistic clients. The following case study is an example of one such consultation; it involved a young autistic woman who came

to us with a comorbid diagnosis of PTSD. This young woman, K., age 20, presented to our service on March, 2000, with severe behavioural problems and indicators of significant internal distress. Her behaviour included waking up at night terrified and accusing male staff of sexually abusing her, physical aggression towards staff at her group home and peers at school, repetitive questioning, and asking for harsh punishments.

She had been diagnosed with autism at age 5. At the time this diagnosis was made, K. was experiencing severe abuse that was not known to the Children's Aid Society (CAS), despite their involvement with K. and her family since K. was 3 years old. Had the severity and chronicity of the abuse been fully understood, K. would have been removed from the home by the CAS. There is no evidence that this was attempted. There was therefore at the time of the initial diagnosis of autism, potential for confounding of this diagnosis given the undisclosed abuse history. However, K. had received a recent psychiatric assessment in which the diagnosis of autism/PDD was confirmed – along with severe learning disabilities, borderline intelligence and disclosure of the abuse history. This disclosure and associated symptoms led to a further diagnosis of PTSD.

K. was born to a single adolescent mother who had had alcohol, drug and psychiatric problems. K. as an infant frequently received physically rough treatment from her mother, such as being thrown into her crib and having her hair pulled. She had, in addition, been the victim of severe physical abuse at the hands of her mother's male friends. There was also a strong suspicion that the mother's male friends had sexually abused K. As previously stated, the CAS had undertaken to investigate physical or sexual abuse of K. by the time she was 3 years old. The CAS continued their involvement until age 9. At that time, the CAS moved K. from her home when her mother was no longer willing to continue caring for K., and K. was given into the care of the maternal grandmother.

Despite the fact that no serious protection issues had been identified by the CAS, at the time she was removed from her mother's care, K. was observed to run for 45 minutes at a time, screaming "Don't hurt me" and "I'll be good." As previously noted, K.'s profound history of physical and sexual abuse was first fully disclosed by K. and her grandmother to a mental health professional during the psychiatric assessment many years later in January, 2000, at which time the diagnosis of PTSD was made.

From age 9 to 18, K. lived with her grandmother most of the time, but spent some time in group homes. At age 18, she was moved to a specialized group home for adult autistic clients. Since the disclosure of abuse by K. and her grandmother during the psychiatric assessment in January, 2000, K.'s behaviour had worsened. She was able to attend school only 50% of the time because of inappropriate or aggressive behaviour. Her acts of physical aggression were aimed at smaller or physically

handicapped students. When not on medication, she would awaken at night, both terrified and very angry. These symptoms are consistent with her abuse history.

K. was on Mellaril, Epival and Resperidol that was prescribed by the psychiatrist who had assessed her in January, 2000. She was seen as requiring male staff to contain her extremely volatile, aggressive behaviour. She would, however, repeatedly make allegations of abuse against the male staff. They had initially begun to work in pairs, but then began to refuse to work with her at all for this reason. All of K.'s allegations regarding the male staff at the current group home had been thoroughly investigated and had been proven to be unfounded.

Although the provision of 2:1 staffing for K. 24 hours a day was helpful to some extent, the costs were prohibitive. As a consequence, K.'s group home was planning to move her to a different group home. K. was referred to our outpatient autism service, which offered a consultation to the staff of the current group home at our offices on March 7, 2000, and a second consultation at the group home on May 2, 2000. The purpose of the consultations was to help staff develop a better understanding of how K.'s autism and PTSD would affect her needs for support and treatment. We did not see counselling or psychotherapy as her primary needs at this time. K. was about to lose her placement at a group home where even a sympathethic and highly trained staff was unable to contain her high levels of disruptive behaviour. Our primary goal for K. was to achieve stabilization by obtaining a secure home for her.

The March 7 consultation was offered solely on the basis of the history provided by the director and the behaviour therapist from K.'s group home and without our team having met K. Our team was composed of three psychologists, a psychiatrist, a behaviour therapist, and a speech/language pathologist. The consultation focussed on ways to alleviate K.'s repeated experiences of separation and loss, involving her mother at age 9, her grandmother at age 18, and now potentially the current group home. This part of the consultation would, it was hoped, reduce any further experience on the part of K. of one of her central traumatic experiences, that of repetitive losses of her caretakers. It would also begin to address the need of the autistic individual for continuity and predictability in their environment.

We reasoned that K.'s current allegations of abuse against the male staff at the current group home reflected her wish to get rid of the males. We therefore recommended that K. remain at her current group home, but have female staff assigned to her on an ongoing basis to create a sense of safety, continuity and reliability in her environment. These recommendations were addressed to her need for a stable environment that was related to her autism, as well as to her hypothesized need to get rid of the men, perhaps related to some of her abuse experiences involving male perpetrators.

On May 2, 2002, the group home staff were provided with further consultation by a psychologist and behaviour therapist from our team, at the group home. At the time of this consultation visit, the current behavioural program in place at the group home prior to our involvement was a system of Differential Reinforcement of Zero Behaviours (DRO). In this method, when a pre-defined interval of time in which the behaviour of concern does not occur elapses, reinforcement is given. If the behaviour of concern does occur within the pre-defined time interval, it is ignored. Some amendments to the DRO were recommended by our behaviour therapist. These included that the length of time of the DRO interval be a slightly shorter interval of time than the average of times between aggressive episodes, increasing the DRO interval in small increments contingent on K. 's success and posting of the program in an area where staff would see it frequently. The purpose of the latter was to increase consistency of administration of the program among staff.

During the May, 2000, consultation, K.'s tendency to repeat her early abuse experiences in myriad forms was discussed. For example, when being physically aggressive, K. was likely identifying with those who previously had hurt her. At such times, K. would become elated and laugh in a way that suggested that she was enjoying the discomfort of her victim. This was seen as an indicator that K. was using the defense of identification with the aggressor. K. also appeared to long to be touched and to touch, but when she did touch, she would touch with strong overtones of a sexualized, physical attack on the other. Again this appeared to reflect a repetition of her early experiences, when the wished for affectionate touch could become aggressive or sexualized. These re-enactments are a typical feature of clients who have experienced trauma (Putnam, 1997, p.300).

One of the cardinal symptoms of persons with a history of severe trauma is frequent, involuntary re-entry into states of over-arousal. To minimize this, we recommended that K. be helped to learn and practice at least daily relaxation exercises (e.g. deep breathing, progressive muscle relaxation). We recommended that she should learn to be adept in eliciting a relaxation response within herself, using the same cue each time. When this was well-established, the cue could be used by staff to remind K. to use her relaxation skills when she was anxious/excited/angry/hyperactive. Thus, an overarching goal of K.'s program would be to teach her to self-sooth. The absence of this capacity in individuals with PTSD predisposes them to use actions, such as aggression, self-mutilation and other maladaptive behaviors to achieve internal homeostasis (van der Kolk, May 2001, p.130).

K. was assigned two female support workers who were to become devoted to her care. Her sexualized and aggressive behaviours dropped dramatically following the consultations and she enjoyed a lengthy period of stability, lasting about two years. Whereas previously her care had been perceived as a burden, her two support workers regarded K. with affection and found her company enjoyable. K.'s period of stability

ended in December 2001, when her biological mother re-entered the picture over Christmas time. Her biological mother was herself in distress regarding a significant interpersonal loss she had experienced. After seeing her mother over Christmas of that year, K. again deteriorated and she was admitted to inpatient treatment of a local hospital, under the care of a psychiatrist.

Interpretation

This case demonstrates one presentation of a young autistic adult with PTSD. K.'s highly distressed sexualized and aggressive behaviour became more understandable in the context of her diagnosis of autism, complicated by the diagnosis of PTSD. Current stressors related to both diagnoses were seen as reducing K.'s capacity to cope effectively. Consultations whose purpose was to alleviate the symptoms that are the frequent result of autism and of severe abuse were found to be effective for nearly two years. While there were other stressors in K. 's life during the Christmas of 2001, given the early and severe nature of K. 's abuse experiences, it seems likely that the return of her biological mother stirred up the early traumas again, precipitating a regression in K.'s behaviour.

Awareness of the potential for autistic clients to develop PTSD may alter our understanding of some types of regressed, self-destructive or disorganized behaviour in autistic clients. With this in mind, we continue to work with K. to achieve a better understanding of her early overwhelming life experiences and how these may contribute to a more complete view of her autism. Our goal is to assist K. and her caretakers to enable K. to achieve a more lasting psychological stability, based upon a conceptualization that includes both her autistic and PTSD diagnoses.

References

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