Commentary

Geraldine Holt

The concept of autism has widened from the typical, classic or nuclear autism of Kanner (1943), to include those with the 'triad of social impairments' (Wing & Gould, 1979); that is impaired social interaction, communication and imagination which is associated with narrow, stereotyped, repetitive patterns of behaviour. These features make up the 'autistic spectrum disorders' and include Kanner's and Asperger's syndromes (Box 1).

Autism is an organically based neurodevelopmental disorder (Rutter *et al*, 1994) in which genetic factors are important (Bolton *et al*, 1994). The majority (75%) of people with autism are learning disabled, many severely. About 50% do not have speech. A variety of conditions are associated with autism e.g. maternal rubella, tuberose sclerosis, birth trauma. The different areas of brain affected may lead to additional disabilities; such cases may be described as 'atypical', as in the person presented. Additionally, an individual's personality gives them a unique adaptation to their disabilities.

In an effort to reduce later handicap, there is interest in teaching skills from an early age. Such input should be part of a wider programme designed to positively affect an individual's lifestyle across a range of settings, people and target behaviours (Singh *et al*, 1995).

The communication difficulties of people with autism, their difficult behaviour and sometimes apparent indifference to pain may mean that medical and dental problems are missed. This must be thought about when there is an unexplained change in behaviour.

Box 1. Features of autistic spectrum disorders

Triad of social impairments (Wing & Gould, 1979):
- Impaired social interaction
- Impaired communication
- Impaired imagination

Narrow, stereotyped, repetitive patterns of behaviour

People with learning disabilities are prone to develop emotional disorders (Menolascino, 1990). Cases are described in the literature of people with autism suffering from affective disorders: mania, depression, bipolar illness and seasonal affective disorder (Kurita & Nakayasu, 1994; Lainhart & Folstein, 1994) and schizophrenia-like disorders (Sverd & Montero, 1993). An association with Tourette's syndrome has also been reported (Sverd & Montero, 1993).

In the case under consideration the possibility of mental illness is raised and discounted. Making a diagnosis of mental illness in someone with limited communication is often difficult, especially when the person has particular problems in understanding emotional states and thinking abstractly, and shows a lack of vocal and facial expression, as is usually the situation in autism. Lainhart & Folstein (1994) reviewed 17 cases of affective disorder in people with autism and comment that changes in mood and self-esteem were rarely reported by the patient, but were inferred from the observations of others. Vegetative signs were present in all the patients, so their absence in the present case is important. Difficult behaviour, such as aggression, self-injurious behaviour and destructiveness, tearfulness and a family history of affective disorder were indicators of affective disorders in the patients.

Given the pattern of disabilities in autism it is not surprising that challenging behaviour is common. It is likely to occur when routines are changed or there is a lack of routine; when due to poor communication skills, messages are misunderstood (either by the person with autism or others); when inappropriate social pressures are applied, or when demands are made beyond the person's ability. It may take many forms including aggression, self-injurious behaviour and an increase in repetitive stereotyped behaviour.

When thinking about interventions to help people with autism with emotional disorders it is appropriate to first consider prevention. Reference has already been made to work to increase skills and reduce disabilities. Whether this reduces vulnerability to later emotional disorders is not known. A degree of structure and routine to life is

Dr Geraldine Holt is a Consultant and Senior Lecturer in Psychiatry, Division of Psychiatry and Psychology, Section of Disability, UMDS (Guy's Hospital), London SE1 9RT.

https://doi.org/10.1192/apt.2.4.176 Published online by Cambridge University Press

Box 2. Issues to consider if behaviour changes

Is the person physically unwell?
Has there been a change in the person's routines or environment?
Has a communication been misunderstood?
Is the person under too much social pressure?
Is the person mentally ill?

needed, with carers who are sensitive to and knowledgeable about the needs of the individual. This will allow change to be managed more appropriately, taking account of the person's communication skills. Life events predispose people with autism to depression (Ghaziuddin *et al*, 1995). Awareness by carers of the potential impact of, for instance, bereavement will enable them to provide or seek relevant support for the individual and hopefully avoid unnecessary distress.

Careful assessment of a client may lead to hypotheses as to the function of a difficult behaviour which can then be tested by manipulating the variables. This assessment might include, (apart from taking a history from the client, if possible, and others, and performing a physical and mental state examination), behavioural observation, and the use of behavioural questionnaires and interviews. The information may allow steps to be taken to avoid the setting conditions which increase the likelihood of the behaviour occurring, e.g. reducing noise levels. Such an approach has the advantage of not requiring extensive staff training to implement, special vigilance or structuring of contingencies. It is not unusual to find several factors contributing to the occurrence of the behaviour, and the intervention should take account of these. Luiselli *et al* (1994) describe such an approach in a man with severe ruminative vomiting. However, it is not always possible to identify the factors maintaining behaviour in those with long-standing problems (Singh *et al*, 1995). They suggest the use of behavioural momentum in such cases.

There is controversy about the use of medication to control behaviour when there is no psychiatric diagnosis (Berry & Gaedt, 1995). Its use in those with mental illness can be very beneficial. People with autism are often sensitive to medication (Wing, 1994), so caution is necessary. Lainhart & Folstein (1994) suggest that mania is unlikely to respond to major tranquillisers alone, but may require the addition of lithium or valproic acid; whereas depression may respond to either lithium, carbamazepine or fluoxetine alone. In the cases they reviewed tricyclics were generally unsuccessful. In some not only did mood improve but so did the autistic features. Gordon *et al* (1993) provide evidence that serotonin-reuptake inhibitors improve autistic features and repetitive behaviours in people unselected for mood disorder. Further work in this area is needed. Psychotherapeutic techniques may be helpful, providing these are tailored to the individual's level of understanding and communication skills.

It is to be hoped that as our knowledge of autism grows we will be better able to help people reduce their disabilities and their effects by providing appropriate environments and interventions.

References

Berry, P. & Gaedt, C. (1995). Psychiatry of mental retardation. *Current Opinion in Psychiatry*, **8**, 293–300.

Bolton, P., MacDonald, H., Pickles, A., *et al* (1994) A case-control family history study of autism. *Journal of Child Psychology and Psychiatry*, **35**, 877–900.

Gordon, C. T., State, R. C., Nelson, J. E., *et al* (1993) A double–blind comparison of clomipramine, desipramine, and placebo in the treatment of autistic disorder. *Archives of General Psychiatry*, **50**, 441–447.

Ghaziuddin, M., Alessi, N. & Greden, J. F. (1995) Life events and depression in children with pervasive developmental disorders. *Journal of Autism and Developmental Disorders*, **25**, 495–502.

Kanner, L. (1943) Autistic disturbances of affective contact. *Nervous Child*, **2**, 217–250.

Kurita, H. & Nakayasu, N. (1994) Brief report: an autistic male presenting seasonal affective disorder (SAD) and trichotillomania. *Journal of Autism and Developmental Disorders*, **24**, 687–692.

Lainhart, J. E. & Folstein, S. E. (1994) Affective disorders in people with autism: a review of published cases. *Journal of Autism and Developmental Disorders*, **24**, 587–601.

Luiselli, J. K., Medeiros, J., Jasinowki, C., *et al* (1994) Behavioural medicine treatment of ruminative vomiting and associated weight loss in an adolescent with autism. *Journal of Autism and Developmental Disorders*, 24, 619–629.

Menolascino, F. (1990) The nature and types of mental illness in the mentally retarded. In *Handbook of Developmental Psychopathology* (eds M. Lewis & S. Mill), pp. 397–408. Plenum.

Rutter, M., Bailey, A., Bolton, P., *et al* (1994) Autism and known medical conditions: myth and substance. *Journal of Child Psychology and Psychiatry*, **35**, 311–322.

Singh, N. N., Oswald, D. P. & Ellis, C. R. (1995) Behavioural methods in mental retardation. *Current Opinion in Psychiatry*, **8**, 290–292.

Sverd, J. & Montero, G. (1993) Brief report: cases for an association between Tourette syndrome, autistic disorders, and schizophrenia–like disorder. *Journal of Autism and Developmental Disorders*, **23**, 407–413.

Wing, L. (1994) The autistic continuum in mental health. In *Mental Retardation* (ed. N. Bouras), pp. 108–125. Cambridge: Cambridge University Press.

—— & Gould, J. (1979) Severe impairments of social interaction and associated abnormalities in children: epidemiology and classification. *Journal of Autism and Developmental Disorders*, **9**, 11–29.

https://doi.org/10.1192/apt.2.4.176 Published online by Cambridge University Press