Dealing with Trauma in Individuals with Autism Spectrum Disorders: Trauma Informed Care, Treatment, and Forensic Implications

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Abstract

Trauma is prevalent in the lives of adults with an autism spectrum disorder (ASD). As a result, a routine screening for trauma is essential especially when autism-related symptoms are heightened or when violence is exhibited. Case studies and empirical analyses of individuals with ASD and trauma have indicated that traditional Post-Traumatic Stress Disorder (PTSD) as well as PTSD characterized by hyperarousal, and mood disorders have been diagnosed. After trauma is identified and the changes in functioning assessed, a safety plan, effective secure care management, behavioral support planning, trauma informed care, and treatment are important areas to address. Guidelines which are sensitive to the needs and proper treatment for all of these forensic areas will be discussed. Recommendations for future trauma research are also presented.

Keywords: Autism spectrum disorders; trauma; post-traumatic stress disorder; PTSD; treatment.

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Allely and Faccini (2019) have previously emphasized the importance of identifying traumatic experiences in individuals with autism spectrum disorder (ASD) who become involved in the criminal justice system in order for appropriate follow-up forensic interviews and criminal investigations to take place. For these reasons, it is appropriate for examiners to *rule out the occurrences of traumatic stressors* when evaluating individuals with an ASD. Use of the Trauma Information Form (Hill, 2012) and the Trauma Symptoms Investigation Form in Autistic Spectrum Disorders (TIF-ASD, see Mehtar & Mukaddes, 2011) to assess trauma and any changes in functioning, and then any pathological symptoms/disorders would be essential. The TIF-ASD (Mehtar & Mukaddes, 2011) examines changes in verbal communication, behavioral problems, stereotypical and ritualistic behaviors, self-care skills, and vegetative symptoms. Primary disorders such as traditional PTSD as well as PTSD characterized by hyperarousal, and mood changes should be assessed. The presence of other comorbid disorders or mental health conditions should also be assessed.

Screening for trauma should be integrated into routine assessment and also carried out when ASD-related symptoms are heightened and/or when the individual exhibits violent behavior. After trauma is identified and the changes in functioning are assessed, a safety plan, effective secure care management, behavioral support planning, trauma informed care, and treatment are important areas to address next. Guidelines sensitive to the needs and proper treatment for all of these forensic areas will be explored in the present article. It is important to highlight what is forensic secure care. Forensic secure care services provide care for mentally disordered offenders. In England in the United Kingdom (UK), this is provided at three different

levels of security including: low, medium, and high. It is also important to note that a large number of patients within these particular secure care settings remain detained for protracted periods of time.

Individuals with an ASD within various forensic settings are potentially more vulnerable to being set-up, exploited, taunted (Goldman, 1999; Murphy & McMorrow, 2015) and abused (Myers, 2004). They often received poor services (Barron et al., 2004), and have longer secure care stays when compared to other patients (Hare et al., 1999). Staff usually do not consider any difference in care that an individual with an ASD may require (Murphy & McMorrow, 2015) which is primarily due to a lack of training and resources (Schacht & Monihan, 2004). As a result, staff experience a universal frustration when caring for an individual with IDD/MI (Schacht & Monihan, 2004) and it has been highlighted that antipsychotic medications are routinely used despite little evidence for treatment efficacy and also the potential serious health concerns of taking antipsychotic medications (Clare & Murphy, 1998; Antonacci et al., 2008; Matson et al., 2009; Matson & Neal, 2009; Oliver-Africano et al., 2009; Tyrer et al., 2008). An IDD/MI dual diagnosis refers to individuals with an intellectual/developmental disability (IDD) who are also experiencing a mental health condition. Typical secure care settings have relatively few resources to help health care professionals address how to most effectively decrease offending behaviors in individuals with ASD (Goldman, 1999).

There are a number of areas where the combination of trauma and ASD may have forensic implications. We outline six of the key areas below.

1. Consistent with trauma informed care, routine screening for trauma is good clinical practice. Due to diagnostic overshadowing (where difficulties are primarily attributed to/or assumed to be related to the patients ASD or coexisting mental health condition

and other causes of the patient's symptoms are not fully explored), practitioners in forensic hospitals (secure psychiatric care) and criminal justice settings may not identify trauma or misattribute traumatic symptoms to ASD and behavioral difficulties and challenges. As a result, the forensic case conceptualization may not include trauma and its pathological sequelae. It is recommended by Hall and Dow (2017) that case conceptualization is critical particularly given the lack of any current risk assessments for violence or sex offending for individuals with ASD. All current risk assessments are normed on neurotypical individuals (Murphy, 2013; Westphal & Allely, 2019). If trauma is unrecognized and not addressed, the individual with ASD may remain unstable, and not benefit from the other treatments provided. Unidentified trauma and its sequelae may function as a treatment interfering factor. Shrine and Cooper-Evans (2016) developed an ASD specific framework for forensic case formulation. They recommend identifying autistic symptoms and carrying out appropriate diagnostic assessment(s), carrying out an assessment of the index offense using a behavioral analytic (i.e., antecedent-behavior-consequence) framework, and then determining exactly how ASD features may be functionally linked to the offending behavior (how the various features of ASD may have provided the context for vulnerability to engaging in offending behaviour). They suggest an analysis of any behaviors that may be exhibited during a forensic placement, particularly if it is similar to the index offense. We suggest that screening for trauma and its sequelae should be added to their forensic conceptualization framework so that it is more comprehensive and avoids or reduces the chances of the symptoms of trauma being misidentified or unrecognized.

2. Clinical experience also suggests that forensic practitioners may not identify traumatic experiences and triggers for individuals with ASD who are court placed due to a violent offense. In these instances, violence attributed only to a behavioral function (e.g., for the purposes of obtaining attention, obtaining a desired item, escaping an undesirable condition or for sensory stimulation) may not be differentiated from violence which is caused by traumatic triggers. Violence may only be viewed as being primarily arising in order to serve a behavioral function. Despite behavioral stabilization, when a traumatic trigger is encountered in the secure site, the person with ASD may relapse and engage in "defensive" behavior with near lethal violence (as in the index offense). There is a clear advantage to differentiating different types of violence and their aetiology in order to inform appropriate treatments that would address the type of violence that the individual engaged in.
3. Often times in a forensic hospital, individuals are placed in seclusion and/or restraint due to dangerous behaviors. The identification of past traumas would be critical especially when evaluating if physical and/or mechanical restraints should be utilized to help contain dangerous behaviors. Unrecognized trauma could lead to a heightened fight response and contribute to an increased possibility of the ineffectiveness of physical restraint which may subsequently result in a heightened risk for injuries and re-traumatization. Tucker (2002) identified trauma as complicating/hindering treatment efficacy and that it should be assessed when considering physical restraint of the patient.
4. Trauma re-enactment may also interfere with behavioral management involving false/ unsubstantiated allegations of abuse against secure care staff. Faccini and colleagues (2013) previously identified two trauma-related dynamics, namely, triangulation and re-

enacting trauma, that directly relate to the false allegation of abuse against staff. Subsequent clinical experience suggests that the same conditions contribute to false allegations from individuals with an ASD (Faccini et al., 2013). The first trauma-related dynamic involves a triangulation situation, the false allegation re-enacts the perpetrator-victim-rescuer/helper triangle which is also known as the Karpman Triangle (Karpman, 1968). An individual with an ASD may have an identified and/or unresolved trauma of being physically attacked, and the trauma sequelae involves frequently finding or putting himself in a situation where another peer attempts to physically attack them. As a result, when staff intervene and separate them, the individual with ASD and a trauma history continues to be frustrated and angry, and since they were not able to retaliate towards the other peer, alleges that staff attacked them. An interpersonal triangle is set up where the peer that initially attempted to attack is perceived (by the individual with ASD and trauma) as the perpetrator, the person almost attacked the "victim", and the staff functions as a "helper or rescuer". Due to the experience of being victimized again, the interpersonal roles are easily reversed, and the staff as helpers/rescuers are then regarded by the initial "victim" with ASD as persecutors and they subsequently align themselves with the other aggressive peer. An amended investigative procedure in addition to trauma informed care and therapy have been found to be effective in managing future instances of false allegations. The second trauma-related dynamic involves false allegations of abuse being made due to re-enacting a past trauma. This situation involves an individual with trauma encountering an unknown traumatic trigger and subsequently makes the allegation that a member of staff attacked them in a manner consistent with the long past injury which resulted in trauma. In essence, upon admission, it is critical to

identify trauma and its sequelae in order to inform the development of therapeutic guidelines for staff to follow in order to reduce the chances of false allegations of abuse against a member of staff. It is advantageous to identify these trauma sequelae as early as possible for the purposes of management and treatment and also to avoid unnecessary civil, criminal suits or human resources administrative hearings.

5. According to the Pennsylvania Coalition Against Rape (2011), a sexual assault forensic examination needs to be adapted for an individual with an ASD. Overall, these guidelines are deemed necessary since the "noise, smells and bright lights" of an emergency room in a hospital may cause issues for some adults with ASD. Specifically, the "noise, smells and bright lights" of an emergency room may result in difficulties focusing on the questions being asked, understanding and processing the questions and expressing themselves". Guidelines have been developed for the practitioner or health professional to calm and empower the individual. Some examples of aspects to consider in these guidelines include: the recommendation that the practitioner identify themselves and state what their role is, speak to the individual and not primarily to accompanying family or staff, stay with the person and make communications short and precise, ask what the individual may want and respect their decisions. The guidelines also recommend that the examiner should break down the stages of the exam into smaller and understandable parts. Guidelines also recommend that the examiner also ask law enforcement officers and other hospital staff to ask one question at a time and to wait patiently for a response. Neutral nonverbal and verbal communication is important so not to encourage inappropriate acquiesces on the part of the patient.

6. Murphy and Allely (2019) highlighted that addressing violent behavior and trauma in individuals with ASD in high secure psychiatric care (HSPC) is a highly specialized area, even for experts in ASD. There is a need for such specialty services (providing more individualized, sensitive care) especially due to the difficulties and challenges that these settings experience in assessing and treating these individuals (see also, Allely, 2018).

Trauma Treatment for Individuals with Developmental Disabilities

Once trauma has occurred, the development of a safety plan is essential. The National Sexual Violence Resource Center (2015) recommended creating a safety plan that was adapted for individuals with ASD. This plan would address who the individual could trust, ensuring that staff routinely checking in on them, putting in specific measures to prevent future abuse or hurtful situations from occurring, obtain contact information regarding law enforcement, caregivers etc.

Charlton and Tallant (2003) outlined how trauma therapy should be modified for individuals with a developmental disability. They modified the four phases of *Acknowledgment, Safety and Competency, Processing the Trauma, and Transitioning beyond the Trauma*. In regard to *Acknowledgment,* the practitioner should take extra care and time explaining the trauma to the individual and also listen for misunderstandings and address them as soon as they arise. Also informing the individual's support system regarding the nature of the trauma, how threatening it was, explaining that the individual's reaction to the trauma is normal, providing information to ensure that they do not misattribute post trauma symptoms to the patients ASD and/or coexisting mental health condition(s) (diagnostic overshadowing) is crucial. The individual's experience should be respected and they should be informed that not everyone's

response to their trauma will be supportive. *Safety and Competency* involves the support system ensuring that the individual's various environments are safe and addresses those facets which are unsafe. It involves the support system ensuring that the individual re-engages in a normal routine and regimen of self-care. Essentially, the support system should support the individual to transition from a sense of helplessness to feeling in control of their environment and self, mainly through promoting assertiveness and self-advocacy. *Processing the trauma* should be from a perspective of safety, empowerment and competence by using play therapy, art therapy and even social stories to process thoughts and feelings about the trauma and address the worst aspects of the trauma for that person. *Transitioning beyond the trauma* involves the individual using their new understanding about what occurred as well as their new competence, self-protection and advocacy skills and rehearsing the use of these skills in order to aid them to more appropriately handle triggering situations that they may encounter in the future.

Specialized treatments have also been developed for use with adults with ASD and trauma including trauma-informed behavioral interventions (Harvey, 2012), a group therapy program (Razza & Tomasulo, 2015), and Eye movement desensitization and reprocessing (EMDR) therapy (Kostka & Ona, 2014; Lobregt-van et al., 2019). In regard to trauma-informed behavioral interventions, Harvey (2012) advocates a recovery, strength-based approach and recommends addressing safety, empowerment and connection in the behavioral plan. She identifies safety as having understanding and supportive staff who provide comfort, physical safety and meet an individual's social, emotional and medical needs. There may also be the identification of a "safe person" which the individual can seek help from when they are feeling overwhelmed. Empowerment entails the staff doing the following: assisting the person to make real choices and provide meaningful input in order to assist the individual in developing a good

life, listening to them and providing a "real caring" approach. Her keys to connection involve fostering good peer and staff relationships by learning and practicing communication and listening skills. Harvey (2012) recommends including positive identity development and addressing pleasure, achievement and finding meaning in one's life. Developing a positive and successful identity should be developed first so that trauma can be addressed from a position of strength.

With regards to group therapy for individuals with developmental disabilities (including ASD) and trauma, Razza and Tomasuleo (2015) developed a "behavioral-interactive group therapy" where change in behavior is an outgrowth of the connection and communication between the individuals in the group. The process progresses from a warm-up stage where the individuals greet, orient towards each other, and where trust and safety issues are addressed. The warm-up and sharing phase includes a deeper discussion of issues and the selection of a protagonist. During enactment, psychodramatic techniques are used to explore issues, modify interactions and develop coping skills. The affirmation stage entails praising participation and prosocial behavior as well as affirming change. Efficacy data suggests that this approach is perceived as helpful, improves self-esteem, interpersonal relationships (Lundrigan et al., 2007), and global functioning (Daniels, 1998). However, efficacy data directly related to traumatic symptom abatement is urgently needed.

Another treatment that has some research support is Eye Movement Desensitization and Reprocessing therapy (EMDR). Kosatka and Ona (2014) investigated the effectiveness of EMDR for a 21-year old female with Asperger's Disorder who had experienced multiple traumas deriving mainly from physical abuse inflicting on her by her school peers. With therapy three times per week for three weeks (involving eight EMDR sessions), they reported improvement in

PTSD symptoms which were found to be maintained at an eight month follow-up. Lobregt-van, Sizoo, Mevissen and de Jongh (2019) investigated the use of EMDR for individuals with ASD and exposure to past adverse events over eight weeks of therapy and found when EMDR was added to talk therapy, significant improvements in the reduction of autistic features, PTSD and psychological distress were observed. Overall, investigations in the use of EMDR to date suggests that it could be an effective treatment for individuals with ASD. However, more empirical, larger scale studies are needed.

An area that has been relatively unexplored is the symptom overlap between ASD and PTSD. Disentangling whether the observed sensory processing impairment is related primarily to the ASD in the adult or their PTSD. Adults with ASD have been reported to have experience difficulties processing sensory information across the range of modalities (sounds, sights, touch and smells). The difficulties in processing sensory information can range from hypersensitivity (acute, heightened or excessive sensitivity) to incoming stimuli which includes strong reactions to sounds which are loud and sudden, bright lights, fluorescent lights, the touch of others or one's own clothes and strong smells, to hyposensitivity to incoming stimuli which would be considered below normal (Crane et al., 2009). Neuro-typical individuals with PTSD were reported to have extreme responses to sensory stimulation and common psychophysiological characteristics similar to people with sensory processing impairments, such as those found in some individuals with ASD. Different sensory methodologies (i.e., deep pressure message, qigong massage, weighted garments and blankets, etc.) have been used with sensory processing problems. However, no study to date has examined the use of these modalities as an aid to treatment for adults with ASD and PTSD which underscores the need for further research.

Conclusion

Until now, there has been very little research which has looked at the association between trauma and ASD. As highlighted by Allely and Faccini (2019), there is a very real need for further research investigating the association between trauma and ASD. Further research is required in order to explore the potentially unique perception of traumatic events (most notably from the social domain) in individuals with ASD (Haruvi-Lamdan et al., 2018). Additionally, further research is needed to explore the possibility and ways in which individuals with ASD may manifest symptoms of traumatic stress in a distinct manner when compared to typically developing individuals and the traditional diagnostic criteria for PTSD (Kerns et al., 2015). The knowledge from such research is of significant importance to the identification of trauma in individuals with ASD and to increase our understanding of the posttraumatic clinical picture in individuals with ASD. This understanding can help inform the development of (or modification of existing interventions) appropriate and timely treatment strategies and support measures/interventions (Haruvi-Lamdan et al., 2018).

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