TRI-STATE WEBINAR SERIES

Catatonia and ASD: Hidden in Plain Sight

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The Ziggurat Group

Tri State Webinar Series 2015-2016

Tri-State Autism Spectrum Disorder Webinar Series

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Polling Questions

- Interactive feature used throughout the webinar

What is your role?

What is your role?

- Administrator
- Parent/Family Member
- Related Service Professional
- Teacher
- Other
- No Vote

What state are you from?

What state are you from?

- Colorado
- Kansas
- Nebraska
- Other
- No Vote

Presenter Information

RUTH ASPY, Ph.D., is a licensed psychologist who specializes in transdisciplinary assessment and intervention for individuals with autism spectrum disorders. She is co- creator of a comprehensive model of intervention, the Ziggurat Model. Along with Dr. Barry Grossman, Dr. Aspy has written The Ziggurat Model, which earned the 2008 Literary Achievement Award from the Autism Society of America. The Model is being used successfully throughout the United States and internationally in countries including Japan, Greece, Canada, and Mexico. Dr. Aspy speaks nationally and internationally.

BARRY G. GROSSMAN, Ph.D., is a licensed psychologist and author. He is in private practice with the Ziggurat Group and specializes in assessment and intervention for individuals with autism spectrum disorders. Dr. Grossman, along with Dr. Aspy, wrote The Ziggurat Model—a book on designing interventions for students with Asperger's Disorder and high-functioning autism. He and his co-author present on this model internationally. The Ziggurat Model has been adopted at the district-wide and state-wide levels.

Learner Objectives

- List three red flags for catatonia in ASD
- List the two primary forms of medical treatment
- Describe psychological intervention strategies that are helpful for individuals with ASD and catatonia

Presentation Summary

- Catatonia is a treatable condition that can be identified based on symptoms.
- Deterioration in psychomotor functioning and an increase in unresponsiveness are red flags for catatonia in ASD.
- Both medical and psychological interventions are recommended for individuals with ASD and catatonia.

Catatonia

A disorder of posture/movement, speech, mood, & "behavior."

DSM-5 Catatonia Associated with Another Mental Disorder (Catatonia Specifier)

1. Stupor
2. Catalepsy
3. Waxy flexibility
4. Mutism
5. Negativism
6. Posturing
7. Mannerism
8. Stereotypy
9. Agitation, not influenced by external stimuli
10. Grimacing
11. Echolalia
12. Echopraxia

Same Thing – Different Words

"Psychiatrists, neurologists, pediatricians, psychologists, and other child specialists often have their own criteria and terminology that are never compared **across disciplines**. Like with the Tower of Babel, synergy that may advance the field of autism and catatonia is lost due to **confusing diagnostic terminology** among specialties."

(Dhossche, Shah, Wing, 2006, page 269)

4 to 17 percent

of adolescents and adults with ASD have catatonia

(Wing and Shah, 2000, Billstedt et al., 2005, Oheta et al., 2006, Hutton et al., 2008, and Ghaziuddin et al, 2012)

Onset

- Between 10 and 19 years
- Often gradual

(Wing and Shah, 2000)

ASSESSMENT

Imperative

"Catatonia should be considered in any patient if there is an obvious and marked deterioration in psychomotor function and increase in unresponsiveness compared with previous levels" p. 465

Dhossche and Wachtel (2008)

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Red Flags For Catatonia in ASD

- Markedly increased psychomotor slowness
- May also display alternating excessive motor activity (purposeless and not influenced by external stimuli)
- Extreme negativism or muteness
- Stereotypy
- Peculiarities of voluntary movement
- Echolalia or echopraxia

(Dhossche, 2014)

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Identification of Catatonia in ASD

- Typical catatonia assessment may not apply well to individuals with ASD and catatonia.
- Dhossche, Shah, & Wing (2006) proposed new criteria for recognizing catatonia in ASD (e.g., Decreased speech is used in place of mutism)

Dhossche, Shah, & Wing, 2006

Identification of Catatonia in ASD

Criterion A:

- Immobility, drastically decreased speech, or stupor of at least 1 day duration, associated with at least one of the following: catalepsy, automatic obedience, or posturing

Dhossche, Shah, & Wing, 2006, p.272

Identification of Catatonia in ASD

Criterion B

In the absence of immobility, drastically decreased speech, or stupor, a marked increase from baseline, for at least 1 week, of at least two of the following: slowness of movement or speech, difficulty in initiating movements, or speech unless prompted, freezing during actions, difficulty crossing lines, inability to cease actions, stereotypy, echophenomena, catalepsy, automatic obedience, posturing, negativism, or ambitendency

Dhossche, Shah, & Wing, 2006

Examples of Shared Motor Features in ASD and Catatonia

- Selective mutism
- Staring
- Rocking
- Repetitive head banging
- Tics
- Obsessive–compulsive features

Case study
14 Year Old Female - Diagnosed with autism from early age
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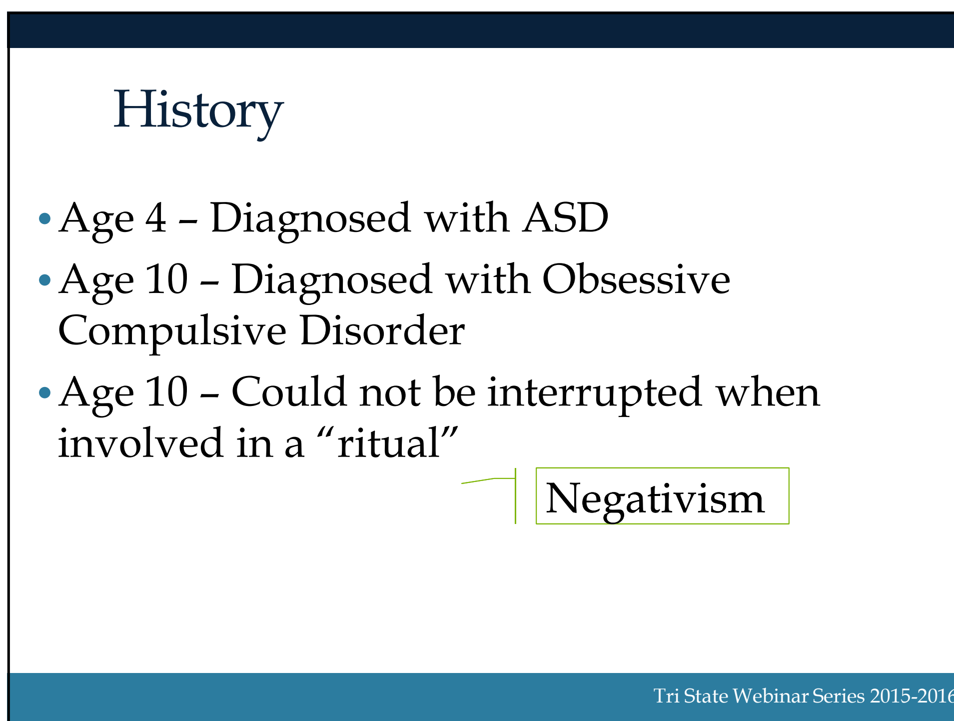
History
• Age 4 – Diagnosed with ASD
• Age 10 – Diagnosed with Obsessive Compulsive Disorder
• Age 10 – Could not be interrupted when involved in a "ritual"
Negativism
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History: School Records

- Age 10
  1. **Prompt Dependent** for completing work and transitioning
  2. **Physical "Aggression"** – lunging toward, hitting and kicking others [more appropriately described as purposeless agitation]

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School Records

Age 14 (current)

- Charges at and hit others — Excitement/Agitation
- Has difficulty transitioning into building — Dystonia/Negativism
- Stares off, laughing, and mumbling to self — Unmotivated eccentricity
- Starts to talk to nobody — Unmotivated eccentricity
- Sleeps during the school day — Reversal of day/night

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Additional Concerns

Stupor with mutism

Age 14 (current)

- Stares off as if she does not hear directions – nonresponsive
- "**. . . clearly wanted to complete the task, *but for some reason* could not get started.** While it took a long time for her to point, once she did, she continued pointing on the following items. **It was as if she had to be *primed*.**"

Dystonia/Negativism

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Additional Concerns (Choice Vs. Disease)

Age 14 (current)

- Displays "shut down" behaviors – " During these periods, she stared off, shut her eyes as if she was asleep, & did not respond to voice. **Even when she was offered a highly valued reinforcer at these times** (i.e., chocolate candy), **she still did not respond**."

Stupor with mutism

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Additional Concerns

Age 14 (current)

- Significant weight loss
- Hospitalized for not eating/drinking
- Sudden occurrences of "aggression" [purposeless agitation/destructive behaviors]
- Repeats own words
- Endless pacing

Catalepsy/Negativism

Excitement/Agitation

Echolalia/Verbigeration

Excitement/Agitation

Additional Concerns

Age 14 (current)

- Grabbing others spontaneously
- Difficulty crossing thresholds (e.g., classroom to hallway)
- Property destruction
- Hitting parents and staff

Excitement/Agitation

Immobility

Excitement/Agitation

Excitement/Agitation

Immobility
&
Excitability

TREATMENT

Fink's View of Catatonia

Treatment for catatonia in ASD will not "cure their social problems [autism]. When patients also have catatonic signs, treat it as an independent syndrome. You will find that once catatonia is relieved, many signs of autism are relieved as well."

Fink, Personal Communication (12-29-15)

Fink's View of Catatonia

"The best explanation for failure to respond to treatment is inadequate treatment."

Fink, Personal Communication (12-29-15)

Summary – "Incredibly Simple"

1. Benzodiazepines (Lorazepam)
2. Discontinue antipsychotics
3. ECT

Wachtel (2013)

Poll

- How many of you live or work in a community where there is a fear of ECT?

"Antipsychotic agents should be discontinued because they are contraindicated in patients who exhibit the signs of catatonia because of the reported increased incidence of malignant catatonia or NMS in patients with incipient signs of catatonia" p.465

Dhossche and Wachtel (2008)

Need for Screening & Early Support

"Following all types of treatment, patients may continue to display catatonic symptoms and are **unlikely to return to baseline levels of function**. This may be **particularly** true where there has been a **long duration of catatonic symptoms before effective treatment**. There is some indication that **early intervention** may be more successful."

(DeJong, Bunton, & Hare, 2014, JADD 44 page 2134)

Psychological Interventions

1. Use verbal or gentle physical prompts
2. Identify and reduce stress
3. Keep active (e.g., walk, trampoline, dance)
4. Maintain predictable structure & daily routine
5. Provide enjoyable activities
6. Caregivers should remain **positive** in their interactions

Shah & Wing, 2006

Verbal Prompts

Prompts are often needed to initiate or discontinue an activity.

- **Verbal**: can include use of person's name or providing instructions for each action. Repetition of prompt is often required.

Shah & Wing, 2006

Physical Prompts

Prompts are often needed to initiate or discontinue an activity.

- **Physical**: start with light touch. Increase as necessary to initiate movement.

Shah & Wing, 2006

Standing Still

- Use verbal prompt or light touch to help initiate movement. **Then immediately engage person in an activity.**

Prompts

"**Prompts** are **necessary** to enable individuals...**to overcome** the difficulties in the central control of voluntary movement **and** gradually **regain** their **independence**"

(Shah & Wing, 2006 p.256).

Prompts → Independence

(Prompts keep them moving)

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Prompts

"If left to their own devices and expected to learn the 'hard' way, the person concerned may become increasingly **unable to initiate movements** and gradually less active and less independent" (Wing and Shah, 2006 p.256).

Prompts → Independence

(Prompts keep them moving)

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Poll

- How many of you find it challenging to think of providing a prompt as a way to build independence?

Eating Problems

- Problematic due to complex motor coordination required (e.g., eating with utensils; movements of lips, jaws, and tongue)
- Use verbal and physical prompts (e.g., light touch on elbow, cheek, or touch lips to loaded spoon)
- If prompts are not effective – feed the person

Shah & Wing, 2006

Excitement (Destructive Behavior)

- Verbal suggestions to do something different
- Mild physical restraint, or simply physically leading the person into a different environment and prompting them to sit down
- After the episode: Reassure and encourage person to carry on with normal routine

Habit and routines make life better

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Prompts

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Prompts Discussion

"Once I had access to that, my own movement kicked in again."

Identify and Reduce Stress: Stress can trigger catatonia

Stress can come from a variety of sources including:

- Unstructured environments
- Loss of routine & structure
- Programs that fail to properly address the ASD
- Loss of meaningful activities

Shah & Wing, 2006

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Identify and Reduce Stress: Stress can trigger catatonia

Stress can come from a variety of sources including:

- Tests
- Increased social, adaptive & independence demands
- Significant life events
- Conflict
- Illness, pain, hormonal changes

Shah & Wing, 2006

Stress

Maintain and Increase Activity Level

- Keep individual **active, goal-oriented, and stimulated**. Use **1:1 support** if needed.
- Activities requiring **rhythmic, repetitive movements** are believed to be beneficial (e.g., swimming, walking, dancing, cycling, jumping on trampoline). Participating in a small group may also be beneficial.
- **Avoid activities that are physically strenuous** and those that the person finds to be difficult.

Shah & Wing, 2006

Approach When Catatonic Symptoms Are At Their Lowest

- "It is effective to approach catatonic ASD patients during minutes or hours when severity of catatonia diminishes within a day." (page 52, Ohta, Kano, and Nagai in Dhossche, Wing, Ohta, and Neumarker, 2006)

Predictable Structure & Routine

- Structure and routine are "necessary . . . to develop the habit of participation. Habitual actions are much easier . . . in contrast to new or sporadic activities that are hard, even impossible for them to start" (Shah & Wing, 2006, p.257).
- Lack of structure and predictability increases stress and may trigger catatonia.

Habit and routines make life better

Use of Routine

8:02
Monday Feb 10, 2014
Edit
Morning
Afternoon
Evening
Timer
Chores
Now
7:30 PM
Free time
Next
8:30 PM
Bedtime Routine
9:00 PM
Bedtime
Day
Week
Month
4:10
Tuesday Feb 11, 2014
Wash Laundry
Timer
15:34
Sort clothes…
Check pockets
Add clothes t…
Set the temp…
Set the time
Add detergent
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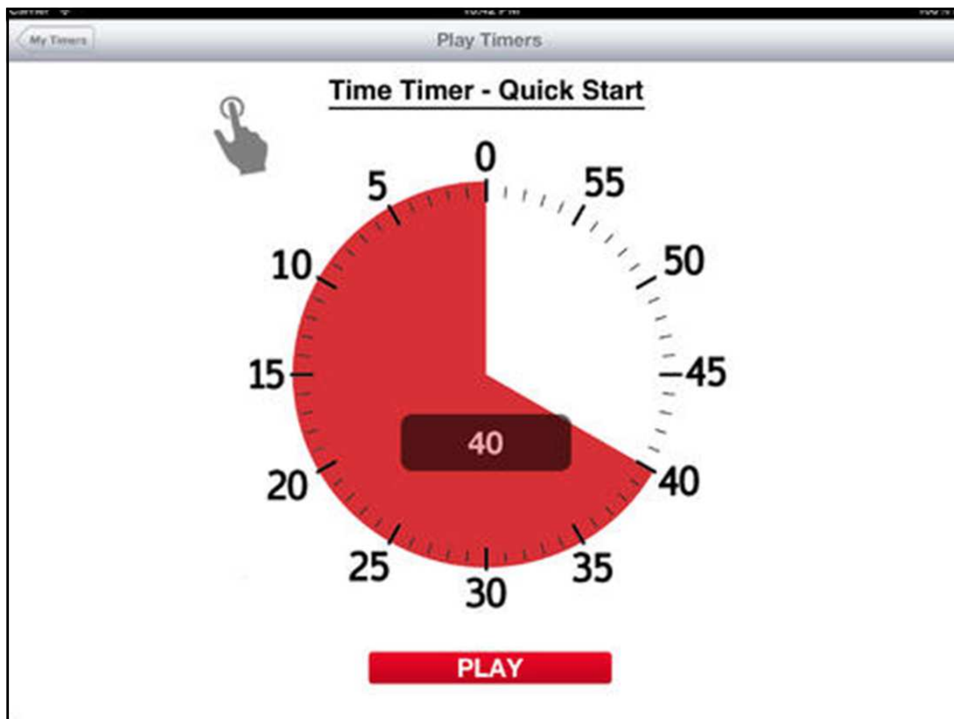
Play Timers
Time Timer - Quick Start
0
5
10
15
20
25
30
35
40
45
50
55
40
PLAY

Provide Enjoyable Activities

- High interest
- Positive Interactions
  NOT CONTINGENT ON BEHAVIOR
- Reinforcement

Remain Positive

- Caregivers should remain **positive** in their interactions
  Shah & Wing, 2006

Remain Positive

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THANK YOU!

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