Autism case study:

Case introduction:

Marcus, a 4-year-old Hispanic male, presented to a university medical clinic, Specializing in anxiety disorders and related conditions, for a diagnostic evaluation and treatment of “tics” and disruptive behaviours. A polite and inquisitive child, Marcus experienced moderate levels of distress and exhibited mildly disruptive behaviours when faced with social demands involving select novel people (e.g., being questioned by new people, being addressed by wait staff or clerks in the community). In addition, Marcus displayed many diagnostic markers associate with autistic disorder (e.g., limited eye contact, absence of joint attention, late-onset developmental regressions) The presence of multiple motor routines (i.e., leg and ankle extension, yawn-like flexing of the lower jaw), originally diagnosed by the family paediatrician as motor tics, was reported.

Mother’s complaints:

Marcus’s mother, Sandra, reported an unremarkable developmental history until shortly before his second birthday, at which point he displayed decreasing levels of attention to and awareness of verbal communication with his family. At the time of evaluation, in addition to the multiple motor routines, Marcus exhibited a marked aversion to social demands from others (e.g., avoiding eye contact and turning away when questions were asked) and minimal expressive language, consisting mainly of grunts and repetitive fragmented speech patterns when requesting attention or desired items. By Sandra’s report, onset of motor routines was between 12 and 18 months and socially avoidant behaviours between 18 and 24 months. Sandra noted that Marcus’s motor routines were associated with the greatest impairment, as they are the most observable to others. Sandra also expressed concern related to the potential for peer teasing as Marcus began his kindergarten year of school but denied any current interpersonal
problems related to the routines beyond parental concern. The pediatrician’s diagnostic impressions of Marcus’s motor routines as tics led to the family being referred to our specialty clinic for further evaluation and treatment.

Case conceptualisation:

Overall, Marcus presented as a quiet and gentle child, with few clinically significant problems aside from the motor routines and socially avoidant behaviors. However, Sandra reported distress related to interference from his avoidant behaviors with respect to interactions with same-age peers and, to a lesser extent, family members. In particular, there was a clear progression from parental frustration (due to lack of compliance with parent-driven social demands), to conflict between parents (associated with differing behavioral expectations), to removal of Marcus by Sandra from the immediate area. The parents reported that Marcus would engage in disruptive behaviors—including physically turning away from others and immediately breaking eye contact to gaze upward or downward—presumably to escape from social situations.

With respect to the motor routines classified as motor tics by the family’s paediatrician, observation and clinical judgment revealed that the motor routines were behavioural stereotypies consistent with ASD, differentiated from motor tics based on multiple diagnostic indicators. First, the onset of Marcus’s motor routines occurred between 12 and 18 months, as expected of stereotypies (typically prior to age 3), and much earlier than the average onset of motor tics (typically 5-7 years of age). Second, the motor routines were reported as relatively static and well established since their onset, consistent with stereotypies and inconsistent with motor tics, which commonly evolve or progress over time. Third, Marcus’s motor routines were not limited only to areas of his body at shoulder level or above (as expected with motor tics) but also involved muscles in his legs, ankles, arms, and hands, a characteristic indicative of motor stereotypies. Fourth, rather than sudden, brief paroxysms
indicative of simple motor tics, the motor routines reported
and observed were rhythmic in nature and relatively
prolonged (i.e., ranging from 2-5 seconds), characteristics
more closely aligned to stereotypies.

Regardless of aetiology, Sandra expressed concerns
regarding the social stigma associated with his stereotypies,
particularly given their comorbid presentation with significant
anxiety related to social demands from others. Marcus’s
parents displayed a relatively consistent understanding of
how the desire to escape social demands acted to maintain
his problematic behaviors. However, deficits in their
understanding with respect to how the various core
symptoms of ASD manifest (e.g., lack of social engagement,
aloofness, behavioral stereotypies, significantly limited social
repertoire, poor coping skills) frequently resulted in the
parents perceiving such characteristics as reflecting
malicious or defiant intent, rather than as significant skills
deficits. Thus, the level of familial distress, coupled with
knowledge and skills deficits, indicates the need for an
intervention that provides psychoeducation to increase the
parent’s level of knowledge with respect to ASD and anxiety,
while remaining primarily focused upon anxiety
management techniques and prosocial skill building.

Case history:

At the intake assessment, Marcus was living with his mother,
father (Liam), and younger sister in a small, urban city in the
Southeastern United States. He was scheduled to begin his
kindergarten year in a local public elementary school several
weeks after treatment onset. His parents were married with
no presenting concerns related to familial stressors aside from
those associated with Marcus’s behavioral routines. Given
Marcus’s age and communicative impairment, he was
unable to provide responses to most screening items;
however, Sandra denied past or present concerns about his
mood or substance use and denied any history of psychosis,
mania, or suicidal ideation. She did note some limited
symptoms of anxiety that were attributed to social stress