


JAMES COPLAN, M.D.  
Neurodevelopmental Pediatrician · Author · Speaker  
Making Sense of Autistic Spectrum Disorders

## Mental Health and Autism Spectrum Disorder: The Elephant in the Room

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# The NERVOUS CHILD

Quarterly Journal of Psychopathology, Psychotherapy,  
Mental Hygiene, and Guidance of the Child


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## AUTISTIC DISTURBANCES OF AFFECTIVE CONTACT

By LEO KANNER

SINCE 1938, there have come to our attention a number of children whose condition differs so markedly and uniquely from anything reported so far, that each case merits—and, I hope, will eventually receive—a detailed consideration of its fascinating peculiarities.

Kanner, L. Autistic Disturbances of Affective Contact. *Nervous Child*, (2) 217-250, 1943  
[www.drcoplan.com](http://www.drcoplan.com)



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Welcome

James Coplan, MD

Related Links

Here are some of my favorite links to other web sites and resources for parents. Check them out!

- AAP Offers Sound Advice on Autism: New Resource
- American Academy of Pediatrics
- autismresources.com
- Early Language Milestone Scale (ELM Scale-2)
- Early Language Milestone Scale (ELM Scale-2)
- Leo Kanner: Autistic Disturbances of Affective Contact (Nervous Child, vol. II, 1943, pp. 217-250). The original and still the best description of autism in the young child.
- Making Sense of Autism: A Guide for Parents
- Pediatric@ Journal
- The Incredible 5 Point Scale
- Variety

[www.drcoplan.com](http://www.drcoplan.com)

PATHOLOGY

“Transfused and intense emotional problem is most difficult. Psychologists and psychiatrists have recognized, and still recognize, that the autistic child is not merely ‘different’ but is a unique individual who is not like any other child.”

AUTISTIC DISTURBANCES OF AFFECTIVE CONTACT  
By Leo Kanner

## Kanner, 1943

- N = 11 (M 8; F 3)
- Age: 2 to 8 yr.
- Symptoms in four domains:
  1. Impaired socialization
  2. Idiosyncratic language
  3. Repetitious behaviors
  4. Unusual responses to sensory stimuli

Kanner, L. Autistic Disturbances of Affective Contact. *Nervous Child*, (2) 217-250, 1943  
[www.drcoplan.com](http://www.drcoplan.com)

## Impaired Socialization

- “Aloof”
- “Withdrawn”
- Limited eye contact
- Indifferent to others

[www.drcoplan.com](http://www.drcoplan.com)

### **Idiosyncratic Language**

- Echolalia
- Delayed Echolalia
- Pronoun Reversal
- Odd inflection

[www.drcoplan.com](http://www.drcoplan.com)

### **Repetitious Behaviors**

- Rigid Routines
- Stereotypies
- Lining up / spinning objects

[www.drcoplan.com](http://www.drcoplan.com)

### **Unusual sensory responses**

- “Petrified of vacuum cleaner”
- Drawn to, or afraid of, spinning objects
- Mouthing behavior
- Ingesting inedible materials
- Food selectivity

[www.drcoplan.com](http://www.drcoplan.com)

### **Kanner, 1938 → 1943**

- Gradual improvement in early childhood
  - Social skills
  - Language
  - Cognitive flexibility
  - Sensory Aversions

[www.drcoplan.com](http://www.drcoplan.com)

### **Kanner, 1938 → 1943**

“Between the ages of 5 and 6 years, they gradually abandon echolalia and learn spontaneously to use personal pronouns.

“Language becomes more communicative, at first in the sense of a question-and-answer exercise, and then in the sense of greater spontaneity of sentence formation....

Kanner, L. Autistic Disturbances of Affective Contact. Nervous Child, (2) 217-250, 1943  
[www.drcoplan.com](http://www.drcoplan.com)

### **Kanner, 1938 → 1943**

“Food is accepted without difficulty. Noises and motions are tolerated more than previously. The panic tantrums subside. The repetitiousness assumes the form of obsessive preoccupations...

Kanner, L. Autistic Disturbances of Affective Contact. Nervous Child, (2) 217-250, 1943  
[www.drcoplan.com](http://www.drcoplan.com)

**Kanner, 1938 → 1943**

**“Reading skill is acquired quickly, but the children read monotonously, and a story or a moving picture is experienced in unrelated portions rather than in its coherent totality...”**

\* **“Central coherence”**

Kanner, L. Autistic Disturbances of Affective Contact. *Nervous Child*, (2) 217-250, 1943

[www.drcoplan.com](http://www.drcoplan.com)

**Kanner, 1938 → 1943**

**“Between the ages of 6 and 8, the children begin to play in a group, still never with the other members of the group, but at least on the periphery alongside the group.**

Kanner, L. Autistic Disturbances of Affective Contact. *Nervous Child*, (2) 217-250, 1943

[www.drcoplan.com](http://www.drcoplan.com)

**Kanner, 1938 → 1943**

**“People are included in the child’s world to the extent to which they satisfy his needs...”**

Kanner, L. Autistic Disturbances of Affective Contact. *Nervous Child*, (2) 217-250, 1943

[www.drcoplan.com](http://www.drcoplan.com)

**Kanner, 1938 → 1943**

**All of this makes the family feel that, in spite of recognized ‘difference’ from other children, there is progress and improvement.**

**Leo Kanner, 1943**

Kanner, L. Autistic Disturbances of Affective Contact. *Nervous Child*, (2) 217-250, 1943

[www.drcoplan.com](http://www.drcoplan.com)

**Kanner, 1943**

It is not easy to evaluate the fact that all of our patients have come of highly intelligent parents. This much is certain, that there is a great deal of obsessiveness in the family background. The very detailed diaries and reports and the frequent remembrance, after several years, that the children had learned to recite twenty-five questions and answers of the Presbyterian Catechism, to sing thirty-seven nursery songs, or to discriminate between eighteen symphonies, furnish a telling illustration of parental obsessiveness.

One other fact stands out prominently. In the whole group, there are very few really warmhearted fathers and mothers. For the most part, the parents, grandparents, and collaterals are persons strongly preoccupied with abstractions of a scientific, literary, or artistic nature, and limited in genuine interest in people. Even some of the happiest marriages are rather cold and formal affairs. Three of the marriages were dismal failures. The question arises whether or to what extent this fact has contributed to the condition of the children. The children’s aloneness from the beginning of life makes it difficult to attribute the whole picture exclusively to the type of the early parental relations with our patients.

**Kanner, 1943**

We must, then, assume that these children have come into the world with innate inability to form the usual, biologically provided affective contact with people, just as other children come into the world with innate physical or intellectual handicaps. If this assumption is correct, a further study of our children may help to furnish concrete criteria regarding the still diffuse notions about the constitutional components of emotional reactivity. For here we seem to have pure-culture examples of inborn autistic disturbances of affective contact.\*

## Kanner, 1971

- Deceased: 1
- Lost to follow-up: 2
- Institutionalized: 5
- Living on work farm: 1
- Living at home: 2
  - BA degree / bank teller
  - Sheltered workshop / machine operator

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## Kanner's contributions

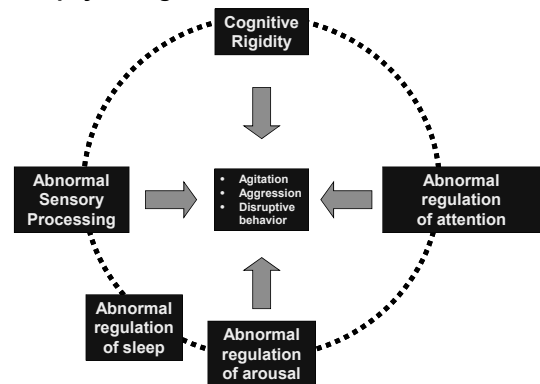
- **Clinical Description**
  - Social, Language, Repetitious behavior, & Sensory aversions / attractions
- Described the *Natural History* of improvement over time (irrespective of treatment)
- Attribution: An “inborn disturbance of affective contact”

www.drcoplan.com

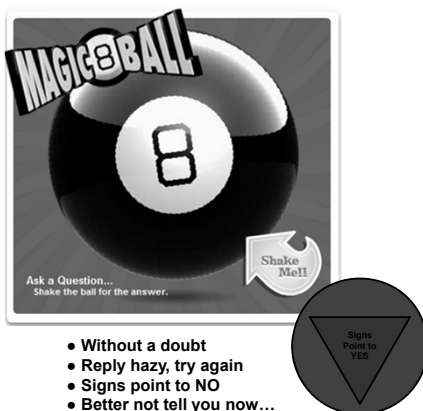


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## Neuropsychological Deficits in Children with ASD

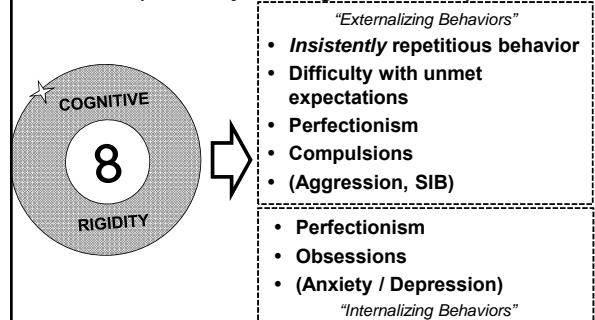


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- Without a doubt
- Reply hazy, try again
- Signs point to NO
- Better not tell you now...

## Cognitive Rigidity (Difficulty shifting mental sets)



### Cognitive Rigidity:

*Changes in Routine / Unmet Expectations*



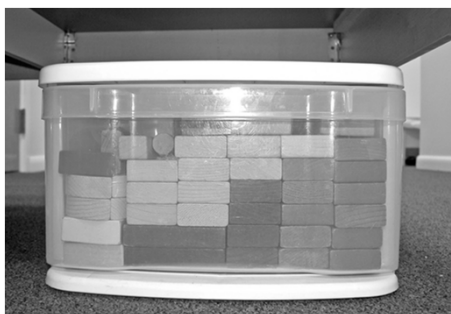
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Rainman, 1988

### Perfectionism



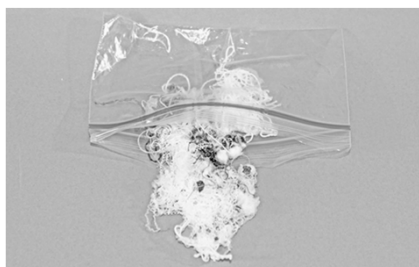
### Perfectionism



### Perfectionism



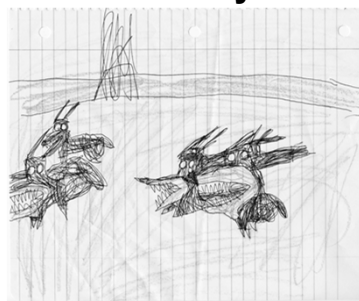
### Compulsions



Joseph F: 15 y.o. boy Asperger Syndrome

MRN: 05-0096

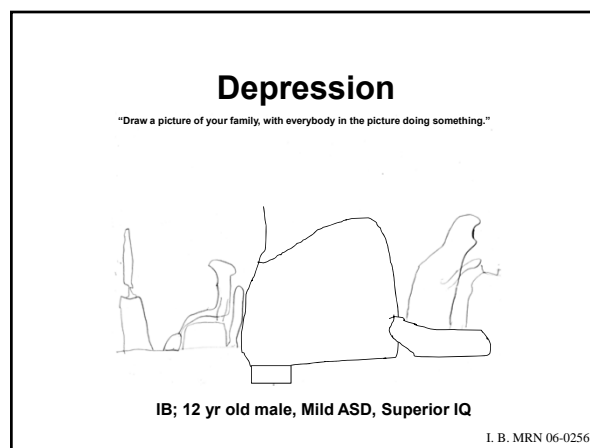
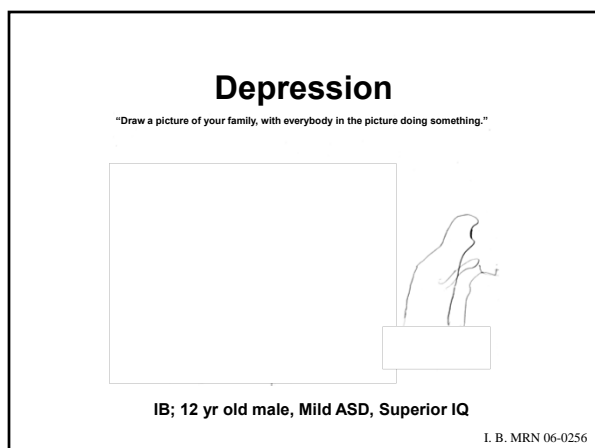
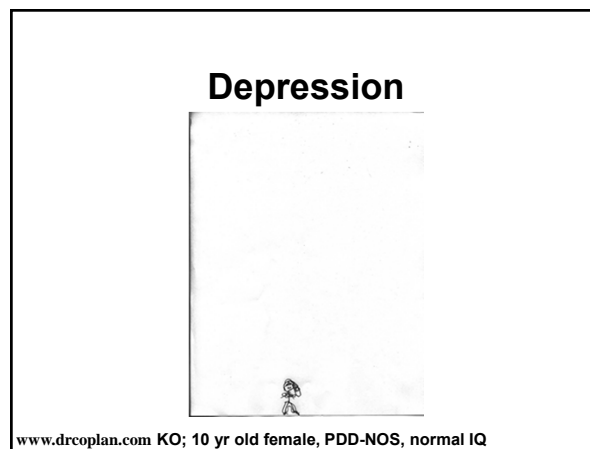
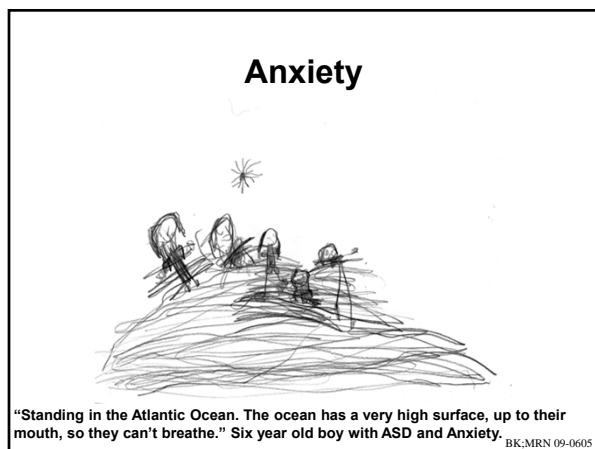
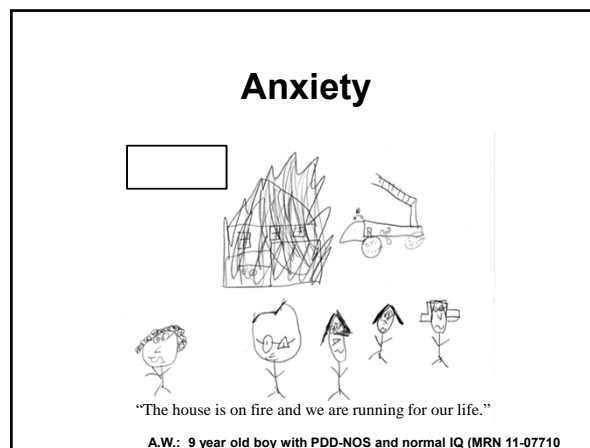
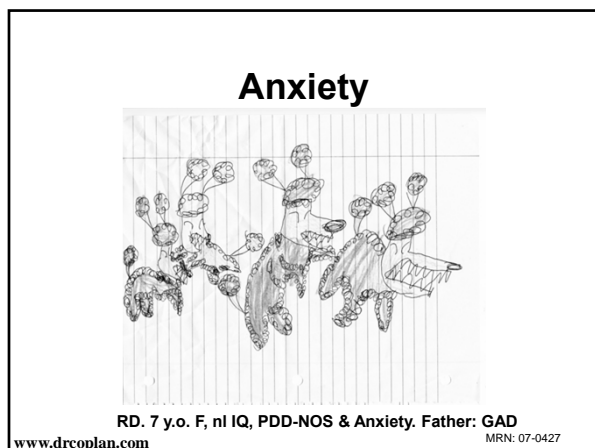
### Anxiety

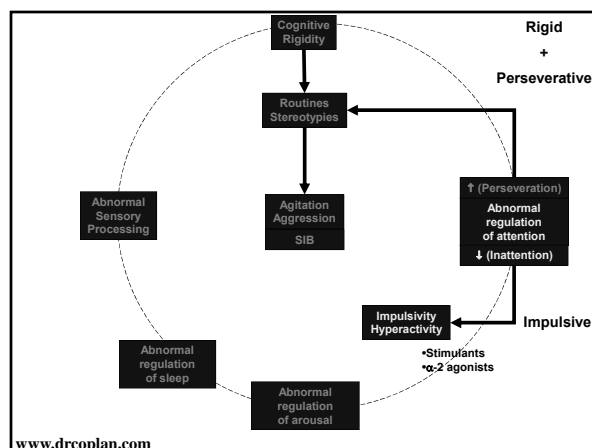
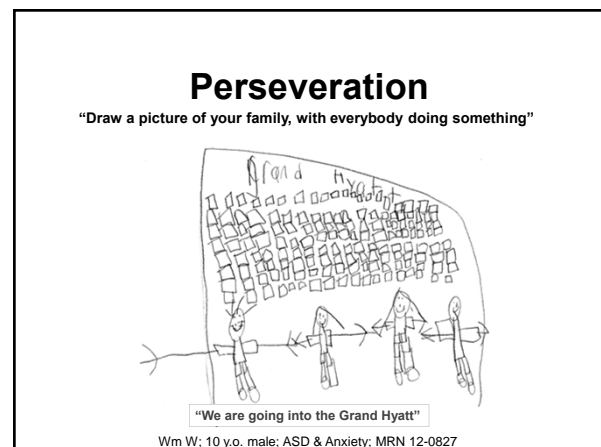
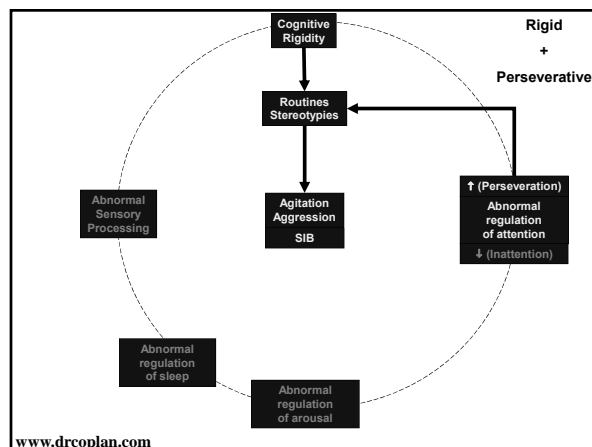
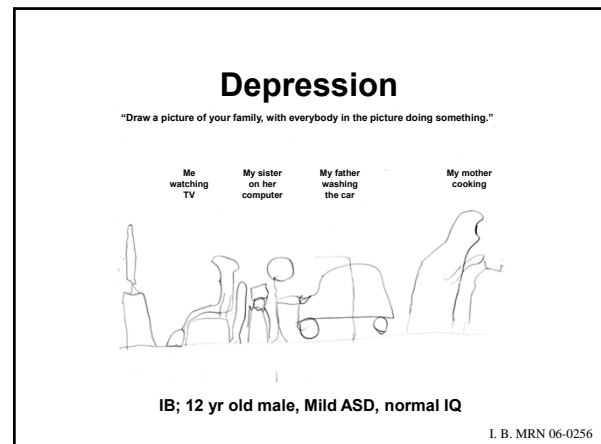
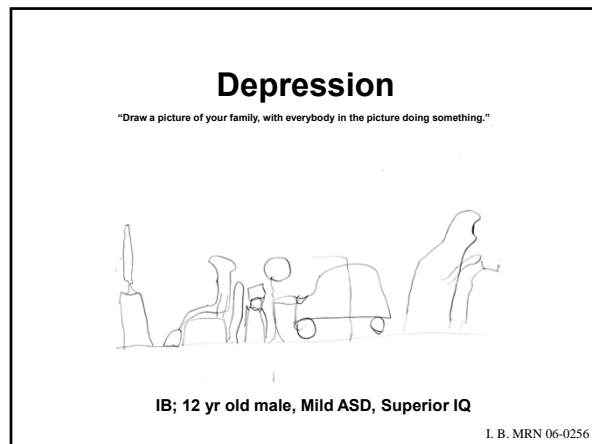


RD. 7 y.o. F, nl IQ, PDD-NOS & Anxiety. Father: GAD

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MRN: 07-0427

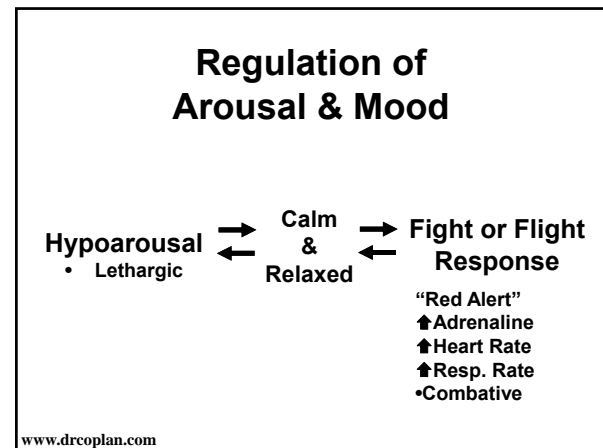
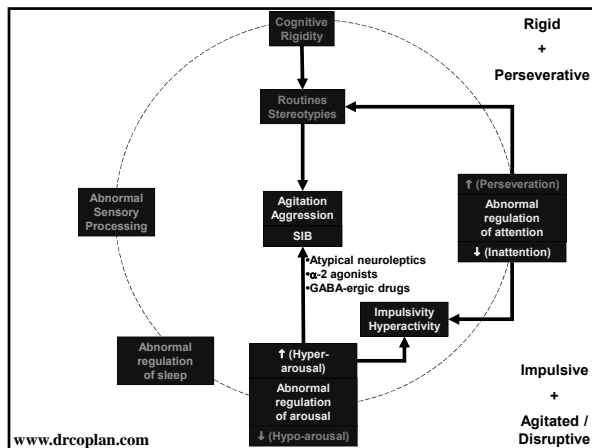




### Clinical Pearl

- **Beware of Cognitive Rigidity masquerading as ADHD**
  - Perseveration on inner stimuli: "Inattentive"
  - Perfectionism:
    - "Problems w. task completion"
    - (Or: Task avoidance!)
  - Anxiety:
    - "Rushes through work"
    - "Out of seat behavior"

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### Dysregulation of Arousal & Mood

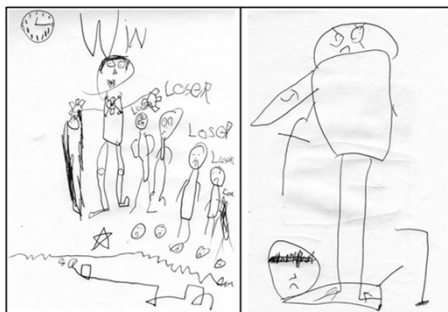
- "If he gets up on the wrong side of the bed we know it's going to be a bad day."
- "We feel like we're walking on egg shells"

### Mood

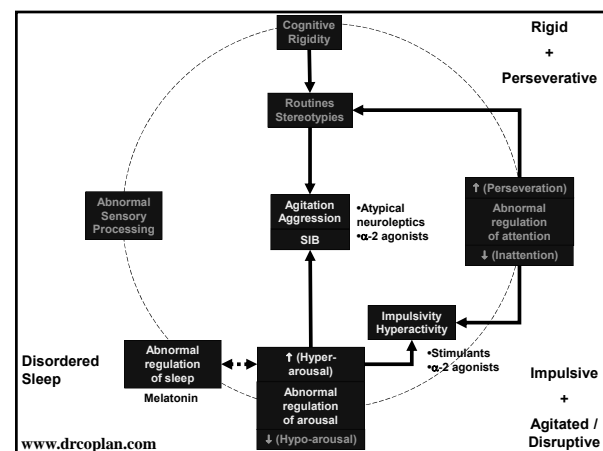


JH; 10 yr old male, PDD-NOS

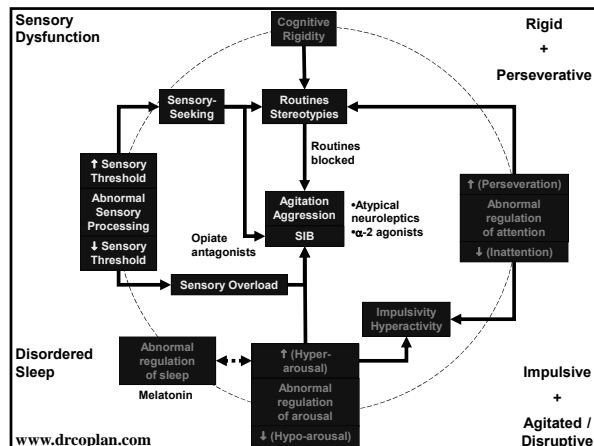
### Anger (mood)



JH; 10 yr old male, PDD-NOS



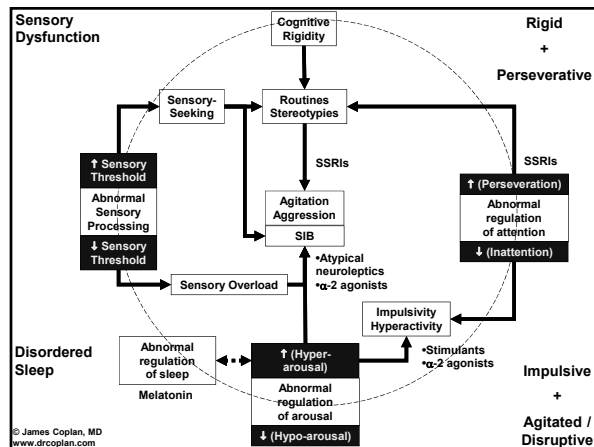




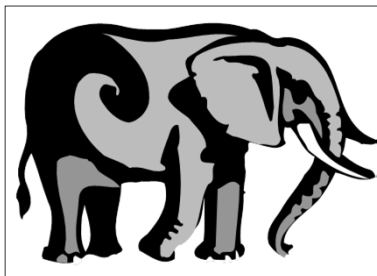
The whole is greater than  
the sum of its parts

Max Wertheimer

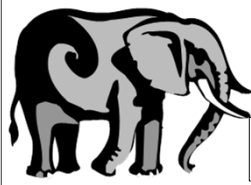
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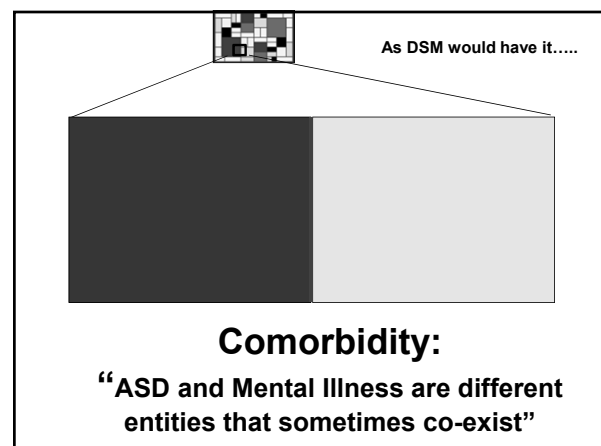
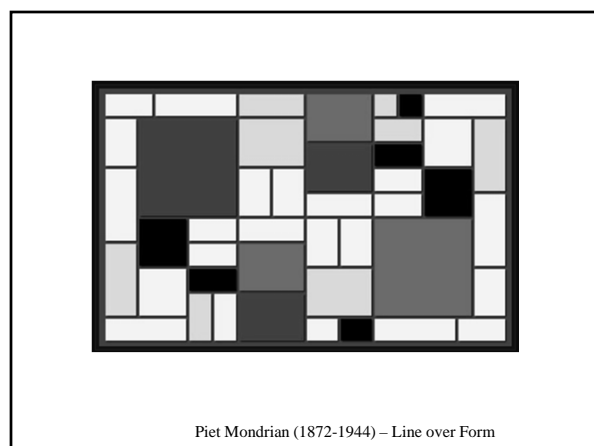
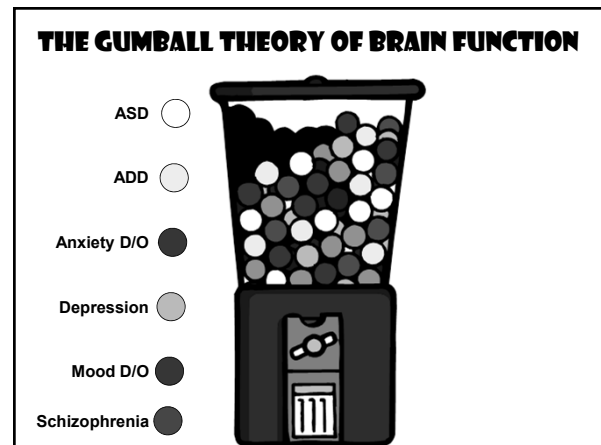
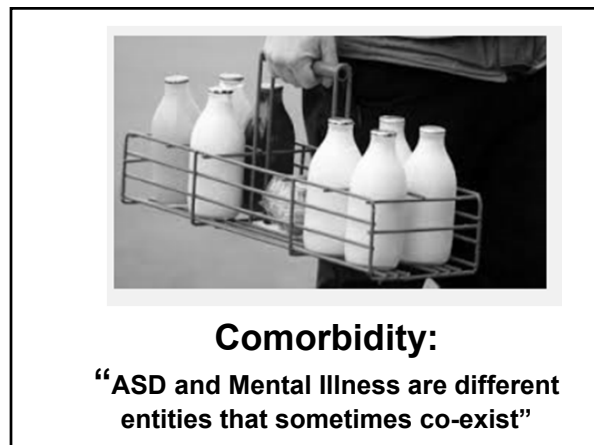
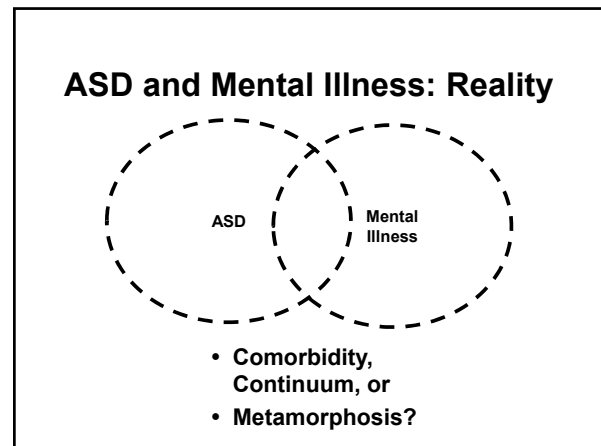
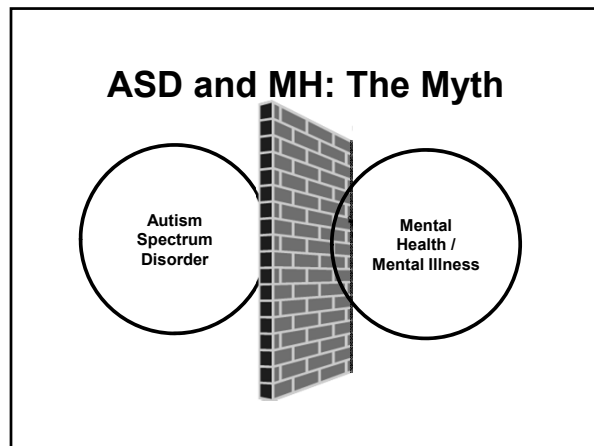


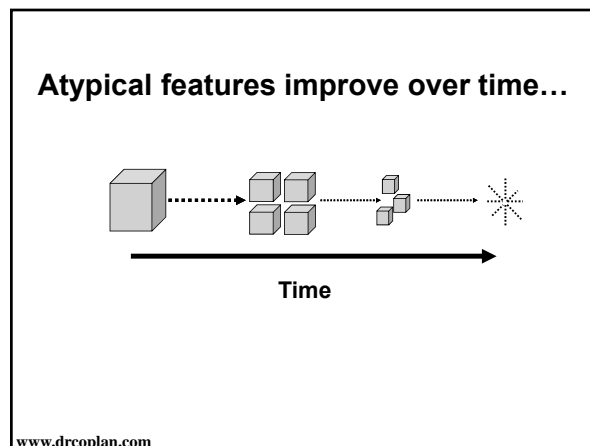
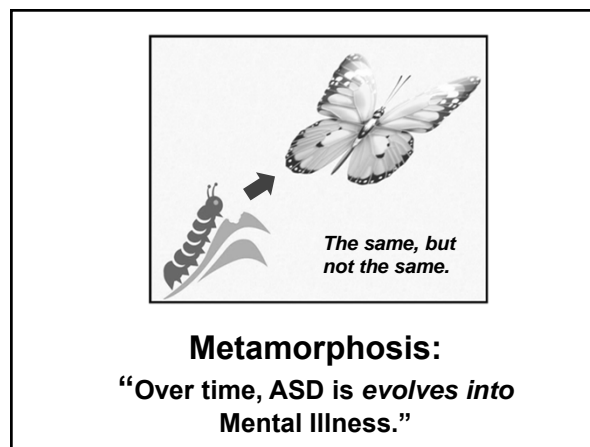
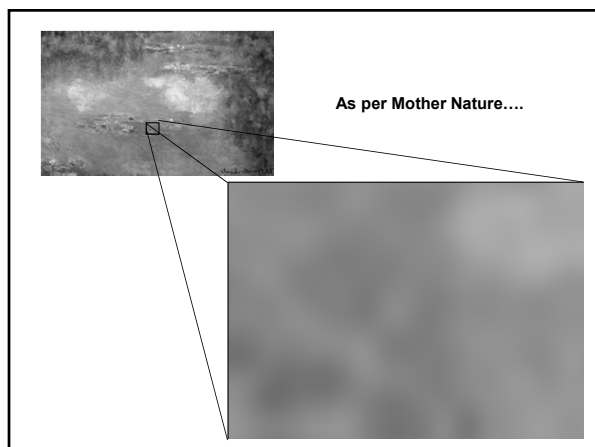
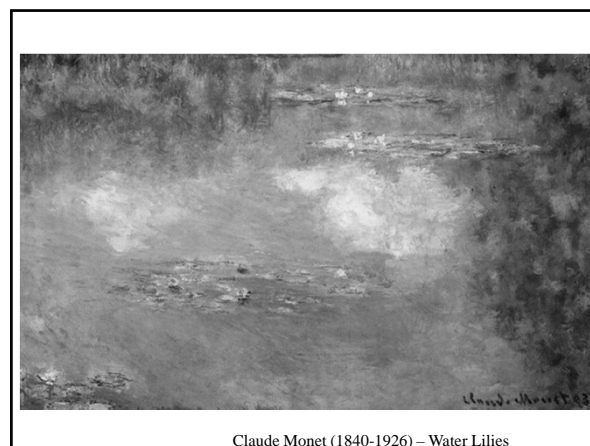
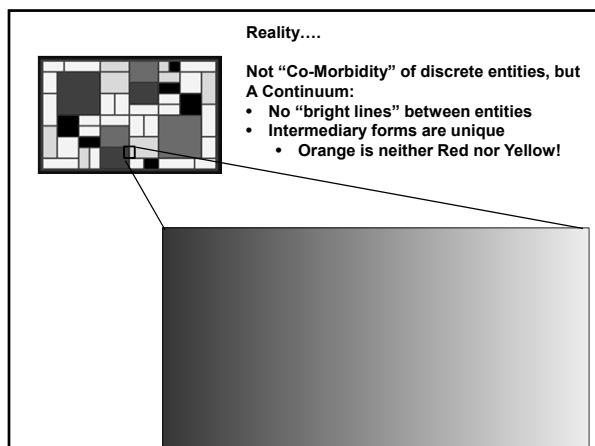
## Mental Health in ASD.....



*the elephant in the room*

	
Searches	Results
exp Autistic Disorder/	16657
exp Mental Health/	21539
1 and 2	21





**...But society is raising the bar.**



### Transition to Middle School

***“Friendship is getting more complex and he is falling further behind his peers... We think he may be lonely.”***

Parent of a 10 y.o. boy with ASD and normal IQ

ZE; MRN 06-0361

### Transition to Middle School

***Now that he’s 10, he’s less cute. It was cute when he was 5; not when he’s 10.***

MRN 06-0299

### Transition to Adulthood

***Our son turned 13 last year. We are noticing that...the world interacts very differently to an autistic child vs. an autistic man.***

MRN 04-0011

### Transition to Adulthood

***Sometimes he is so average. Sometimes he is so autistic.***

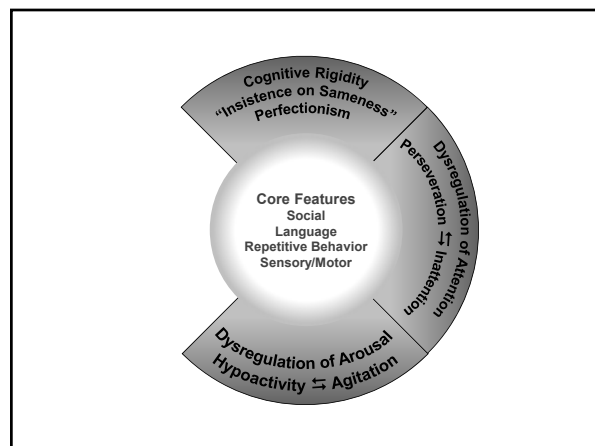
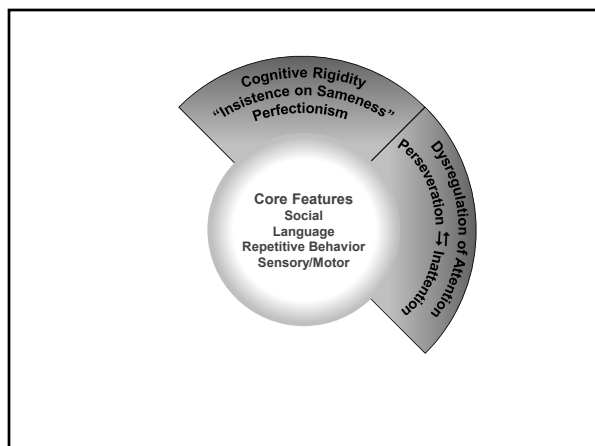
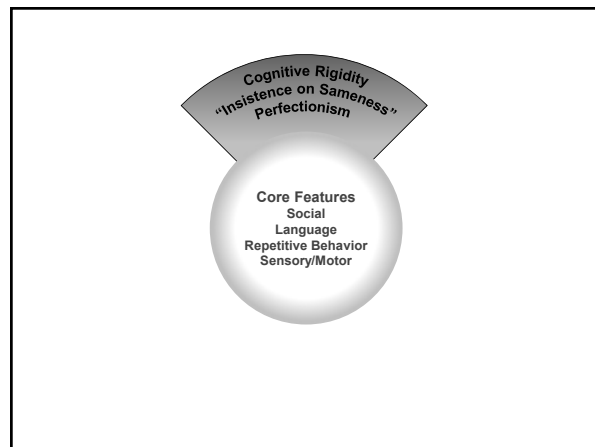
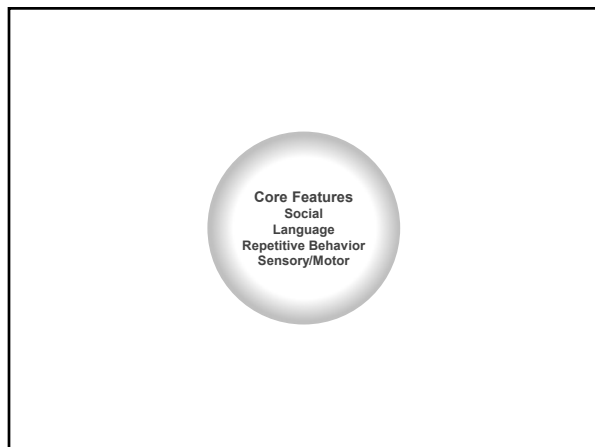
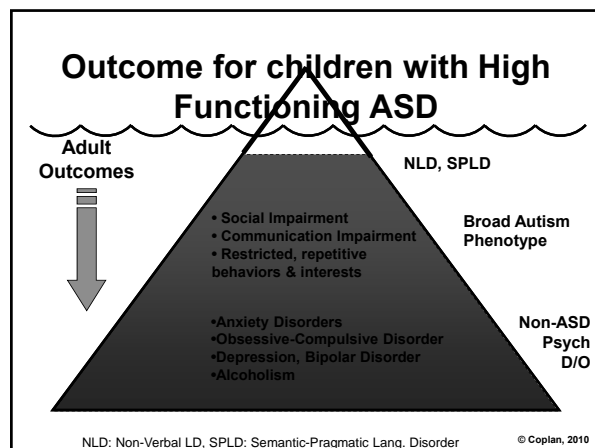
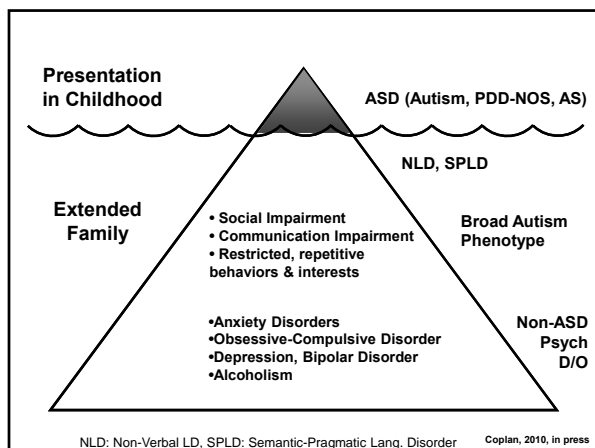
Mother of a 16 y.o. boy with ASD and uneven cognitive development

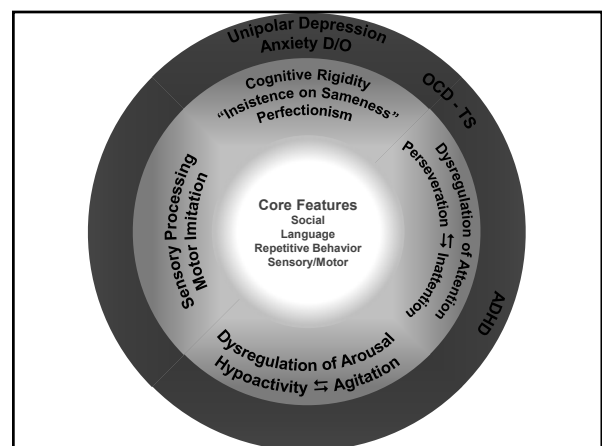
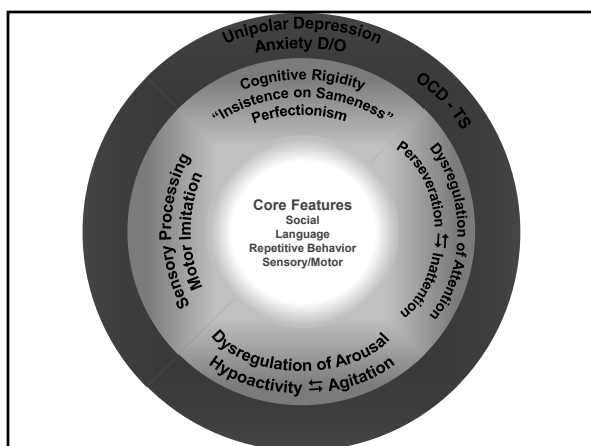
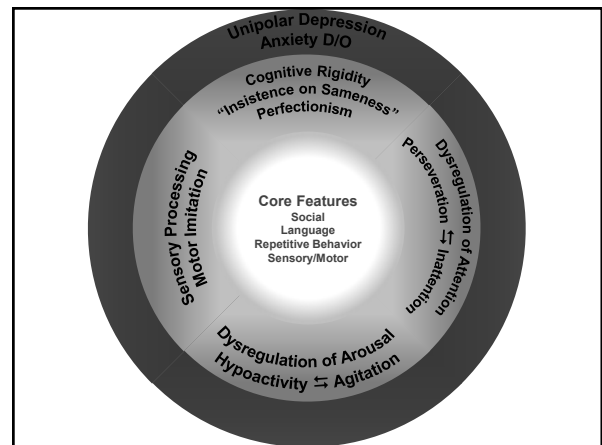
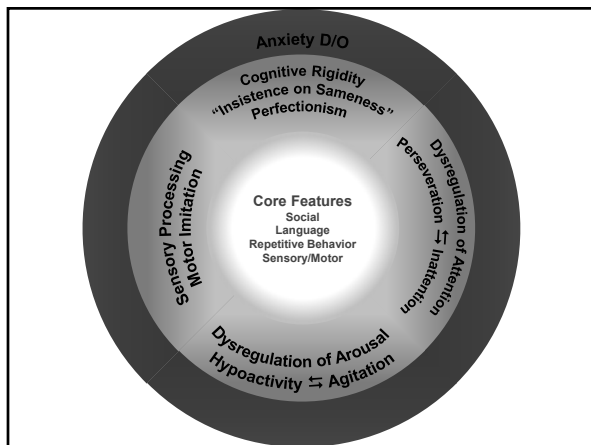
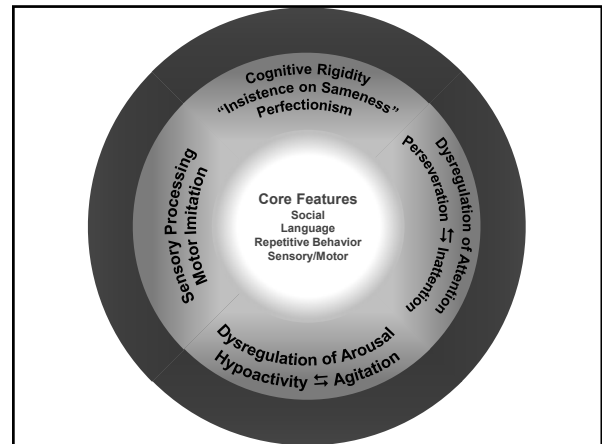
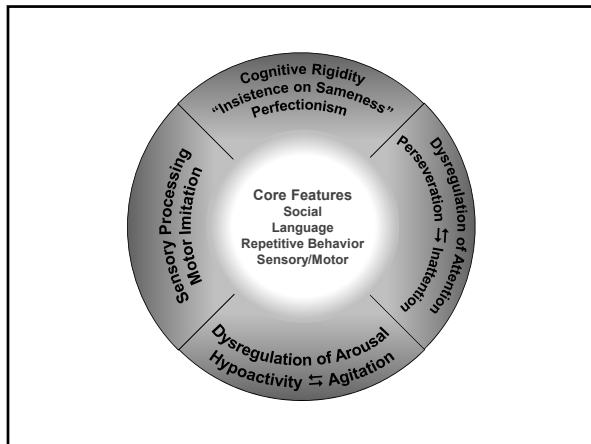
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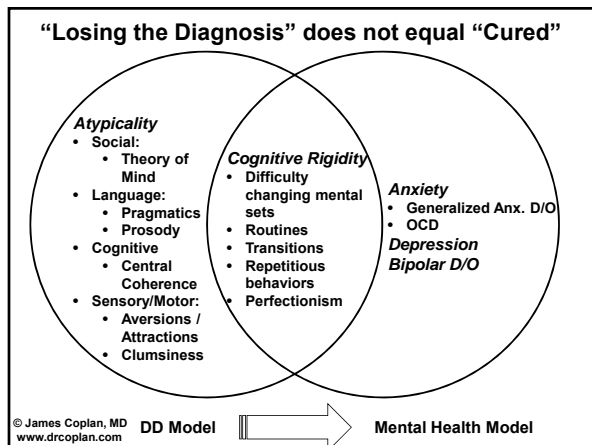
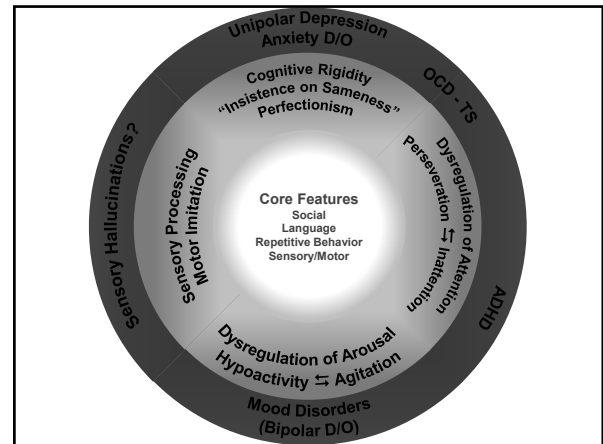
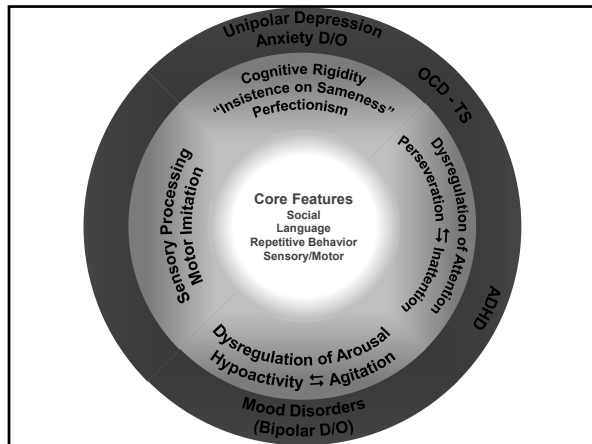
### Long-Term Outcome

- “Losing the diagnosis” does not mean “cured”
- Persistence of
  - Cognitive patterns
  - Behavioral patterns
  - Emotional patterns
- Symptoms ⇒ Quirks ⇒ Traits
- Non-ASD neuropsychiatric disorders

[www.drcoplan.com](http://www.drcoplan.com)

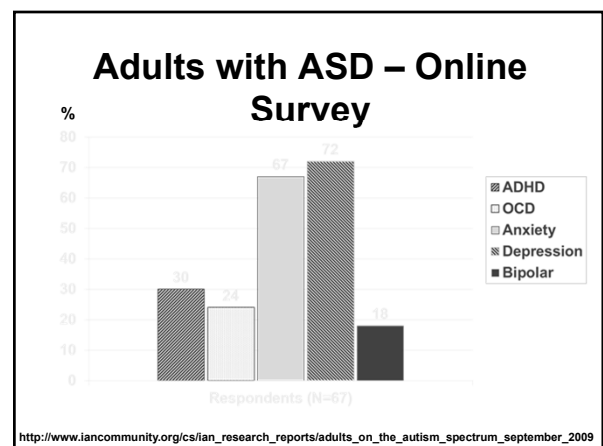
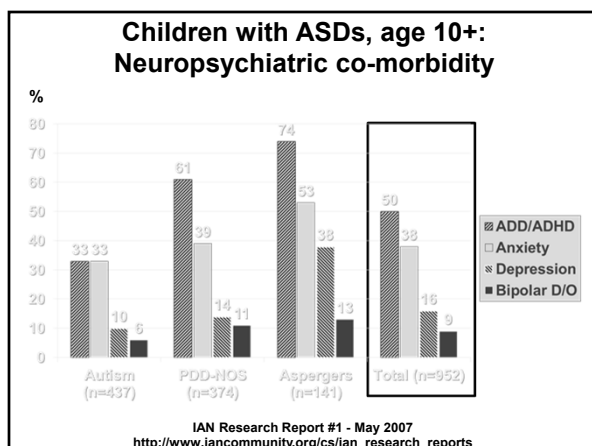






**Neuropsychological and Neuropsychiatric impairment in persons with ASD**

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Examining the comorbidity of bipolar disorder and autism spectrum disorders: a large controlled analysis of phenotypic and familial correlates in a referred population of youth with bipolar I disorder with and without autism spectrum disorders.

J Clin Psychiatry, 2013 Jun;74(6):578-86. Joshi G, Biederman J, Petty C, Goldin RL, Furtak SL, Wozniak J.

- **Subjects & Methods:**
  - Secondary analysis of data from a family study of youth with Bipolar I D/O (probands = 157, relatives = 487)
- **Results**
  - 30% (47/155) of Bipolar I probands met criteria for ASD
  - Onset of Bipolar I occurred earlier in the presence of ASD ( $4.7 \pm 2.9$  y vs  $6.3 \pm 3.7$  y;  $p=.01$ )

## **“Is Schizophrenia on the Autism Spectrum?”**

*King & Lord, 2011*

- “Schizotypal Personality” is distinguished by “unusual preoccupations, unusual perceptual experiences, odd thinking and speech (e.g., overelaborate, or stereotyped), inappropriate or constricted affect, behavior or appearance that is odd, eccentric, or peculiar; lack of close friends or confidants other than first-degree relatives, and social anxiety...”

## **“Is Schizophrenia on the Autism Spectrum?”**

*King & Lord, 2011*

- “What arguably distinguishes schizophrenia spectrum from autism spectrum in two individuals who otherwise share all of these symptoms is the presence of paranoid ideation...”

## **“Is Schizophrenia on the Autism Spectrum?”**

*King & Lord, 2011*

- “Given the degree of overlap, one might reasonably ask if paranoid thinking could be a logical downstream consequence of a common underlying difficulty in the perception of social communication”

## **Theory of Mind**

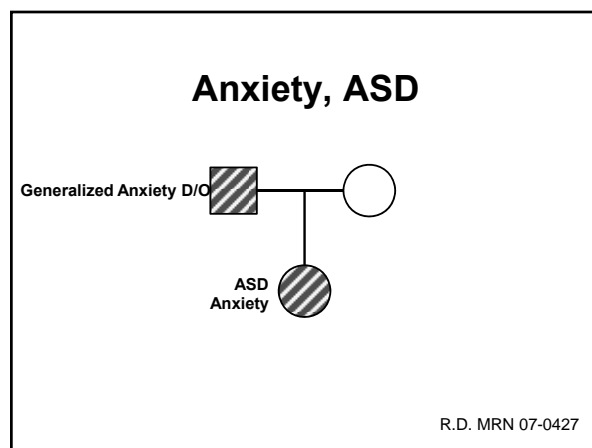
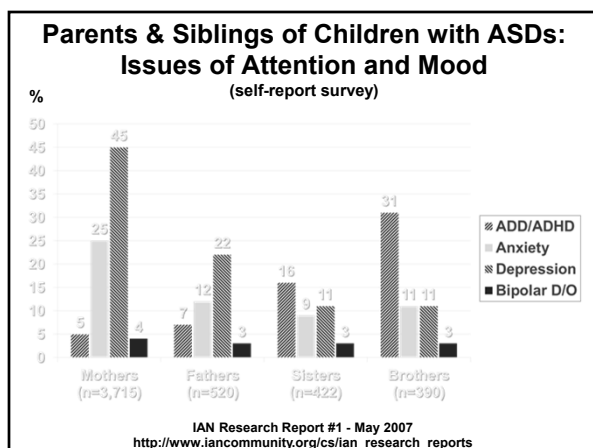
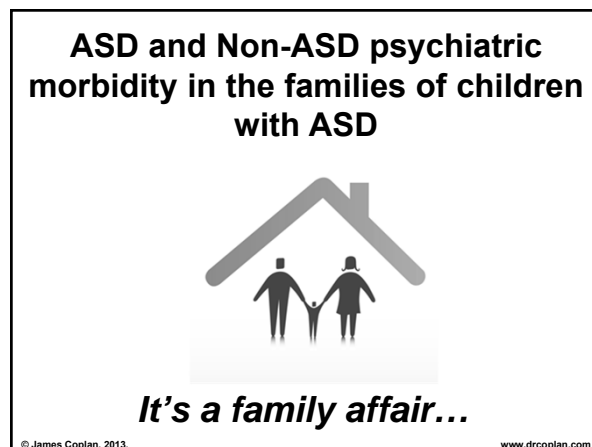
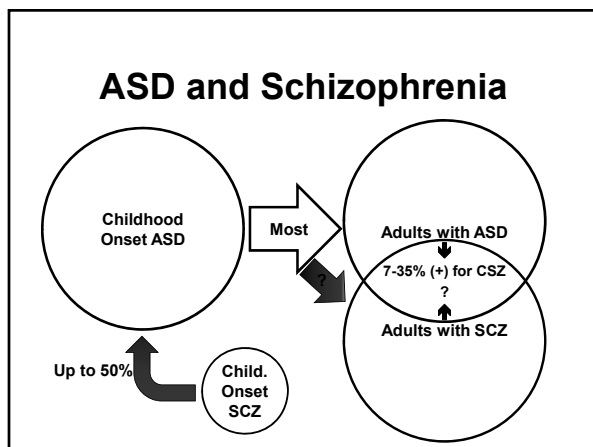
- Realization that other people have an internal mental & emotional state, different from one’s own
- Ability to gauge the internal mental & emotional state of others
  - Able to infer motives & predict behavior of others
  - Empathy
  - Humor

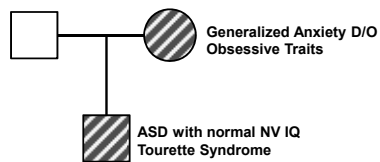
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What’s happening in this picture?

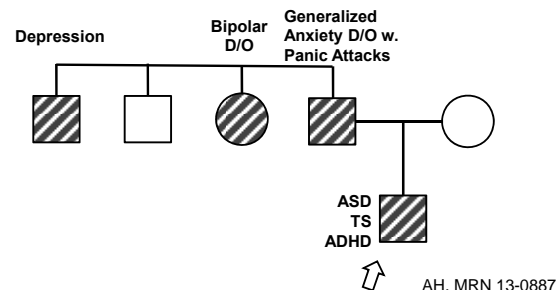
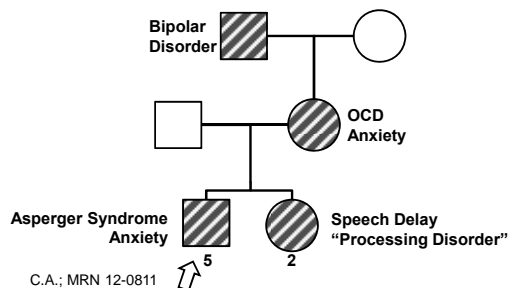






**TS, Anxiety, ASD**

DB, MRN: 08-0543

**TS, Anxiety, Depression,  
Bipolar D/O, ASD, ADHD****BPD, OCD, Anxiety, AS****Laboratory Evidence**

- ADHD
- Anxiety
- ASD
- Bipolar D/O
- Schizophrenia

**Developmental brain dysfunction: revival and expansion of  
old concepts based on new genetic evidence**

Andres Moreno-De-Luca\*, Scott M Myers\*, Thomas D Challman, Daniel Moreno-De-Luca, David W Evans, David H Ledbetter

Lancet Neurology 2013; 12: 406-414

	Frequency in clinical cohorts*	Intellectual disability or developmental delay	Autism spectrum disorder	Schizophrenia	Epilepsy
22q11.2	1 in 167	✓	✓	✓	✓
16p11.2	1 in 241	✓	✓	..	✓
1q21.1	1 in 309	✓	✓	✓	✓
15q13.2-q13.3	1 in 358	✓	✓	✓	✓
7q11.23	1 in 415	✓	✓	..	✓
15q11.2-q13	1 in 553	✓	✓	✓	✓
17q21.31	1 in 700	✓	✓	..	✓
16p13.11	1 in 788	✓	✓	✓	✓
17q12	1 in 985	✓	✓	✓	✓
17p11.2	1 in 985	✓	✓	..	✓
8p23.1	1 in 1854	✓	✓	..	✓
5q35	1 in 1970	✓	✓	..	✓
3q29	1 in 2101	✓	✓	✓	..

\*Frequency in individuals referred for chromosomal microarray testing. Common indications for testing include neurodevelopmental disorders and multiple congenital anomalies.<sup>21</sup>

Table 1: Variable expressivity in selected microdeletion syndromes

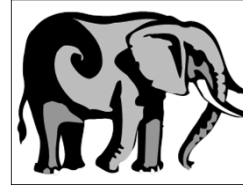
Morena De Luca et al, 2013

	Intellectual disability or developmental delay	Autism spectrum disorder	Schizophrenia	Epilepsy
A2BP1	✓	✓	✓	✓
AUTS2	✓	✓	..	✓
CACNA1C	✓	✓	✓	✓
CASK	✓	..	✓	✓
CDKL5	✓	✓	..	✓
CNTNAP2	✓	✓	✓	✓
DISC1	✓	✓	✓	..
EHMT1	✓	✓	✓	✓
FMR1	✓	✓	✓	✓
FOXP1	✓	✓	..	✓
FOXP2	✓	✓	✓	..
⋮				

Table 2: Variable expressivity in selected single gene mutations

Morena De Luca et al, 2013

## The Real Elephant in the Room



Child w. ASD + Parent with MH D/O =



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## Family Mental Health

("We give our children roots and wings" — Hodding Carter)

**Family Mental Health is a key ingredient in outcome for all children, but especially for the child with developmental disability, who is less able to work around obstacles arising from family dysfunction than a child with normal development.**

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## Signs of Family Mental Health

- **Cognitive, Emotional, and Tactical Flexibility**
  - Shifting alliances (adults vs. kids, "boys vs. girls," etc.)
  - Shifting roles (role of "hero" or "in the doghouse")
  - Shifting solutions (one size does not fit all; "equitable" vs. "equal")
  - Shifting combinations for activities. All legitimate combinations should come up once in a while.
- **Sense of humor / playfulness / resilience**

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## Individual Mental Health as a contributor to family mental health

- **Parents of children with ASD: High frequency of neuropsychiatric disorders (esp. anxiety, depression)**
- **Limits adult's ability to achieve full differentiation**
- **Limits adult's ability to respond in a flexible manner to the extraordinary demands from child w. ASD**

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## Danger Signs

- **Inflexibility**
  - Fixed roles
  - Fixed solutions
- **Hypervigilance**
  - Lack of trust in care providers
- **Social Isolation**
  - "Circle the wagons" mentality
  - "Nobody helps us!"



## House Rule #1

- **Get both parents to come in for the interview & informing session**
  - Have a sofa if possible, and watch the body language
  - “What do you think about what your spouse just said?”

## Probe Questions

(In ascending order of intimacy)

- Do you and your partner ever go out as a couple? When was the last time?
- Who else do you have as supports?
- What have you told your other children / parents?
- Tell me a little bit about yourself / how you were raised / your own mental health?

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## House Rule #2

- **No medication unless parents agree to behavioral and MH evaluation for their child and/or themselves, if you deem it necessary**

### Neurodevelopmental Pediatrics of the Main Line, PC

#### Psychoactive Medication – Informed Consent Form

Medication cannot cure developmental or behavior problems. However, medication can sometimes alleviate biologically-based symptoms, such as inattention, impulsivity, anxiety, depression, cognitive rigidity, agitation, disruptive, or self-injurious behavior. Medication alone is frequently less effective than medication plus behavioral or mental health services.

Therefore, in addition to administering psychoactive medication to your child, Dr. Coplan may recommend behavioral and/or mental health services as part of your child's treatment plan as follows: .....

### Neurodevelopmental Pediatrics of the Main Line, PC

#### Psychoactive Medication – Informed Consent Form

Therapy for your child focusing on:

- Direct modification of your child's behavior
- Anxiety management
- Enhancing your child's self-esteem
- Enhancing your child's social skills
- Self-awareness, including the implications of your child's diagnosis

Therapy for yourselves (parents) to address one or more of the following:

- Differences between parents in management style
- Intrinsic parental issues, such as anxiety or depression, that may be impacting your ability to address your child's behavior
- The impact of your child's disability on family function

### House Rule #3

- The family is a system → *The unit of treatment is the family*
- Assess mental health of all players
- Assess relationships among the players
- Fostering the family's ability to move forward is my #1 goal. The child's parents & siblings will be involved with my patient long after I have left the stage.

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### Summary

- ASD has a natural history for improvement over time, insofar as visibly atypical features are concerned
- Cognitive & behavioral patterns persist
- Mental Illness is not “a separate problem.” Rather, impaired MH is another expression of shared neurobiology
- Over time, mental health issues present a progressively greater challenge, that may supersede the ASD

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### Summary

- ASD in a child is a red flag for developmental and/or mental health disorders in parents / siblings
- Optimal outcome for the child with a disability depends upon addressing the parents' mental health issues, as well as the child's developmental and mental health needs

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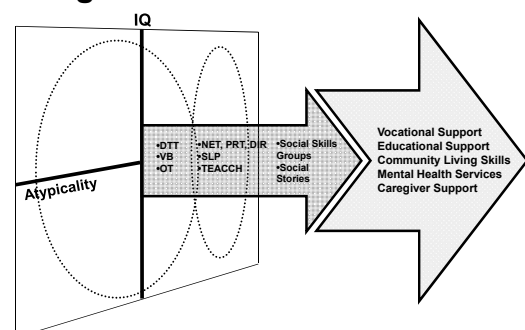
### Summary

- To be successful, intervention needs to be multimodal and family-centered
  - Mental health intervention
    - Child: Self-awareness, self-esteem, self-regulation
    - Parents: Address their own MH issues
    - Family: Take a family-system approach
      - Flexibility / Resilience within the family structure
      - Siblings are at high risk for genetically based morbidity, and/or collateral damage bec/o family system dysfunction
  - Educational / Vocational services
  - Psychotropic Medication - often

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### Progression of Interventions

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## Summary

- **Need for Adult Services**
  - Clinics for “Long-Term Survivors of Childhood ASD” patterned after Long-Term Survivors of Childhood Cancer
    - Mental Health
    - Job coaching
    - Social contact
    - Family / Caregiver support (parents, partners)
    - Developmental screening of offspring

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## Summary

- **Need for Better Research**
  - Prevalence of ASD in adults?
  - Psychiatric Comorbidity
  - Obstacles
    - Privacy issues
      - “Informative censoring”
    - Cross-Disciplinary collaboration
      - Child / Adult
      - DD / Mental Health
    - Long-term funding


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## Resources


- Coplan, J. *Making Sense of Autistic Spectrum Disorders*. Random House, 2010.
- *Married with Special Needs Children; A couples' guide to keeping connected*. Marshak LE and Prezant, FP. Woodbine, 2007
- *Voices from the spectrum*. Parents, grandparents, siblings, people with autism, and professionals share their wisdom. Ariel, CN and Naseef, R (eds). Jessica Kingsley, 2006
- The American Association of Marriage and Family Therapy <http://www.aamft.org/iMIS15/AAMFT/>
- The Bowen Center: <http://www.thebowencenter.org/>

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***Thank you***  
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