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Self-Injurious Behaviours in Children and Adolescents with Intellectual Disability and Autism Spectrum Disorder

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Dear Editor,

Self- Injurious behaviours are one of the commonest reasons why children and adolescents with neurodevelopmental disorders present to health services. They are a significant cause of carer stress and often require increased supervision and redirection from caregivers[1] to reduce the risk of potentially serious physical complications. Identifying triggers underlying self-injurious behaviours is challenging particularly in children with complex neurodevelopmental needs. There is a risk of diagnostic overshadowing which may delay access to appropriate interventions, improvements in functioning and reduced care burden[2].

I would like to present this case of a twelve-year-old white Irish male with a background diagnosis of severe intellectual disability. He was referred to child psychiatry services for assessment of a two-year history of self-injurious behaviours in the form of repetitive fist banging against his face and facial skin picking with significant bruising. He has a history of neonatal withdrawal syndrome at birth, a maternal history of opiate abuse in pregnancy and a sibling with a diagnosis of Autism spectrum disorder and Intellectual Disability.

There had been numerous presentations to paediatric medical and dental services with extensive physical investigations and medication trials to identify and treat a possible physical cause for his self-injurious behaviours. Dental extraction of all of his baby teeth was carried out to manage potential dental pains underlying his self-injurious behaviours.

A psychiatric assessment was completed across clinic and special school settings. He impressed as an anxious boy particularly impaired during transition periods and changes to his environment resulting in high arousal, increased stimming, dys-regulation and self-injury. He was diagnosed with a Generalised Anxiety Disorder DSM V 2013 and Autism Spectrum Disorder DSM V 2013 in a background of Severe Intellectual Disability by the child psychiatry team. Fluoxetine medication 1ml daily was commenced and titrated up to a 3mls daily over a twelve-week period.

Over the past three years since he commenced medication, there has been a complete remission of self-injurious behaviours with a reduction in repetitive behaviours and stimming. There have also been significant improvements in his mood, anxiety levels and functioning across home and school settings.

Self-injurious behaviours are a common manifestation of both physical and mental health disorders in children with neurodevelopmental needs. It is difficult to directly elicit features suggestive of a mental health concern from children with moderate to profound intellectual disability given their significant verbal communication deficits[3]. This

results in a reliance on clinical investigations to identify reasons behind self – injury and may progress to unnecessary complex physical investigations. Interventions may also include procedures and medications which may bring further adverse risk challenges. These may delay psychiatric diagnosis and treatment.

It is imperative that clinicians have an index of suspicion for mental health disorders when medical diagnosis and management proves a challenge in patients with an Intellectual disability. Early consideration should be given to a psychiatric referral to confirm or exclude co-morbid mental health disorders underlying self-injurious behaviours particularly when there is medical diagnostic uncertainty in children and adolescents with moderate to profound intellectual disability.

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