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Aims: An increasing number of patients with Autism Spectrum Disorder (ASD) and Intellectual Disability (ID) are being admitted to general psychiatric wards and managed by general psychiatrists. This case report describes a crisis admission and reviews the models of care, interventions, and outcomes delivered by a non-specialist multidisciplinary team (MDT) following the closure of a specialist ID unit.

Methods: X is a 30-year-old female with ASD and Moderate ID, presenting with complex self-harming behaviours (self-punching, head-banging), psychogenic polydipsia, self-neglect, and risks to others (aggression, property damage). She required 2:1 staffing observations. After the closure of the specialist ID ward, X was transferred to Cygnet Churchill Hospital in January 2024, initially for community discharge, but an unforeseen admission necessitated continued complex care.

Results: An interdisciplinary intervention programme including carer-informed change in antipsychotic medication and Clinical Genetics history review. Psychological interventions targeted three areas: patient-centred care, MDT-centred care, and personalized risk assessment. Patient-centred interventions involved exploring emotions and dysregulation management, with X identifying strategies to manage emotional regulation and self-expression. MDT interventions included rapid PBS training to upskill non-specialist staff in managing ID and ASD, alongside discontinuing communication aids. A personalized START risk assessment, integrating five case-specific items, enhanced X's understanding of her behaviours.

The Vona du Toit Model of Creative Ability (VDTMoCA) was applied to create an individualized intervention plan promoting choice, including an interest checklist, healthier eating options, choice cards, and reformatted social stories tailored to X's preferences. These strategies developed X's Occupational identity and supported emotional regulation.

The comparison of pre- and post-admission Global Assessment of Progress (GAP) Scores showed a 44.7% improvement, with the highest gains in complex challenges (50%), Daily Living Skills Observation Scale (41.7%), Family Caregiver Support Program (64.2%), and Daily Risk Assessment (DRA). There was a significant reduction in self-harm (81.25%) and physical aggression (28.13%), but an increase in restraint (52.4%), verbal aggression (350%), property damage (183.3%), and absconding (33.3%). No changes were observed in rapid tranquillization or medication adherence. Discarding communication mats and Makaton led to notable improvements, with X independently chairing her ward rounds for the past four months, demonstrating progress in self-advocacy.

Conclusion: This case highlights the importance of regular reviews of long-stay patient interventions and demonstrates that general adult psychiatrists, when supported by interdisciplinary teams, can achieve significant improvements in managing complex cases, leading to better outcomes for individuals with ASD and ID.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

A Case of Depersonalization-Derealization Disorder

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Aims: Background: Depersonalization-derealization disorder (DPDR), classified under ICD–11 code 6B66, involves persistent or recurrent experiences of depersonalization, derealization, or both. Depersonalization refers to a sense of detachment from one's thoughts, emotions, or body, whereas derealization involves perceiving the external world as unreal or distorted. These symptoms cause significant distress or impairment, are not attributable to other mental disorders, substance use, or medical conditions, and occur while reality testing remains intact.

Methods: Case Report.

An 18-year-old female A-level student presented with a two-year history of frequent episodes in which her surroundings, including people and familiar environments, felt unreal. These episodes varied in duration and were highly distressing, particularly during emotional extremes such as heightened happiness or stress. Symptoms were most pronounced in the evenings or when she was unoccupied, leading to emotional breakdowns. Despite these experiences, she remained aware of her own reality, with disturbances centred on external perceptions.

Her symptoms began following a nine-month psychiatric hospitalization. Prior to admission, she experienced unexplained gastrointestinal symptoms, and in the absence of an identifiable physical cause, she was diagnosed with conversion disorder. The hospitalization was distressing due to frequent invasive procedures, a perceived sense of blame for her condition, and feelings of entrapment. She subsequently developed post-traumatic stress disorder (PTSD), characterized by flashbacks, nightmares, and avoidance of medical settings. However, DPDR symptoms persisted outside of PTSD-related re-experiencing episodes, causing ongoing distress and impairment.

Results: Discussion: This case highlights the complex interplay between DPDR and PTSD, particularly following medical trauma. While dissociative symptoms frequently occur in PTSD, ICD–11 differentiates DPDR as a distinct disorder when symptoms persist beyond re-experiencing episodes. In this case, the patient's prolonged hospitalization, combined with perceived invalidation and invasive interventions, likely contributed to the development of DPDR as a maladaptive dissociative response.

The exacerbation of symptoms during emotional extremes aligns with research indicating that dissociation may function as an affect regulation mechanism. Trauma-related dissociation has been linked to disruptions in emotional processing, potentially interfering with adaptive coping strategies. This underscores the importance of targeted psychological interventions to reduce distress and improve functional outcomes.

Conclusion: A trauma-informed, multidisciplinary approach is essential in managing this patient's complex presentation. Psychological interventions such as EMDR or trauma-focused CBT should be integrated with ongoing medical care to address both dissociative symptoms and physical health concerns. Collaborative management between psychiatric and medical teams will be crucial in promoting long-term recovery, enhancing her psychological resilience, and improving overall quality of life.

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Providing Virtual Psychosocial and Trauma Support to Displaced Women in Nigeria: A Case Study of Courage, Innovation and Collaboration; Core Values and Behaviours of the Royal College of Psychiatrists

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