

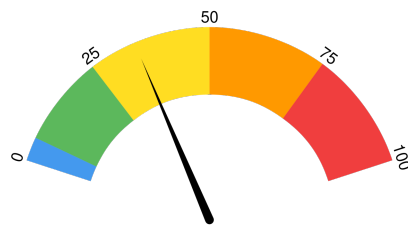
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Autism Spectrum Disorder (ASD)

Student's Name

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Autism Spectrum Disorder (ASD)

Background Information

Autism spectrum disorder (ASD) is neurological and developmental disorder that assumes early onset during childhood, before the age of 3, lasting throughout the affected individual's life. In its earliest years of discovery, it was referred to as Asperger syndrome or pervasive developmental disorders (Stoppler, 2020) with Asperger syndrome assuming a separate diagnostic entity in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) but recent versions of this manual have removed Asperger syndrome as a formal diagnosis with individuals with the disease currently grouped in the category of autism spectrum disorder (APA, 2013). The disease processes in ASD affects how an individual act and especially how they interact with others, learn, and communicate since the pathogenesis of the disease arises from the disturbances in social functioning and communication (Martinez-Pedraza & Carter, 2009). Consequently, the affected individuals tend to present with problems talking to other people or avoiding eye contact when they are engaged in a face-to-face conversation with someone else. In learning, thinking, and problem-solving abilities, people with ASD can range from gifted to severely challenged (CDC, 2020).

The other signs and symptoms of the disease include unresponsiveness, restricted interest in certain activities or items or subjects, repetitive behavior, and failure to understand social cues such as tone in spoken language or body language (Wiggins et al., 2015). The severity and occurrence of the signs and symptoms of this disease varies significantly from one affected individual to the next. Therefore, the manner in which this disease will present in one individual might be very different from the manner in which it presents in another individual with some

having milder forms of the disease while others experiencing debilitating forms of the disease. The most severe form of the symptoms of this disorder include self-abusive behavior, learning to speak relatively late, lack of empathy, social withdrawal, and avoidance (Wiggins et al., 2015). The other signs and symptoms of the disease depend on the age of the child at presentation and the combination of symptoms unique to that child. For example, affected children who have not yet developed sufficient language skills may tend to act out including screaming or crying to call the attention of others to their needs (Wiggins et al., 2015; Martinez-Pedraza & Carter, 2009).

The use of the term “spectrum” in the name of this disorder stems solely from the fact that people affected by this disease tend to depict a range of symptoms and might vary widely in their level of functioning (Mandal, 2019). Not all of the affected individuals will experience all of the identified symptoms and the presentation of the disease is greatly dependent on the age of the affected individual such that signs and symptoms in babies IQ may include lack of eye of contact and the back-and-forth play with the baby being overly focused on one item (Stoppler, 2020; Parmeggiani, Corinaldesi, & Posar, 2019). In contrast, signs and symptoms in young children might be a bit refined and easy to identify the affected neurological functions of the brain given the affected child’s continued loss of interest in social contact and social withdrawal (Wiggins et al., 2015; Parmeggiani, Corinaldesi, & Posar, 2019). In etiology, the definitive cause of the disease is not known however interplay of genetics and environmental factors has been implicated in the pathogenesis of the disease (Martinez-Pedraza & Carter, 2009).

Diagnosis Criteria

The American Psychiatric Association’s Diagnostic and Statistical Manual, fifth edition (DSM-5) provides standardized criteria to help with the diagnosis of ASD. Diagnosis of autism

spectrum disorder (ASD) now includes symptoms of autism, Asperger syndrome and those of pervasive developmental disorders (APA, 2013). Under DSM-5 directions, the diagnosis of ASD must demonstrate the existence of persistent deficits in each of three areas of social communication and interaction in addition to at least two of four types of restricted, repetitive behaviors (APA, 2013). The diagnostic criteria under social communication and interaction, the affected individual must demonstrate three of these symptoms which include: deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions (APA, 2013). Secondly, deficits in verbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expression and non-verbal communication (APA, 2013). Lastly, deficits in developing, maintain, and understanding relationship, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers (APA, 2013). Eliciting all of these three deficits under this category is one of the criteria that must met for the diagnosis of autism spectrum disorder.

The second criteria require the demonstration of at least two of four manifestations of types of restricted, repetitive patterns of behavior, activities, or interests. These include stereotyped or repetitive motor movements, use of objects, or speech such as simple motor stereotypes, echolalia, and or idiosyncratic phrases. Secondly, insistence on sameness, inflexible adherence to routines, or ritualized patterns of behavior, both verbal and non-verbal, such as extreme distress at small changes, rigid patterns of thinking, and the need to take same route or

eat same food every day (APA, 2013). Thirdly, it is the highly restricted and fixated interests of abnormal intensity or focus such as strong preoccupation or attachment to unusual objects or demonstration of excessively circumscribed or perseverative interests (APA, 2013). Lastly, there is demonstration of hypo-or hyper-reactivity to sensory input or unusual interest in sensory aspects of the environment such as apparent indifference to pain and temperature, adverse response to specific sounds or textures, or visual fascination with lights or movements (APA, 2013).

In the diagnosis of this disorder using the DSM-5 manual, the symptoms of the affected individual is examined both in recent time or based of history of the patient. The severity of the individual symptoms need to be clarified based on the patient's present complaints and adequately categorized based on social communication impairments and restricted, repetitive patterns of behavior. In compliance with the diagnostic criteria of the disease as outlined under DSM-5, additional requirements for the diagnosis of the disorder include: demonstration of the presence of the symptoms in the early developmental period of the individual despite the fact that these symptoms may not become fully manifest until social demands exceed limited capacities, and they might be masked by learned strategies in later life (APA, 2013). The second essential requirement for the diagnosis of this disorder include the demonstration of the impact of the symptoms of the disorder as causing significant impairment in social, occupational, or other important areas of current functioning (APA, 2013). Lastly, it is the demonstration that the symptoms presented by the patient are not better explained by intellectual disability or developmental disorder, or global developmental delay, therefore, a diagnosis of exclusion (APA, 2013).

²⁸ The diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified using the DSM-IV is ascribed to the ⁵⁰ diagnosis of ASD under ¹² DSM-5. Individuals with marked social communication deficits, but whose symptoms do not otherwise meet the criteria for autism spectrum disorder, are required to be subjected to evaluation for social (pragmatic) communication disorder. Lastly, it is important to specify the diagnosis ASD especially in the case of associated or accompanying disorders, most notably, ¹¹ intellectual impairment with or without accompanying language impairment, known medical or genetic condition or environmental factor, another neurodevelopmental, behavioral, or mental disorder, and catatonia, with specific reference to the appropriate additional codes and criteria for identifying the associated conditions (APA, 2013).

Differential Diagnosis Information

The list of differential diagnoses that can be obtained with suspected ASD encompasses all diseases with similar symptoms as those of ASD and the associated comorbid diseases that complicate the diagnosis of ASD. To begin with, under the DSM-5 manual, ASD encompasses three different but related disease processes that make the first list of differential diagnoses. These diseases include autism disorder, Asperger syndrome, and pervasive developmental disorders (APA, 2013). Further exploration of the severity and nature of the symptoms presented by the patient is the only potent way to determine the definitive diagnosis of the disease and to characterize between the differentials enlisted under the clause of ASD. Secondly, the associated diseases make another list of potential differential diagnoses especially those diseases that elicit similar symptoms to those observed in ASD. These include the likes of intellectual and language impairments or developmental disorders that might lead to symptoms of deficits in communication, thinking, and learning synonymous with those elicited by ASD. The other

associated diseases include catatonia, known genetic condition or environmental factors, and another neurodevelopmental, behavioral, or mental disorder (Stavropoulos, Bolourian, & Blacher, 2018). All these disease make for good differential diagnoses that can be eliminated by further investigation, thus stressing on the fact that ASD is diagnosis of exclusion; once all possible causes of the symptoms are eliminated, then a diagnosis of ASD is made (APA, 2013).

Another set of diseases that make for good differential diagnoses include the associated comorbidities such as psychiatric comorbidities or known medical conditions. In psychiatric comorbidities, the most common comorbid diseases include anxiety, depression, and attention deficit/hyperactivity disorder (ADHD) most commonly in affected children (Stavropoulos, Bolourian, & Blacher, 2018). Anxiety disorders make the most common comorbid disorders in ASD with an estimated 40-45% of youth with ASD having a comorbid anxiety disorder and another 11-84% of children with ASD suggested to experience impairing levels of anxiety (Stavropoulos, Bolourian, & Blacher, 2018). Anxiety disorders make a potential differential diagnosis because their related behaviors are among the most common presenting problems for children with ASD in the clinical settings (Stavropoulos, Bolourian, & Blacher, 2018). The other psychiatric comorbid disease associated with ASD and that makes a potential candidate for a differential diagnosis is posttraumatic stress disorder (PTSD). PTSD is characterized by negative alterations in cognition and mood, avoidance, intrusion symptoms, and reactivity (Stavropoulos, Bolourian, & Blacher, 2018). Important to differential diagnosis is the overlap between avoidant behavior and repetitive play themes that occur with both PTSD and ASD (Stavropoulos, Bolourian, & Blacher, 2018). There is however the lack of consensus over the occurrence rates of PTSD and ASD with some literature pointing to 67% of children with ASD in the outpatient clinic as having concurrent PTSD which is shown to be twice the amount found in the

population, while other studies have reported 0-3% rates of PTSD with ASD (Stavropoulos, Bolourian, & Blacher, 2018). Regardless of the occurrence rates, for similarities in presenting symptoms, PTSD makes a potential differential diagnosis for ASD.

Multicultural and Gender Concerns

Reporting of cultural factors is important in addressing the disparities that occur in diagnostics and treatment of children with ASD from diverse backgrounds (Engstrand et al., 2018). The existing disparities in diagnosis and treatment of children with ASD from diverse backgrounds stem from the differences in race and ethnicity within the population with the minority and majority populations showing disparities in accessing high-quality healthcare services or getting eligibility for special education services (Engstrand et al., 2018). ASD depicts male predilection in occurrence rates which coupled with the observable disparities led to the creation of *Comprehensive and Coordinated Efforts for the Management of Autism Spectrum Disorders* during the 67th World Health Assembly (WHA67) (Engstrand et al., 2018). Under this new provision, member states were urged to “to identify and address disparities in access to services for persons with autism spectrum disorders and other developmental disorders” (Engstrand et al., 2018).

Prevalence

Autism spectrum disorder has had prevalence rates of between 10 and 16 per 10,000 inhabitants since 1960s. The current estimated rates depict a 10-fold increase in the prevalence rates of the disorder (approximately 60 per 10,000 inhabitants) as compared to earlier reports of the disease in literature (Brentani et al., 2013). This increase can partly be attributed to improvements in diagnostic practices and public awareness of the disorder. In diagnosis,

pervasive developmental disorders (PDD) is often the most frequent diagnosis (3 per 1,000 inhabitants), followed by autistic disorder (2 per 1,000 inhabitants), while Asperger's disorder makes the least common diagnosis in frequency (6 per 10,000 inhabitants) (Brentani et al., 2013). The extremely rare diagnoses include Rett's disorder and Childhood disintegrative disorder (CDD) with occurrence rates of approximately 2 per 10,000 inhabitants (Brentani et al., 2013). It is estimated to affect 1 in every 68 children in the United States (Stavropoulos, Bolourian, & Blacher, 2018), with an overall prevalence rate of approximately 1% for ASD in several regions of the country (Brentani et al., 2013). The combined prevalence of ASDs across the globe renders them the most frequent neurodevelopmental disorders the world over, constituting a major Public Health concern (Brentani et al., 2013).

Demographics

Autism spectrum disorder (ASD) demonstrates early onset in children with the disease currently being diagnosed in babies who are between 18-24 months (Brentani et al., 2013). However, most children are still being diagnosed after the age of 4 years (Maenner et al., 2020). Prevalence data obtained from the CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network as of 2016 revealed average incidence rates of ASD as affecting 1 in every 54 (1.9%) 8-year-old children in the United States. ASD is 4.3 times more common in boys (3.0%) than in girls (0.7%) with the disorder occurring in all racial and ethnic groups (Maenner et al., 2020). Prevalence among boys is 29.7 per 1000 population and 6.9 per 1000 population in girls. Distribution of the disease among the different race and ethnicity is as follows: 18.5 per 1,000 (1.9%) in whites, 18.3 per 1,000 (1.8%) in blacks, 17.9 per 1,000 (1.8%) in Asian/Pacific Islander and 15.4 per 1,000 (1.5%) in Hispanics (Maenner et al., 2020).

Regarding the impact of ASD, 31% of the affected children with ASD have an intellectual disability (intelligence quotient [IQ] <70), 25% are in borderline range (IQ 71-85), and 44% of the affected children have IQ scores in the average to above average ranges, that is, IQ score of above 85 (AS, 2020). ASD affects all members of the population from all socioeconomic groups with patients from the minority groups depicting tendency of late diagnosis with less frequent cases. In terms of genetics, it is postulated that parents with an autistic child have a 2-18% chance of having a second child who is affected (AS, 2020). Among identical twins, the occurrence of ASD in one child is associated with a 36-95% chance that the other child will be affected. In fraternal twins, the chances that the other child will be affected are 31% (AS, 2020). It is now clear, thanks to extensive research in the area, that vaccination does not cause autism (AS, 2020).

Prognosis

ASD begins in early childhood and tends to persist into adolescence and adulthood. The symptoms of the disease tend to improve with adequate intervention throughout the lives of the affected individual. However, prognosis of the disease is highly correlated with the IQ of the affected individual such that low-functioning patients might depict poor prognosis with the result effects being life-long dependence on their caregivers. In contrast, high-functioning patients could develop independence, successfully hold jobs, and even get married and have children (Mandal, 2019). Consequently, depending on the level of functioning, recent surveys report 49% of ASD adults are still living with their parents and only approximately 12% have full time employment (Mandal, 2019). Children with milder forms of the disorder might depict improvement by ages 4-6 years when treated at an early age. Improvement can allow these children to successfully integrate with their peers with the current policy of inclusion within the

educational system helping to support the majority of children with ASD within mainstream schools (Mandal, 2019). The rates of improve among ASD population in the United Kingdom as of 2004 was 10%. A study conducted in 2004 among autistic adults diagnosed as autistic children with IQ above 50 depicted 12% of the autistic adults as achieving high level of independence as adults, 10% as maintain a social life and some form of employment but still required some support, 19% with some independence but still living at home, 46% as being in need of specialist residential provision, and 12% as being in need of high-level hospital care (Mandal, 2019). The prognosis of ASD is also dependent on co-existing mental retardation and the occurrence of co-morbid diseases like genetic and or chromosomal abnormalities with 25-75% of patients shown to have varying degrees of mental retardation with an estimated 10% to 15% of ASD cases having an identifiable chromosomal abnormality.

Effective Intervention

As of now, there is no single treatment for ASD, however, there are many modalities to help increase the affected child's ability to grow and learn new skills. For these treatment modalities to prove effective in managing and improving the signs and symptoms of the disease, early initiation into therapy is of invaluable importance and is associated with better results (Brentani et al., 2013). This therefore renders the accurate and timely diagnosis of the disease of strategic importance in the management of the disease, and especially in improving the symptoms of the disease (Stavropoulos, Bolourian, & Blacher, 2018). Timely and accurate of diagnosis of this disorder is currently augmented by the increase in both prevalence and awareness of the disorder (Stavropoulos, Bolourian, & Blacher, 2018). The available intervention include psychosocial therapy such as behavioral, skills, and communication therapies, and lastly, pharmacologic therapy using certain drug classes to control symptoms of the disease (Stoppler,

2020). One such potent psychosocial therapy includes applied behavior analysis (ABA) that aims to improve socially adaptive behavior and lead to acquisition of new skills by applying the principles of operant learning through intensive practice and targeted reinforcement (Brentani et al., 2013). It is important to pay attention to the available comorbid diseases which complicate the diagnosis and management of ASD, for example, children with ASD are more likely to have psychiatric comorbidities such as attention deficit/hyperactivity disorder (ADHD), depression, and anxiety (Stavropoulos, Bolourian, & Blacher, 2018) thus necessitating the initiation of both psychotherapies and pharmacological therapies tailored to the available psychiatric comorbidities presented by the patient.

Conclusion

In conclusion, the priority of the intervention is in restoring functional and spontaneous communication and social instruction across settings, play skills, with a focus on peer interaction, maintenance and generalization of new skills within a natural context, and providing support for functional assessment and positive behavior to address the problem behaviors (Brentani et al., 2013). The interventions used need to be evaluated regularly at intervals of every 3-6 month with the intervention focusing on adaptive, communication, organizational, and social skills (Brentani et al., 2013). The essential characteristics of effective interventions for children with ASD include beginning the intervention program as early as possible, and giving intensive treatment for five days a week for a minimum of five hours per day. The other characteristics include making use of repeated planned teaching opportunities that are structured over brief periods of time, and providing adequately individualized adult attention on a daily basis. Lastly, effective interventions should include a family component such as parent training as part of the

6
intervention program, and institute mechanisms for ongoing assessment with corresponding adjustments in programming (Brentani et al., 2013).

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