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IDENTIFYING AND MANAGING AUTISM SPECTRUM DISORDER IN CHILDREN

AUTISM SPECTRUM DISORDER (ASD)

Autism Spectrum Disorder (ASD) is a part of a group of permanent neurodevelopmental disorders that typically presents in the pre-school period. ASD features include persistent impairment in social communication, and social interaction with limited, repetitive patterns of behaviour, interests, and activities. These deficiencies interrupt the child's ability to develop and maintain relationships in social situations, such as at home and school.

The term 'spectrum' is used due to the inconsistencies in the description and seriousness of ASD features, as well as the differences in the abilities and level of functioning of individuals who have ASD.

Individuals with a well-established DSM-IV diagnosis of Asperger's disorder or Autistic disorder will receive the diagnosis of ASD in the DSM-5 (The Diagnostic and Statistical Manual of Mental Disorders). Sensory abnormalities are now included in the DSM-5 ASD criteria.

CASE STUDY 1:

The mother of a seven year-old boy reported that he had been different from her other kids since the age of three years. She noted that he showed less interest in social interaction and would smile and look at her as less when compared to his five month old sister.

He also experienced problems with unusual and decreased speech. He didn't use his words to express thoughts or feelings like other children and would only speak in simple sentences.

She also reported problems with social interaction and communication when interacting with family, fellow learners and teachers.

The mother described his play as unusual as he'd become upset when his play was disturbed or when small changes were made in his environment. He had a preoccupation with lightbulbs and preferred to play alone and failed to acknowledge other kids' attempts to

play with him.

His lack of educational progress was due to ongoing tantrums triggered by his inability to change focus and comply with commands. He was irritable and sensitive to food textures and loud noises, affecting his routine care such as haircuts and dental check-ups.

The diagnosis of autism spectrum disorder (ASD) was made, without accompanying intellectual impairment and with language impairment (phrase speech). It was noted that he required substantial support for shortfalls in social communication and restricted, repetitive behaviours.

A trial of risperidone medication was initiated for treatment of his stubbornness and irritability. His tantrums decreased dramatically, and he was more responsive to the school curriculum.

DSM-5 FEATURES FOR ASD:

A: Shortfalls in social communication and interaction as illustrated currently or by history:

- Problems in forming shared relationships due to a lack of social-emotional exchange such as sharing interests, limited conversation, and restricted social engagement.
- Limited nonverbal communication (body language) such as lack of eye contact, confined social gestures, and absent facial expressions.
- Problems in developing and maintaining relationships such as lack of flexibility, problems adapting to situations and change, difficulties in sharing, lack of imaginative play, and troubles in friendships.

B: Limited- and uninteresting patterns of behaviour, interests and activities as illustrated currently or by history:

- Aimless and repetitive motor movements or speech, such as lining up toys, flipping objects, echolalia (meaningless repetition of another person's speech), repetitive phrases.
- Insistence on sameness reflected by inflexible routines, ritualised patterns, rigid thinking
- Limited, fixed, and intense interests: preoccupation with objects or topics.
- Hyper or hypo-reactive response to sensory input expressed by sensitivity to sound/textures, excessive smelling/touching of objects.

Specifying the current severity is based on the level of support needed for each of the two psychopathological areas (A&B) e.g., A. Social communication impairments and B. Restricted, repetitive patterns of behaviour

- Level 3: "Requiring very substantial support"
- Level 2: "Requiring substantial support"
- Level 1: "Requiring support"

Other measures include:

C: Symptoms begin during early child development

D: Symptoms cause significant loss in functioning

E: The disturbance is not better explained by an intellectual disability (mental impairment) or global developmental delay (extensive child-developmental disruption). It is common for ASD to co-occur with intellectual disability.

Specify if:

- With or without accompanying intellectual impairment
- With or without accompanying language impairment
- Associated with a known medical or genetic condition or environmental factor
- Associated with another neurodevelopmental, mental, or behavioural disorder
- With catatonia

Comorbidity of neurodevelopmental disorders: These disorders often co-occur with other neurodevelopmental disorders and/or may occur with other psychiatric disorders (anxiety disorders) and/or other medical conditions (epilepsy). This may complicate prognosis and treatment. Early detection of ASD with immediate intervention improves the prognosis.

ROLE OF THE GENERAL PRACTITIONER (GP) IN THE MANAGEMENT AND TREATMENT OF ASD:

A. Psychoeducation:

- Reported incidences for ASD are approaching 1% of the population.
- ASD is diagnosed four times more frequently in males than females.
- A positive outcome for ASD depends on the absence of associated intellectual disability, language impairment and additional mental health problems.
- Age of onset is typically 12-24 months of age but maybe earlier than 12 months.
- A small number of complex cases with clear dramatic loss of words or skills are included under DSM-IV childhood disintegrative disorders, showing the worst prognosis.

B. Early symptom identification and screening

- Physical, psychiatric, and neurological examinations to exclude other medical conditions, including eye tests and a hearing evaluation.
- Side room and blood tests, special investigations such as the Electroencephalogram (EEG) and/or Brain-/MRI scan, referral to a paediatrician or neuro-paediatrician, if indicated.
- Referral to a qualified child and adolescent professional mental health care practitioner and/or

multi-professional team (MDT). This team usually consists of a child and adolescent psychiatrist, a psychologist, an occupational therapist, a social worker, a nursing sister, a schoolteacher and an educational psychologist.

- A final diagnosis of ASD should be based on the findings of the MDT, taking the results of the team's assessments into account.
- Parents should not attempt to diagnose their child or try treatment ideas without consulting with professionals.

B. Interventions should focus on the following educational areas:

1. Improve functional spontaneous communication.
2. Enhance social skills.
3. Boost play skills.
4. Increase cognitive development in a natural setting.
5. Reduction of problem behaviours.
6. Teaching functional academic skills.

C. Psychosocial support (assessments and therapies):

1. **Family support:** support groups, individual supportive counselling
2. **Parent** psychoeducation: Families play a key role in effective treatment for children with ASD. Individuals with ASD and their families should become partners with professionals in all aspects of planning. Assist parents in managing co-occurring disorders of sleep and feeding, gastrointestinal tract symptoms, obesity, seizures, attention-deficit/hyperactivity disorder, anxiety, and the increased risk of wandering behaviour.
3. **Parent behavioural management training:** Use of a behavioural specialist to help parents learn to employ behavioural management protocols to help their child learn appropriate behaviour.
4. **Special education services** should be individualised to the needs of the child
5. **Diagnostic scales** include the Autism Diagnostic Observation Schedule (ADOS) and the Autism Diagnostic Interview (ADI-R).
6. **Occupational therapy (OT) and physical therapy (PT) evaluations.** OT for sensory processing and the fine motor deficits, PT for coordination deficits.
7. **Referral for speech therapy and language testing.**
8. **Referral for disability services and support:** Ensure that the child and the family receive appropriate rights/privileges, suitable to the child and family needs.

D. Psychopharmacological interventions:

It's not standard care to use the medication in all individuals.

Effective drug treatments are available to help with the "irritability" in ASD. Overmedication should be avoided.

- **Behavioural disturbance of aggression and irritability:**
  - **Atypical antipsychotics** such as risperidone and aripiprazole for aggression can also improve repetitive behaviour. Most common adverse effects include weight gain, hyperlipidaemia, hypertension, and increased prolactin.
  - **Anticonvulsants and Lithium** for treatment of aggression but blood monitoring may limit use.
- **Repetitive behaviour:** Selective Serotonin Reuptake Inhibitors (SSRIs) such as fluoxetine, citalopram, escitalopram, fluvoxamine. Potential adverse effects include restlessness, insomnia, mania.
- **Hyperactivity and inattention** to be treated with stimulants such as methylphenidate.
- **Alpha—2 agonists** such as guanfacine, clonidine for hyperactivity, aggression, and sleep dysregulation.
- **Sleep dysregulation** can be treated with melatonin.

References available upon request