The Progress of Autism in the United States

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In the last decade, autism has assumed a greater presence in the headlines of the media and in the minds of the general public. Today, what is nor referred to as Autism Spectrum Disorder (ASD) has grown into a greater concern in the United States as statistics show an increase in its diagnosis among children. In 2006, statistics recorded by the Centers for Disease Control and Prevention stated that one out of every 110 children are diagnosed with autism. This number is drastically higher compared to the one out of ever 2,000 children thought to be affected by autism before the 1980's (Rice, 2006). In light of these new statistics and concerns, however, it is important to consider context in terms of the characteristics of autism, its history, the assessments currently used for its diagnosis, and the numerous therapies necessary for treatment.

According to the American Psychiatric Association (APA), autism is one of a variety of pervasive developmental disorders (PDDs) occurring on a spectrum that causes severe deficits in many areas of development (Block, Block, & Halliday, 2006, p.8). The first few years of a child's life are filled with numerous milestones as they learn to say their first words, to walk, to play, and to explore. A child with autism develops instead with impairments in communication, social interaction, in addition to other repetitive and stereotyped behaviors, interest, and activities (Griffin, 2011). These deficits are usually noticeable shortly after birth and before the age of three, though some cases have noted normal development up to the age of one or two followed by a sudden regression. Noticeable symptoms include an unresponsiveness to sound, avoiding eye contact, shying away from physical touch, social and emotional withdrawal, and lack of verbal communication (Block, Block, & Halliday, 2006, p.8).

The four other disorders that occur on the spectrum vary in severity, symptoms, onset, and co-morbidity with other disabilities. These include Asperger's disorder, Rett's disorder, Childhood Disintegrative Disorder (CDD), and others that fall under Pervasive Developmental Disorder- Not Otherwise Specified (PDD-NOS) (Block, Block, & Halliday, 2006, p.8). Asperger's disorder is a milder form of autism with few cognitive and communication impairments. Many of the impairments occur in social interaction. Rett's disorder is the result of regression and mental retardation after five months to four years of normal development. Child Disintegrative Disorder becomes apparent anywhere after two to ten years of normal development when a sudden loss of skills and abilities occurs. PDD-NOS is the catchall for those who have symptoms very similar to autism and can benefit from services, but do not quite fit the necessary criteria (Kauffman and Hallahan, 2005, p.40).

Because there are such a variety of disorders, each child diagnosed on the spectrum is unique in their abilities and needs. These abilities and needs will vary in three areas: communication, social interaction, and unique behaviors. In milder cases, children with autism may be able to use one or two word sentences and when they speak it may be in a different tone and volume. Echolalia is a common speech pattern where the child may repeat certain phrases said to them that contain sounds or words that are enjoyable for them to say. Children with more severe cases of autism may have no speech at all. In these cases it is more important to use visual cues, pictures, and sign language if they are cognitively able to use it. A child with autism may also have impairments in receptive communication skills. They may not respond to speech or sound because they are so withdrawn into their own world or because they are not able to comprehend what was

said. Those who have more receptive skills may still have trouble understanding figurative and ambiguous speech (Block, Block, and Halliday, 2006, p.9).

Social impairments are often affected by the severity of the communication impairments. In more mild cases, children want to interact with other but may not be sure how to navigate social cues or use appropriate phrases, topics, and speech. Making and maintaining eye contact is also a struggle, especially when there may be co-existing problems with vision. Children with more severe cases of autism may completely lack abilities to interact in social situations. They make no effort and have no interest or joy in seeking interaction (Block, Block, and Halliday, 2006, p.9). This withdrawal into self is both one of the more major characteristics of autism and its namesake.

Besides impairments in communication and social interaction, the factor that causes so much variance in the abilities and needs of children with autism is the other behaviors and features that may be associated with it. Many children are affected by sensory integration dysfunction: "the inability of the nervous system to organize and process sensations from the body and the environment" (Griffin, 2011, Slide 18). They may be hypersensitive to tactile, visual, auditory, and oral sensory input to an extent that causes them a great deal of discomfort and sometimes pain. Examples include certain tones, textures, and images. There are also possibilities of cognitive deficits, emotional problems, physical aggression towards self and others, allergies, restrictive diets, limited motor functioning, seizures, other medical concerns and more that need to be addressed (Griffin, 2011). This endless list offers numerous possible combinations that can occur in one child.

However, autism didn't always have such a wide definition. Eugene Bleuler, a Swiss psychiatrist, first used the term "autism" in 1911, during a study he was conducting about

schizophrenia. He noted that those he studied seemed to retreat into themselves, as if they were in their own private, inner world. In Greek, the term refers to "the act, state, or theory of self" (Autism, 2012). The similar symptoms of social withdrawal, communication impairments, and lack of eye contact led to a close association between the two disorders (Dvir &Frazier, 2011). In spite of this, Leo Kanner, an Austrian child psychiatrist located in the United States, noticed differences that set autism apart from schizophrenia. He discussed this observation and noticeable symptoms of autism in his paper entitled "Autistic Disturbance of Affective Contact" that was published in 1943 after encountering 10 similar cases. The first was that of Donald Grey Triplett, age five, who he examined in 1938 at Johns Hopkins Hospital in Baltimore, Maryland. Donald Triplett became the first person to be diagnosed with autism. (Donald Grey Triplett, 2012).

One major difference between the two disorders was how patients with schizophrenia usually had at least two years of normal development before *gradual* changes began to occur as opposed to these ten patients with autism, who withdrew into their own world at the very beginning of life (Kanner, 1943, p.248). Even in light of this new observation and study, the assessment and diagnosis of autism and schizophrenia were still closely associated for a time. In the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I) published by the American Psychiatric Association in 1952, autism was identified under schizophrenia, childhood type. The identification remained the same in the DSM-II that was published in 1968. It wasn't until the third publication of the manual in 1987 that autism was given its own diagnostic category. It was called "Infantile Autism" and the diagnostic criteria included an onset prior to 30 months in age, pervasive lack of responsiveness to people, gross deficits in language deficiencies, peculiar

speech patterns such as echolalia, bizarre responses to various, and an absence of delusions and hallucinations that are characteristic of schizophrenia (Grinker, 2007).

The revision of the third edition of the manual (DSM-III R) includes sixteen items in three different categories. Each category refers to one of the three major characteristics: (A) impairments in social interaction, (B) impairments in communication, and (C) unique behaviors and activities. A diagnosis requires two items from category A, one item from category B, one from category C, and that the onset of autism was during infancy or early childhood. The current criteria for autism in the DSM-IVR include the same categories and the same number of items from each. However, instead of sixteen items, each category contains four, which lowers the total to twelve (Grinker, 2007).

Scientists disagree about why there has been such a recent rise in the diagnosis of autism. One argument that has been voiced by social anthropologist Dr. Richard Grinker, a professor at George Washington University, is because of the new wider definition. It may not be because there are actually more cases, but that professionals are getting better at finding them, diagnosing them, and providing necessary services. On the other hand, some scientists in the field believe that that is only part of cause for the rise in autism diagnosis. The other part is left to speculations about causation (Macneal, 2011).

To date, no one has found the exact cause of autism. However, many different possible causes are being investigated in different scientific fields such as environmental science and genetics (What Causes, 2011). In an interview, Dr. Irva Hertz-Picciotto, a professor of public health sciences at University of California, David, stated that it is probable there are environmental factors that affect development possibly via infectious agents, chemicals, and nutrition. However, that would not be the only possible cause of

autism. Dr. Hertz-Picciotto believes Autism is multi-factorial in causation at the individual level and across the population (Macneal, 2011).

As speculation continues, the American Psychiatric Association is currently reviewing the criteria published in the DSM-IV-TR that applies to autism in response to the rising number of children being diagnosed with the disorder. This new edition of the DSM would require those being assessed to fit stricter criteria and would eliminate Asperger's and PDD-NOS leaving behind a much narrower category. Many researchers support this proposed definition of autism, saying that it would simplify the process and hopefully slow the rate of diagnosis. However, many are also worried that those who lie on the line between autism and Asperger's or PDD-NOS and need the services but do not fit into the specific criteria will be negatively affected. Without an official diagnosis families will not be able to qualify for the services their child needs to succeed in school or the insurance to cover additional necessary services and medical attention (Gann, 2012). Something to consider a teachers, parents, and advocates is how this will affect the special education program in public schools across the country.

The Diagnostic and Statistical Manual for Mental Disorders is one of the major assessment tools used for autism diagnosis, but there are a few other assessments and screenings that may be part of the process. Psychologists, psychiatrists, or developmental pediatricians usually make a diagnosis using clinical observation, screenings, standardized tests, parental interviews, and medical records. A few of the screenings and tests that might be used include the Childhood Autism Rating Scale (CARS), Checklist for Autism in Toddlers (CHAT), the Autism Diagnostic Observation Scale (ADOS), and Autism Diagnostic Interview-Revised (ADI-R) (Treatments, 2011). Some tests are directed more at parents or

caregivers and others include other professionals as well. Many are based around the three main characteristics of autism that the DSM addresses. The purpose of many of these assessments is to ensure that a child is not being misdiagnosed with autism when they may have an intellectual disability or other impairment.

Depending on the diagnosis that is made for the child and any other observations, certain therapies may be deemed appropriate treatments. Just like every case of autism is different, so is the combination of therapies that work the best to address it. Under the Individuals with Disabilities Education Act (IDEA) of 2004, individuals with an official diagnosis are guaranteed a free and appropriate education in the least restrictive environment. This enables them to be eligible for services through the public school system and for early intervention from birth to age three mandated by Part C of IDEA (Griffin, 2011). Additional services and therapies include Applied Behavioral Analysis, occupational therapy, physical therapy, speech therapy, Dietary Intervention if certain nutrients or a lack there of may be a cause, visual therapy canine companions, and relationship development intervention (RDI) (Treatments, 2011). It is clear that the wide variety of available therapies reflects the idea that autism may be caused by multiple factors. Each addresses a specific characteristic and provides enormous aid in the daily life of each individual.

Applied Behavioral Analysis is a behavioral therapy that views "behavior as a response to an event or object in an individual's environment" (Szapacs, 2006, p. 12). By looking at the events or circumstances that occur before a behavior and the resulting behavior, appropriate changes can be made so that an unwanted behavior doesn't occur.

Instead it is replaced with a more positive behavior (Szapacs, 2006, p. 12). The use of positive feedback for desired behaviors also promotes the elimination of a negative one.

Dr. Steven Gutstein developed another therapy addressing the social interaction and relationship impairments of autism called Relationship Development Intervention. The intervention is a parent-based clinical treatment that works to teach motivation and skills that can help people with autism develop friendship, empathy, love, but more importantly an ability to share their world with others. It begins with the person's current abilities and works forward, so progress for each child may look different (Relationship, 2011). These are just some details of a couple of therapies that may greatly help a child. There are numerous options available for parents and caregivers to look into, receive consultations on, and decide which are best for their child.

As the definition of autism remains at forefront of the United States' attention for the present, it is important to keep in mind the progress it has taken place for it to become what it is today and attend to the needs of so many children. Through education and advocacy within in the general population for this spectrum disorder, the appropriate course of action can take place for the benefit of those it will affect in the future.

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