Diagnosing ASD

***Srinivas Gada** outlines some of the main things to look for if you think a child may have autism*

"I can't change the direction of the wind, but I can adjust my sails to always reach my destination", said James Dean. In my opinion, a similar mindset is required, if you wish to enable a child with autistic spectrum disorder (ASD).

ASD is a condition that affects a person's performance or functioning. It is not caused by anyone. Children with ASD see, hear, learn about, perceive, think about and relate to the world differently to others. It's no surprise then, that some of the greatest inventors, musicians, painters and sculptors the world has ever seen have been attributed with ASD.

Characteristics of ASD

Every child with ASD has three major characteristics. They are:

- difficulties or deficits in social communication
- difficulties or deficits in social interaction
- restricted patterns of behaviour, interests and activities.

Yet, ASD is a very diverse and varied condition. While I have diagnosed twins and many siblings with ASD, I have not seen two children with ASD who were same. This is because the degree of impairment in communication, social interaction, learning and adaptive functioning varies in each child.

Leo Kanner first described Autism in children in 1943. The term "autism" derives from the Greek word "autos", which means "self". Autism can be translated as meaning "alone". But individuals with ASD are not generally lonely. Autism was included as part of a spectrum in the Diagnostic and Statistical Manual fifth edition (DSM-5) classification, a diagnostic tool used in USA and around the world. Autism and Asperger's syndrome are two well recognised prototypes of the ASD spectrum.

ASD is common. It is present in one to two per cent of children. Some studies show prevalence to be as high as one in 40, while others report this to be as low as one in 400 children. Possible explanations for increases in ASD prevalence could be changes in the way it is diagnosed, increased awareness of ASD and the shift to viewing autism as a spectrum condition.

When can ASD be diagnosed?

Symptoms of ASD are usually present by 18 to 24 months of age. Some children appear to achieve early language milestones, but then regress or plateau in their communication and social skills. In general, the more severe the impairments in social interaction and communication, the earlier they present. Some children present in school years when the

social demands exceed their limited capacities. Currently, most children are diagnosed between the ages of four and five years.

Who can diagnose?

Diagnosis of ASD in children can be undertaken by a:

- neurodevelopmental paediatrician
- community paediatrician
- psychologist or
- child psychiatrist.

Depending on the child's needs and difficulties, the following professionals may also be involved in the assessment:

- speech and language therapist
- child psychologist
- occupational therapist
- audiologist.

Why is it important for ASD to be diagnosed early?

There is no cure for ASD, but early diagnosis and intervention can improve a child's behaviour, social functioning and communication. Evidence shows that interventions are more effective the earlier they are commenced. In some cases of children who receive appropriate interventions, the ASD symptoms can be reduced to an extent that they no longer impact the child's functioning and learning. The cost of lifelong care can also be reduced significantly with early diagnosis and intervention. Delays in diagnosing autism can lead to disengagement from learning, secondary mental health conditions such as depression and even family breakdown.

The main features of ASD

Features	Attributes and qualities to look out for
Play	Repetitive play limited in variety. Mechanical or noisy play. Lacking imagination. Preference to play alone. Distress when others join in.
Communication	May lack intent to communicate. Impaired use of non-verbal communicative behaviours such as eye gaze and gestures; for example, not nodding their head for "yes" or shaking their head for "no". Impaired turn taking in conversation. In school years, difficulty in understanding humour, sarcasm or deception. Literal interpretation of what others say.
Social interaction	Not pointing to objects to show interest. Not looking at objects' others point to. Limited or no eye contact when interacting with others. Disinterest or indifference to social hugs and affection. Absent or limited interest in social interaction with peers.

Social and emotional reciprocity	Difficulty in modifying one’s behaviour according to social context. Difficulty in understanding others’ thoughts, feelings and intentions. Consequently, difficulty in responding appropriately to others’ distress and needs. Difficulty in understanding the difference between strangers and family relationships.
Behaviour and interests	No shared interest. Content to play by themselves. Narrow, specific and intense interests, for example in dinosaurs, Thomas the Tank Engine, Pokémon, TV listings, football teams or train schedules. Fixated with personal interests.
Language	Language delay or regression. Repeating words or phrases they have heard. May use rote learned phrases or words. Limited or no use of language to share thoughts or make requests. May speak in single words or very short phrases. Delayed language development. Inability to adjust the complexity of language or choice of topic to others’ needs or according to the context. Understanding of language is more delayed than expressive language.
Preoccupations	Unusual attachment to certain objects. May be obsessed with wheels, spinning objects, edges, lights. Sniffing or licking non-food items.
Mannerisms	Could be self-soothing or self-injurious. This may involve, for example, hand flapping, rocking, tip-toe walking, head banging, running around in circles. Could be brought on by excitement, anger and frustration.
Routines and rituals	Insistence on sameness. Prefer routines. Certain things, like sitting down for a meal, order of dressing, bedtime routine or the route taken to school, must be undertaken in the same specific order. Any change can cause distress, anxiety or temper tantrums. Difficulty with transitions.
Sensory reactivity	Unusual or abnormal sensory perception. May be hypersensitive or hyposensitive to certain tastes, smells, sounds and tactile or visual stimuli. Resists certain textures or touch but may prefer deep pressure. Low/high threshold to pain. Prefer to eat food of only certain colours, textures and tastes.

There are innumerable examples and attributes of ASD. I have listed above some of the more common ones, without being too fussy about the categories I’ve put them in; for example, one can debate whether “preference to play alone” should be under “play”, “behaviour” or “social interaction”.

Age-related pointers to possible ASD

Some of the key signifiers that may suggest a child is on the autistic spectrum include:

- lack of responsive smile by three to six months
- not babbling by ten months
- lack of joint attention by six to nine months
- not responding to their name by ten to twelve months

- not waving goodbye or giving affection by 14 to 16 months
- not pointing to items of interest or objects by 12 to 18 months
- not enjoying sharing a book by 18 to 24 months
- not obliging with simple requests, such as “give me the spoon”, by 18 to 20 months
- lack of pretend play, such as Pat-a-cake, by 18 to 24 months
- no symbolic play, such as riding a broomstick for a horse, by 30 to 36 months
- not taking turns in play by three to four years
- lack of imaginative play, for example playing with dolls, by four years
- not joining in play with other children or group play by four to five years.

What other conditions can be present with ASD?

ASD is often accompanied by a range of neurodevelopmental and other conditions. These can include:

- learning disability
- language impairment
- anxiety (which is often one of the main issues)
- attention deficit hyperactivity disorder (ADHD)
- oppositional defiant disorder (ODD)
- challenging behaviours
- sleeping difficulties
- feeding difficulties
- dyspraxia
- depression
- tics.

Each of these conditions, when present, could vary in severity. Some co-morbid conditions such as ADHD, anxiety, learning disability and language impairment can present as ASD itself; hence, the neurodevelopmental assessment needs to be detailed and thorough.

Does diagnosis help?

A medical diagnosis may help to avoid a child being labelled as “weird”, “difficult” or as having a personality disorder. Moreover, a comprehensive and individualised management plan can be created to build upon the child’s strengths and address their unique needs.

Numerous behavioural, educational and environmental interventions can be implemented to address the (above mentioned) three main characteristics of ASD. Medications can be used to treat symptoms of co-morbid conditions such as ADHD, anxiety or sleeping difficulties. This can improve a child’s functioning and learning.

Diagnosing early helps parents and teachers to seek extra help at school through SEN support and the provision detailed in an education, health and care (EHC) plan.

Having a diagnosis can help with long-term planning, and seeking help and support with respite and leisure services. A comprehensive diagnostic report can help in applying for

disability living allowance (DLA) and certain other benefits and help with housing when required.

“Aerodynamically the bumblebee shouldn’t be able to fly, but the bumblebee doesn’t know it, so it goes on flying anyway”, said Mary Kay Ash. With hope, perseverance and some hard work, what may appear improbable with a diagnosis of ASD can become possible.