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# IS IT AUTISM OR SOMETHING ELSE? CONDITIONS CONFUSED WITH AUTISM SPECTRUM DISORDERS

Susan Vig, Ph.D. and Ruth Kaminer, M.D.

The early identification of autism has recently received a lot of publicity. Early identification means that intervention can be provided as early as possible to optimize the development of children with autism spectrum disorders.

Sometimes a focus on autism means that other developmental problems, existing instead of, or in addition to, autism spectrum disorders, are not recognized or targeted for intervention. Comprehensive multidisciplinary evaluation, investigating the many different kinds of developmental problems young children may experience, is the best way to ensure accurate identification and appropriately targeted intervention.

## *AUTISM SPECTRUM DISORDERS*

A diagnosis of autism is based on impairments in three areas: social interaction; communication; and patterns of behavior, interests, and activities. Autistic disorder is thought to occur at the severe end of a spectrum. Pervasive developmental disorder (PDD) and Asperger's disorder are more mild forms of autism.

According to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR,* 2000), a diagnosis of autistic disorder requires a total of six criteria, including at least two impairments in social interaction (e.g., poor eye contact, impairment in peer relationships, failure to share enjoyment or interests, lack of social reciprocity); at least one impairment in the area of communication (e.g., language delay; impairment in conversational skills; stereotyped, repetitive, or idiosyncratic language; lack of pretend play); and at least one impairment in patterns of behavior, interests, and activities (stereotyped or restricted interests; insistence on particular routines or rituals; motor mannerisms; preoccupation with parts of objects). Not all of these criteria apply to very young children or those functioning at early developmental levels.

*The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R)* includes autism spectrum disorders within the category of "Disorders of Relating and Communicating." The manual states: "These disorders involve severe difficulties in relating and communicating, combined with difficulties in the regulation of physiological, sensory, attentional, motor, cognitive, somatic, and affective processes" (DC:0-3R, 2005, p. 38).

## *AUTISM SPECTRUM DISORDER OR ANOTHER DEVELOPMENTAL PROBLEM?*

Some young children exhibit one or more behaviors associated with autism spectrum disorder, but may instead have a different developmental problem requiring a different kind of intervention. Other problems which should be considered include language impairment, mental retardation, reactive attachment disorder, and multiple complex developmental disorder. The following case examples illustrate these other kinds of problems.

### *Language Impairment*

Jalene is a 4-year-old girl who attends a community childcare program. Her teacher reports that Jalene does not comply with requests. When the teacher tells her to bring juice to the table as the class is getting ready for snack, Jalene ignores her. The teacher says that Jalene gets restless during circle time and may get up and wander away. When the teacher asks, "Jalene, where are your mittens?", Jalene repeats "your mittens", but does not answer the question. She averts her gaze, rather than looking at the teacher.

The teacher shares her concerns with Jalene's mother. The mother says that she has also begun to worry about Jalene. At home Jalene does not listen when people speak to her or ask her to do something. She sometimes looks away, or repeats all or part of what they say. Both the teacher and the mother suspect that Jalene is exhibiting features of autism.

A comprehensive multidisciplinary evaluation is completed for Jalene. Audiological testing shows that her hearing is normal. Jalene sometimes seems confused when members of the assessment team give instructions or ask questions, and she often echoes all or part of what she has heard. Team members have to make a special effort to gain Jalene's attention, as she has a tendency to look around the room when people speak to her. Yet she seems interested in interacting with evaluators. She smiles in a social manner, and points to or labels things she finds interesting, looking at evaluators to share her interest. When her mother is present, she turns around, looks at her mother, smiles, and shows some of the test materials she has enjoyed. She easily manages transitions from one activity to another. When given toys for free play, she pretends to prepare food for a family of dolls, feeding them, and putting dishes in a basket for washing.

Team members share their findings. The psychologist reports that Jalene's nonverbal skills are above average, and much stronger than her language abilities. The speech pathologist identifies severe receptive and expressive language impairment. Jalene does not expect to be able to understand others' communication, so she has developed the habit of not paying attention. She is not able to use language reactively (understanding what other people say and formulating responses meeting linguistic requirements imposed by others' language), so she simply repeats all or part of the questions she has heard.

Jalene does not have autism spectrum disorder. Her failure to look at other people when they speak, and her tendency to echo, are related to her language impairment, rather than representing the self-absorption characteristic of children with autism. Social skills are adequate, and Jalene does not have restricted, repetitive, or stereotyped patterns of behavior.

Intervention for Jalene will include intensive speech/language therapy. If services are available, she can continue to attend her community childcare center. She is expected to make good progress, documented through regular developmental follow-up.

### *Mental Retardation*

Keith is a good-looking 5-year-old boy with a normal gait who attends a special preschool program for children with developmental difficulties. He has received speech/language therapy and occupational therapy at school. Keith is about to age out of the program, and the staff are thinking about what should be considered for kindergarten. They are discouraged by Keith's failure to make expected progress. He shows no interest in playing with classmates. During unstructured time, he wanders aimlessly around the classroom, picking up toys and dropping them without apparent purpose. He does not engage in any pretend play, but occasionally shows interest in the physical characteristics of toys. When the teacher gives a directive, he ignores her, does not comply with the request, and seems to be in his own world. Keith says a few words. He uses them randomly, rather than for communicative purposes, and does not seem to associate the words with their referents. Keith likes to jumble blocks together and listen to their sound. He sometimes jumps in place repeatedly, and flaps his hands when excited. Keith's teacher thinks he might have autism.

Keith is evaluated by a multidisciplinary team. The psychologist finds that he has severe mental retardation, with developmental skills ranging from 14 to 20 months. (Earlier developmental testing had emphasized motor and sensory-motor skills, so that the degree of cognitive impairment had not been evident at that time.) The speech pathologist currently identifies language skills at the 14 to 20 month level. Team members note that Keith relates to other people like a child who is not yet 2 years old. He extends objects to adults while looking at and sometimes smiling at them.

Although Keith shows many features of autism, the primary concern for him is significant mental retardation. This explains why he has made minimal progress despite an excellent program and services. The overlap between mental retardation and autism has been well documented. (See Vig and Jedrysek, 1999, for a review.) Many children with significant mental retardation (those with IQs below 50) exhibit autistic features, and may even meet diagnostic criteria for autism. Approximately 70 to 75% of children with autism have mental retardation.

A program for children with significant mental retardation will best meet Keith's needs. The program will provide an appropriate instructional pace, an emphasis on life skills, and plenty of review so that acquired skills are not lost or forgotten. Speech/language therapy and occupational therapy may be useful if there are difficulties not explained by the mental retardation (for example, feeding problems or a need for augmentative communication devices). The intervention plan for Keith may include parent education and support if desired by the family. Having a name for Keith's problem means that his parents can obtain relevant literature, resources, and information about support and advocacy groups.

### *Reactive Attachment Disorder*

Tamara is a 2½-year-old girl who lives with a pre-adoptive foster family and does not yet attend preschool. When Tamara was 12 months old, she was removed from her biological mother and placed with an elderly great-aunt. Her mother had not been able to meet her most basic needs for care or safety, and had left her alone for long periods of time. When Tamara was 14 months old, the great-aunt developed a serious medical problem and could no longer care for her. She was placed with a non-relative foster mother, but removed from that home after several months when the foster mother was found to be abusing her. She was then placed in another non-relative foster home for several months. The foster mother provided adequate physical care, but avoided establishing an emotional bond with the little girl because she knew the child would soon be placed in a pre-adoptive home.

The current pre-adoptive foster mother knows very little about Tamara's previous history. She suspects that Tamara's language is delayed, but is even more concerned about her emotional status. The foster mother reports that she cannot seem to connect emotionally with Tamara, who ignores her, avoids eye contact, stiffens when hugged, resists attempts to comfort her, and rocks herself to sleep. The foster mother asks whether Tamara might be autistic.

Tamara is evaluated by a multidisciplinary team knowledgeable about early attachment issues as well as developmental disabilities. Members of the team test Tamara and review information about her early psychosocial history, provided by the child welfare agency monitoring her pre-adoptive placement. The team identifies mild developmental delays and a reactive attachment disorder. Tamara's inability to interact with her foster mother in an emotionally appropriate manner stems from frequent changes of caregiver, pathogenic care in the second foster home, and emotional neglect in the third foster home. These circumstances prevented formation of stable parent-child attachments.

The evaluating team recommends a therapeutic nursery, or a developmentally oriented preschool program, supplemented by mental health services, if a therapeutic nursery is not available. The team also recommends parent-child dyadic therapy, based on an infant mental health model, to strengthen Tamara's attachment to her pre-adoptive foster mother. The foster mother states that she and her family are firmly committed to adopting Tamara, and are eager for suggestions that will optimize her development.

### *Multiple Complex Development Disorder*

Hector is a 4½-year-old boy attending a public school pre-kindergarten program. Hector shows little interest in playing with other children. He sometimes seems to be in his own world, and it is difficult to engage him in classroom activities. At other times he complies readily. His eye contact is variable and his mood changes unpredictably. He may giggle and act silly for no reason, and at other times becomes angry and prone to tantrums. Going to the playground often causes great distress. Hector refuses to leave the classroom and may scream, throw himself on the floor, or bang his head against the wall. When escorted to the playground, he stands next to the teacher and stares into space. The teacher says that Hector echoes the language of other people. What concerns her more, though, is his tendency to say things that make no sense. When she asks, "Did you finish your sandwich?", Hector looks at the ceiling and says, "The bread got cut, Knife cut the eye. Eye cut him. He cut the bread. Two toes. He cooked it. No one."

Hector's parents meet with the teacher and express their own concerns. They say that they can't predict how Hector will behave from one minute to the next. He can be calmly watching television, then suddenly becomes agitated and upset. He sometimes hugs and kisses family members and at other times ignores them. He shows no interest in playing with his cousins or neighborhood children. He is terrified of insects and screams whenever he sees a fly or mosquito. The parents report that Hector can speak in long sentences, but often makes no sense. They suspect that he may have autism.

Multidisciplinary evaluation, including psychiatric assessment, is completed for Hector. He receives a diagnosis of multiple complex developmental disorder. Suggested criteria for this diagnosis, which is not included in *DSM IV-TR*, are difficulties regulating affective state (mood) and anxiety, and the presence of intense fears, impaired social behavior, and disordered thinking. (See Klin, Mayes, Volkmar, and Cohen, 1995, for a discussion of criteria.) Hector's rapid and unpredictable mood changes, his high degree of anxiety in situations where this would not be expected, his disinterest in interacting with other children, and the disordered thinking reflected in his atypical language meet criteria for the diagnosis.

The evaluating team recommends a therapeutic school program, where staff can provide on-site therapeutic support to help Hector manage his mood changes and anxiety, and improve peer interaction skills. The team also recommends speech/language therapy, with emphasis on pragmatics (social use of language). Hector's parents are encouraged to participate in parent education and support activities. They inquire about medication to ameliorate Hector's problems and learn that this could be a possibility in the future.

### *CONCLUSION*

These case examples suggest that, even when appearing to exhibit features of autism spectrum disorder (e.g., echolalia, ignoring other people when they speak, problems with peer socialization, repetitive behaviors or mannerisms), many children will be found to have other developmental problems. Comprehensive multidisciplinary evaluation, completed by evaluators who take a broad perspective and consider many different kinds of developmental problems, can most accurately clarify young children's developmental status. Similarly, a broad array of options should be considered when planning intervention. Even though Jalene, Keith, Tamara, and Hector exhibit some behaviors commonly associated with autism, they do not need placement in programs designed specifically for children with autism or intervention involving intensive applied behavior analysis. Jalene needs intensive speech/language therapy, but may remain in her community childcare center. Keith will benefit from a school program designed for children with significant mental retardation, with emphasis on acquisition of life skills. Tamara and Hector need programs and services addressing mental health issues. The families of these children should be offered opportunities for parent education and support if they are interested.

In identifying the developmental problems of young children, and planning intervention for them, it is important to think broadly and flexibly about many different kinds of diagnostic possibilities and options for intervention. By doing so, early childhood professionals can best serve young children and their families.

### *SUGGESTED READING*


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