Autism Spectrum Disorders are a group of disabilities characterized by impairment in socialization and communication, chronic repetitive behaviors, and a narrow range of interests. ASD typically develops early and is a lifelong problem. While the individual can make some improvements, definite limitations will always remain. There is no cure for Autism Spectrum Disorder.

There has been speculation over the years about the cause of ASD. Though a definitive conclusion has not been reached, many doctors and researchers believe that ASD has genetic roots. Each category under the umbrella term of Autism Spectrum Disorder is frequently defined as a neurodevelopmental disorder. Evidence appears to suggest that each disorder originates in the brain (Pickler & Elias, 2009). There have also been individuals who believe that autism can be caused by environmental or drug-related toxins. While researchers do not rule out an environmental influence, the drug-related theories tend to lack sufficient proof. Autism Spectrum Disorder is divided into five categories: autism, childhood disintegrative disorder, Asperger’s syndrome, Rett syndrome, and pervasive developmental disorder.

Autistic Disorder or autism is a neurodevelopmental disorder and possibly the most widely known Autism Spectrum Disorder. No racial, ethnic, or socioeconomic group is immune to the disorder. Boys are four times more likely to develop autism. Because of their behavior, children with autism frequently appear to be lost in a reality of their own. Some of the characteristics of autism include impaired social behavior, lack of response to stimuli, aversion to eye contact and physical affection, and misinterpretation of facial expressions. Children with autism also have difficulty with communication. They may not
speak at all, use unusual language, have difficulty understanding gestures, and are likely to repeat phrases over and over. Additional characteristics include limited interaction with other children, participation in repetitive play, interest only in a narrow range of topics, answering in singsong voice, rocking, twirling, hand wringing, and head nodding (Leach & Collins, 2009).

Another disorder grouped under Autism Spectrum Disorder is Asperger’s syndrome. Diagnosis for Asperger’s is typically made between the ages of 5 and 9. Children with Asperger’s syndrome often possess average to above average intelligence and normal development of language skills. These traits are frequently why children with Asperger’s are not immediately recognized as exhibiting a form of ASD. Asperger’s does share a distinct trait with other spectrum disorders: social abnormalities. Some of the other characteristics shared with classic autism are lack of eye contact, poor motor skills, repetitive behaviors, and a fascination with a particular object. A child with Asperger’s may only want to learn and talk about one object obsessively. Children with the disorder frequently suffer from depression and anxiety. They may become agitated when asked to focus on a task outside of their interest (Carpenter, Soorya, & Halpern 2009).

The cause of Asperger’s is unknown but many individuals with the disorder display abnormal brain scans. These abnormalities most likely contribute to the individual’s unusual thoughts or brain patterns. The most beneficial early intervention program for children with Asperger’s syndrome is instruction in proper communication, social skills, and motor function.
Children with Asperger’s do not qualify under the category of Autism for special education. Language delays in these children are not evident. They do, however, meet the criteria of two of the other core areas: socialization and restricted behaviors (Ruble & Akshoomoff, 2010).

Rett Syndrome is a rare neurodevelopmental disorder primarily affecting females. Some of the characteristics of the disorder are impaired motor function, severe intellectual disability, and unusual behavior patterns. It is a progressive disorder. Children may develop normally at first and then began to loose valuable language and motor skills. The cause of Rett syndrome is typically a random genetic mutation on the X chromosome.

Symptoms are usually visible in infancy from the age of 6 to 18 months. The symptoms include reduced muscle tone, difficulty walking, and unusual hand gestures. A predominant sign of Rett syndrome is when the infant’s skull ceases to grow creating an abnormally small head circumference. Rett syndrome can affect males with no family history of the disorder. These males usually die soon after birth so there is not a great deal of opportunity to study why the mutation occurred (Pickler & Elias, 2009).

Children with ASD have trouble in three core areas: communication, socialization, and restricted patterns of behavior. Children with ASD may exhibit any combination of the three areas. There are two stages of diagnosis. The first stage includes a developmental screening at certain intervals for infants. During this time, the physician and parents will monitor the infant for any warning signs. The second stage may include a comprehensive evaluation. This evaluation could include speech and language evaluation, psychological and clinical observations, and AD diagnostic scales. The child must meet six of the
diagnostic criteria with at least one abnormality in each of the three core areas. The onset must also occur before 3 years of age (Ruble & Akshoomoff, 2010).

Symptoms vary from child to child in type and severity. Speech delays are typically the most recognizable and tend to be the first symptom observed by the parent. The primary care physician is often the second individual introduced to the symptoms. It is up to the primary care physician to determine if the initial symptom warrants further investigation. It is best to begin an intervention program as early as possible (Leach & Collins, 2009).

Many investigations have determined that a moderate percentage of children show normal signs of development and then begin to regress. This is a serious red flag that should garner immediate attention. Unfortunately regression is often attributed to an environmental factor such as the parent but it is a trademark symptom and should not be labeled as a parental mistake. Some of the traits exhibited by children with ASD are a preference to be alone, excessive attachment to objects, little to no eye contact, difficulty relating to other children, uneven motor skills, inexplicable tantrums, and aversion to affection.

There has been speculation over the years about the causes of ASD. The overwhelming majority of researchers believe that the underlying cause is genetic. This cause is supported by the fact that males are four times more likely to develop ASD than females. High-risk groups for ASD are also children with a parent or sibling with the disorder. We may be moving closer to pinpointing a definite cause in genetics due to advances in testing and stable guidelines (Pickler & Elias, 2009).
Environmental factors may contribute to the cause of autism. A maternal illness, such as rubella, during the prenatal period is one possible environmental factor. Some additional factors are exposure to teratogens and thalidomide.

Multiple research studies have been conducted to test vaccines as a possible cause for autism. Among those studied have been the measles-mumps-rubella vaccine and various vaccines containing high levels of mercury. While many still believe that this theory holds merit, researchers have obtained no conclusive evidence that any infant vaccine contributes to the development of autism. The schedule at which infants receive their vaccines has also been called into question. There is no sufficient evidence to support this theory either (Leach & Collins, 2009).

The best approach for diagnosing ASD is a multi-method system that includes observations, interviews, assessments of development, family history, and screening. The diagnosis of ASD is based on the definition in the Diagnostic and Statistical Manuel of Mental Disorders, Fourth Edition, Test Revision or DSM-IV-TR. Several diagnostic tools have been developed over the past several years based on criteria presented in the DSM-IV-TR (Magyar & Pandolfi, 2007).

In order to diagnose ASD a team consisting of a variety of members should be assembled. The team members should include parents, a pediatrician, a speech language pathologist, a child psychologist, and a social worker. The team works together to complete a comprehensive evaluation on the child (Leach & Collins, 2009).

ASD is determined by observing behaviors not by medical testing. Screening tests are available as part of infant checkups. If warning signs are detected, the child is
immediately referred into an early intervention program. Most early warning signs include lack of language skills or developing social problems (Ruble & Akshoomoff, 2010).

ASD diagnosis in very young children may be difficult but research studies have concluded that there are valid tools for diagnosing infants and toddlers. Diagnosis at an early age is crucial in order to receive proper treatment. The Autism Diagnostic Observation Schedule and Childhood Autism Rating Scale are favored among doctors and researchers as being the most valid methods in determining ASD in children. The Childhood Autism Rating Scale is particularly beneficial when working with very small children (Kleinman, Pandey, Verbalis, Barton, Hodgson, Green, Dumont-Mathieu, Robins, & Fein, 2008).

The Autism Diagnostic Interview-Revised is a semi-structured evaluation of the child’s social development, communication, play, and stereotypical behaviors such as repetitive movements or activities. The interview yields separate scores in each of the core areas. The child must meet the criteria as specified by each domain and exhibit these signs before the age of 3. The child receives a classification of autism or non-autistic. This interview does not determine the type of disorder. This comprehensive interview contains sections suitable for diagnosis of abnormal communication, social skills, and repetitive behaviors. It also evaluates the age of onset. Combining the ADI-R and ADOS scores increases the accuracy of diagnosis (Kleinman et al., 2008).

The Autism Diagnostic Observation Schedule is also a semi-structured evaluation that places the child in a setting where social interaction can be initiated. The child’s responses to the situations presented are observed and recorded. The child is also provided with the opportunity for imaginative play. Each of the core areas is scored and combined.
If the child exceeds the cut-off score, then he or she is classified as having autism or as non-autistic.

There are several interactive modules within the ADOS. A child will fall into 1 of 4 modules based on age and level of verbal expression. The modules range from level 1, which is designed for young, nonverbal children, to level 4, which includes adolescents and adults with advanced verbal skills. The examiner will interact with the examinee and assess a score to each task following closely certain criteria. The Autism Diagnostic Observation Schedule only diagnoses autism in the areas of communication and socialization. Repetitive behaviors must be evaluated using a different tool (Pasco, 2010).

The Childhood Autism Rating Scale is beneficial because it addresses issues relevant to infants and toddlers. One of the criteria for ASD is lack of or unusual means of communication. This is difficult to measure in young children especially among those who are not yet old enough to communicate with words. Another characteristic typically not displayed by infants or toddlers is an aversion to change or routine. These types of signs are unlikely to be observed in this age group (Magyar & Pandolfi, 2007).

The Childhood Autism Rating Scale is administered to determine the presence and severity of ASD. The child is presented with 15 items. The child’s behavior during these items will be observed and scored by a clinician. The items focus on the core areas of socialization and communication relevant to the child’s age. The clinician will also monitor emotional responses and sensory sensitivities. This scale classifies the child with mild, moderate, or severe autism. Once again, the child must exceed a cut-off score in order to be classified with ASD at all.
Appropriate management is based on individual symptoms. No two cases of autism are alike. This complicates treatment of the disorder. Goals in ASD management include independence, quality of life, and family support in socialization. Behavior therapy should focus on the child’s interest and contain a highly structured routine. Children with ASD are often opposed to change so a specific routine should be maintained whenever possible.

Children with ASD can qualify for special education services by meeting criteria established by the Individuals with Disabilities Education Act. The criteria include evidence before the age of 3, abnormalities in verbal and nonverbal communication, underdeveloped social skills, and harmful affects to child’s academic performance.

After the evaluations and diagnosis has been made, a referral needs to be made to the school system that the child plans to attend. These referrals are typically made when the child is 3 years of age. This may seem a bit early for a child who will not attend school for another 2 years but the process to create specialized education for the child may be lengthy (Leach & Collins, 2008).

There are several strategies that teachers can use to benefit students with ASD. Teaching students with ASD social and communication skills is paramount in the classroom. Teachers must strive the make events predictable within the classroom. The more structured the environment is, the less likely the child will become overwhelmed or agitated. Another effective classroom tool is providing the child with clear, concise instructions. If a teacher takes simply takes the extra time to express all instructions carefully, this will help the student a great deal. Some other effective strategies for students with ASD include enhancing communication with pictures, providing feedback when the appropriate behavior is displayed, using direct statements, and providing solid examples.
Some children with ASD may require medication in addition to therapy. Psychotropic medications are commonly prescribed to children experiencing high levels of aggression, anxiety, or aggravation. Some of the most frequently used psychotropic drugs are serotonin-reuptake inhibitors, stimulants, and atypical antipsychotic agents.

Children with ASD frequently have additional medical issues that require medication. It is important to remember that there is no cure for ASD. There is no drug designed specifically for the disorder. Medication should only be administered to a child if the child displays another medical condition apart from ASD (Frazier, Youngstrom, Haycook, Sinoff, Dimitriou, Knapp, & Sinclair, 2010).

Anxiety and depression are common among children with ASD. Severe aggression is also observed in children with the disorder although it is not particularly common. Mood stabilizers are generally prescribed for children suffering from bipolar disorder as well as ASD. The mood stabilizers appear to alleviate any signs of aggression in children with ASD so they can be beneficial to some (Frazier et al., 2010).

The various treatment or management programs for ASD are best when they are combined. A child with ASD is more likely to thrive when he or she retains the support of family, school, and community. When assessing management programs, the family as a whole must be considered. Everyone must participate in treatment together in order to ensure the best possible outcome.

Autism Spectrum Disorder is an umbrella term covering five specific disorders: autism, childhood disintegrative disorder, Asperger’s syndrome, Rett syndrome, and pervasive developmental disorder. Each of these disorders shares common characteristics. Lack of social and communication skills and stereotypical behavior are the three primary
characteristics of ASD. Although the cause of ASD is unknown, many diagnostic measures have been created to identify children with the disorder as early as possible. The earlier these children are placed in intervention programs, the more likely they will be able to lead a fairly normal life. There are many important individuals who contribute to the diagnosis and care to children with ASD. Their primary goal is to enrich the lives and offer support to those who must live with this disorder.

Children with Autism Spectrum Disorder are often misunderstood. Individuals who do not have regular contact with these children may believe that they simply possess behavioral issues. It is imperative for the public to become aware of ASD and be able to recognize the signs and symptoms.

It is difficult to imagine having a child who cannot communicate, display affection, or even make eye contact. The sooner a family can come to terms with the disorder, the sooner they can begin to build the best life possible. Children with ASD will experience many disappointments. They are frequently judged more harshly than their peers especially due to their lack of social skills. It is up to those around them to provide positive support and to become educated on the issues that these children face. They deserve what every human being deserves: a life filled with meaning and purpose.
References


Name: _______________

Course: TCED/COUN 716

Protocol For Term Paper: The term paper will be 10 plus full content pages with a minimum of 10-15 plus references from the UT-Martin Library full-text electronic databases.

Rubric For Evaluation of Term Paper: Excellent: 100 points possible-relevant and complete, accurate information and research-based; overall impression including presentational/writing style (APA) is strong.

Points:_____

Acceptable: 50 plus points possible-most of the information is relevant and appears complete, accurate information but research literature appears incomplete; overall impression including presentation/writing style (APA) is acceptable.

Points:_____

Unacceptable: 0-10 points possible-information is either irrelevant or incomplete, information is not sufficiently research-based, overall impression including presentation/writing style (APA) is unsatisfactory.

Points: 10