An Autism Primer for the PCP: What to Expect, When to Refer

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Disclosures

- None

- I will not be discussing any treatments, on or off label, experimental or investigational.
Outline

- **Newer Diagnostic Criteria for ASD**
  - DSM IV – R
  - DSM V

- **Early Detection of Possible ASD**
  - The First Opportunity to Refer

- **Developmental Trajectory in ASD**
  - The Second Opportunity to Refer

- **Behavioral Problems**
  - The Third Opportunity to Refer
DSM IV – R Criteria for Autistic Disorder

The diagnosis of Autistic Disorder previously was established by the presence of atypical development in 3 areas;

- Social Interaction
- Communication
- Restrictive, Repetitive, Stereotyped Behaviors
Impaired Social Interactions
(needed 2 of these)

- Impairment in eye contact, facial expression, posture, gestures to regulate social interactions.
- Failure to develop typical peer relationships
- Lack of sharing discoveries or accomplishments
- Lack of social / emotional reciprocity.
Impaired Communication
(needed 1 of these)

- Lack or delay in spoken language without using gestures to compensate
- If adequate speech, lack of ability to initiate or sustain conversation
- Stereotyped, repetitive use of language or idiosyncratic language
- Lack of varied, spontaneous make-believe play or social imitative play
Atypical Behaviors / Interests / Activities
(needed 1 of these)

- Encompassing preoccupation with 1 or more stereotyped and restricted patterns of interest
- Adherence to nonfunctional routines or rituals
- Stereotyped and repetitive motor mannerisms
- Persistent preoccupation with parts of objects
Autistic Disorder (DSM IV - R)

- A total of 6 of these characteristics with:
  - At least 2 from Social Interaction
  - At least 1 from Communication
  - At least 1 from Atypical Behaviors
- Onset prior to age 3
- Diagnosis not explained by something else
- Often there are cognitive deficits
- May have a range of behavioral symptoms
DSM-IV-R Related Disorders

- Asperger’s Syndrome
- Pervasive Developmental Disorder – Not Otherwise Specified (PDD - NOS)
Autistic Spectrum Disorder (DSM V)

- No Asperger’s Syndrome
- No PDD-NOS
- Everything combined under Autism Spectrum Disorder
Autism Spectrum Disorder (DSM V)

Persistent deficits in social communication and social interaction:

- Deficits in social-emotional reciprocal
ty.
- Deficits in non-verbal communicative behaviors used for social interaction.
- Deficits in developing, maintaining, and understanding relationships.
Autism Spectrum Disorder (DSM V)

- Restricted, repetitive patterns of behavior, interests, or activities:
  - Stereotyped or repetitive motor movements, use of objects, or speech
  - Insistence on sameness.
  - Highly restricted, fixated interests that are abnormal in intensity or focus.
  - Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment.
Autism Spectrum Disorder (DSM V)

- Symptoms must be present in the early developmental period.
- Symptoms cause clinically significant impairment in social, occupational, or other important areas of functioning.
- Not better explained by intellectual disability or global developmental delay.
- Those previously diagnosed with Asperger’s or PDD-NOS changed to Autism Spec Dis.
Social Communication Disorder (DSM – V)

- Problems using verbal and non-verbal communication for social purposes not due to low cognitive ability.
  - Impairment in changing communication to match context or needs of the listener.
  - Difficulty taking turns in conversation, rephrasing when misunderstood, using verbal and non-verbal signals to regulate social interactions.
  - Difficulties understanding what is not explicitly stated.
Social Communication Disorder (DSM – V)

- Problems using verbal and non-verbal communication for social purposes not due to low cognitive ability.
- Must be present in early childhood.
- No restricted, repetitive patterns of behavior, interests, or activities.
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  - The 3rd Opportunity to Refer
Early Detection of ASD

- M-CHAT-R
  - Screen at 18 Months of Age
  - Screen at 24 Months of Age

- M-CHAT-R Maximizes Sensitivity (i.e. high false positive rate)

- Follow-Up Questions (M-CHAT-R/F)
  - To improve specificity
  - Still will be many positive screens w/o ASD
1st Opportunity to Refer

- Positive M-CHAT-R and M-CHAT-R/F
  - Refer to Birth-to-Three
  - Many Children will still not have ASD
    - But they likely have other problems appropriate for Birth-to-Three.
    - Child suspected of having ASD by Birth-to-Three will be referred for a Birth-to-3 Autism Specific Evaluation.
  - If you disagree with B-3’s assessment you can refer for further evaluation.
Birth-to-Three Response

Services provided will be child specific and could include:

- Care Coordinator
- Speech Therapy
- Occupational Therapy
- Early Childhood Educator
- ABA Therapist

Frequency of visits are generally weekly to several times per week.
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Children with ASD Developmental Trajectory

Deborah Fein:

- Investigated children who “outgrew” ASD
- Compared 34 children confirmed as having ASD who had “Optimum Outcomes” with typical peers.
  - Normal Communication and Social Skills
  - 7 with anxiety, depression, impulsivity
  - 3 with mild deficits in social skills (p>0.05)
- How often does this happen?
Children with ASD
Language Trajectories

In 2007 an international consortium

- Followed the language development of 3 groups of children. One group of children with Autism, one with PDD and one with other types of devel dis.

- They performed language assessments at 2, 3, 5 & 9 yrs of age.
Change in Verbal Abilities with Age

Graphs showing the change in verbal abilities with age in months.
Change in Verbal Abilities with Age

Graph showing the change in verbal abilities with age in months. The graph is labeled with percentages: 66%, 26%, 18%, and 14%.
Children with ASD
Developmental Trajectory

In 2011 Baghdadli and her group
● Studied 152 children with Autism over a 10 year time range.
● They examined changes in:
  ● Language
  ● Social Skills
  ● Restricted, repetitive patterns of behavior
Children with ASD
Communication Trajectories
Children with ASD
Socialization Trajectories
Children with ASD
Behavior Trajectories
Children with ASD
Developmental Trajectory

The largest study on this topic was in 2012 by Fountain, Winter and Bearman.

Reviewed the California Department of Social Services records of 6,975 children with Autism (not PDD).

Ranged in age from 2 to 14 years.

Minimum of 4 annual evaluations.

Used the TRAJ analytic method.
Communication trajectories

Figure 1
(A) Modeled communication, (B) social, and (C) repetitive behavior symptom trajectories based on CDER scores by age.
FIGURE 1

(A) Modeled communication, (B) social, and (C) repetitive behavior symptom trajectories based on CDER scores by age.
Repetitive behavior trajectories

FIGURE 1
(A) Modeled communication, (B) social, and (C) repetitive behavior symptom trajectories based on CDER scores by age.
Non-"Bloomers"

- The children in the highest trajectories tended to have been born more recently.
- The lowest functioning groups were more likely to be from minority groups with younger, foreign born, less educated mothers.
- Children with intellectual disabilities were more likely to be on the low functioning trajectories.
Non-"Bloomers"

- Those on the lowest communication trajectory had 6 times the risk of being on the lowest social trajectory and were extremely unlikely to be on the highest.
- The trajectories are bimodal with a slowing of improvement occurring around 6 or 7 years of age.
“Bloomers”

- Communication bloomers were heavily concentrated among the social bloomers. And among the medium high and high functioning social groups.
- Social bloomers were heavily concentrated among the communication bloomers.
- Children with intellectual disabilities and those born to foreign born mothers were more likely to be in the LF group than in the bloomer groups.
- Gender was not a factor in bloomers.
Children with ASD

2nd Opportunity to Refer

- We need to identify these children early and get them services early.
- Our expectation should be that these children get better, and not just those with good communication skills and higher IQ.
- If they aren’t getting better, look for help (2nd opportunity to refer) to find out why.
2nd Opportunity to Refer

- Identify and get services early.
- Expect improvement
- If not getting better, find out why.
Associated Disorders in ASD

- Hyperactivity
- Short Attention Span
- Impulsivity
- Temper Tantrums
- Self-Injurious Behaviors
- Aggression

- Disordered Eating (likely sensory issue)
- Sleep Disturbances
- Anxiety Disorders
- Depression
- Odd Responses to Sensory Stimuli
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The 3rd Opportunity to Refer

- Some of these “Associated Disorders” can create problems at multiple points in the lifespan.
- Out of control or difficult to control behaviors can limit a professional’s and the family’s abilities to engage a child.
- There are a couple of options to address these issues.
The 3rd Opportunity to Refer

- In-home Applied Behavior Analysis therapy.
  - Behavioral approaches are always the first option.
  - In-home ABA is covered by most insurances and Medicaid A, not by Medicaid B.
  - Usually there are long waits.
The 3rd Opportunity to Refer

- Referral to pediatric psychiatry
  - For situations where behavioral therapy is ineffective.
  - When there is aggression towards others, self or property.
Questions?