

Autism and Related Pervasive Developmental Disorders:

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Historically, autism, childhood schizophrenia, mood disorders with psychosis, and a variety of neurodevelopmental disorders were included under childhood schizophrenia. In 1972, a British working group established criteria and split off autism from schizophrenia; later Bipolar and severe major depressive disorders were further subdivided. Over the past 10 years autism has been further subdivided into high and low functioning autism; Asperger's Disorder; Pervasive Developmental Disorder- the idea of autistic spectrum disorder.

Findings:

1. Lack of psychotic symptoms- auditory and visual hallucinations; although a subgroup of high functioning autistic folks will develop psychosis, and Childhood schizophrenia (Very Early Onset Schizophrenia, VEOS) share symptoms. Language, and concrete/literal thought and poor perspective taking may contribute to high rates of diagnosed paranoid personality in adults.
2. Age of Onset- <30 months; higher functioning clients may be diagnosed much later. Level of mental retardation may be a key factor in the clinical picture of autism- 75% with MR; 50% mod and below.
3. Associated neurological, metabolic, or inherited disorders may present with autism-behavioral phenocopies. Rates of seizure disorders are increased, with a second peak of higher frequency of seizures emerging in adolescence. Most children don't look "retarded", but may have a higher incidence of minor neurological and physical anomalies that suggest early developmental insults.
4. Families with multiple autistic children- "multiplex" suggest linkage to developmental language, Obsessive- compulsive symptoms, social anxiety, hyperserotonemia. Language disorders are increased in nonautistic twins and siblings. Some confusion with Fragile X syndrome.
5. 5 males: 1 female for autism; 8 males: 1 females for Asperger's. When present females seem to have worse cases.

B. Common Symptoms:

1. Social communication- the link between language, social relatedness, and emotional interaction is dysfunctional. Range of language dysfunction – aloof/nonverbal to active communicators but odd.
2. Language and communication strategies are impaired.
3. Emotional attachment behaviors- early deficits in perceiving and sending affective communications; lack of anticipation, reciprocity, nonverbal and gestural cues. Aloof,

to awkwardly attached. This is often the key difference between clients with S/PMR and autism.

4. Repetitive and adaptive behaviors- life becomes a ritual; anxiety reducing; stereotypies/SIB overload; behavioral inflexibility, Unable to tolerate unpredictable or unanticipated events Particular difficulty with peers.
5. Lack of symbolic or pretend play; concrete; unable to share perspective- “theory of the mind’. Greatest impact in peer relationships.

Treatment:

1. There is no cure for Autism. We can treat primary psychiatric and neurological disorders (seizures); reduce the intensity of some behaviors (aggression). Although some behaviors and symptoms may improve with age, the core features of autism remain.
2. Target symptom focussed, but do not overlook the relationship to social phobia, OCD, mood disorders, onset of complex partial seizures during adolescence. Puberty is a particularly hard time for autistic children. Most will require special assistance, group home or supervised community services.
3. Sensitivity to psychotropics; overlooked problems with “medical treatments” worsening behavior.
4. Hyperactivity, aggression/tantrums; Self-Injurious Behaviors, stereotypies, avoidance behaviors are the principle focus of most psychopharmacological interventions. Lack of social attachments, language impairments- meds may not effective in reducing these symptoms.
5. Medical, behavioral, and educational treatment programs are often complex, labor intensive, and long-term endeavors. Individualized programs based on specific target behaviors (behavioral analysis), individual vulnerabilities and comorbid conditions are essential. The earlier we start, the potentially better the outcome, but many families are unable to afford or have access to start of the art interventions. From a psychiatric perspective, “each autistic person writes their own psychopharmacology textbook”