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MODULE: MENTAL DISORDERS AND PSYCHOPATHOLOG

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INTRODUCTION:

The mental disorder which will be focused on in this assignment is autism, which is known as autism spectrum disorder (ASD). ASD is caused by there being differences within an individual's brain, due to their being developmental issues. People with ASD often struggle with social interactions such as communicating with other people or even being in environments where there are vast amounts of people such as shopping centres. People with ASD may have different ways of learning, paying attention or moving, this is what often makes things difficult for people with ASD as their ideal world is sometimes completely different to the one, they live in. Many things in the world are not catered for individuals with ASD yet they are so instrumental in their lives. Places such as schools, work environments and hospitals all of which are integral to our lives in general yet may be difficult for people with ASD to fit in with.

THE ICD 10/ Classification:

The classification system was developed in the late 19th century by an individual called Emil Kraepelin (who, 2019). He argues that mental disorders were in need of research, and they should be studied as a branch of medical science. Today classification systems can be used to diagnose mental health disorders just as physical illnesses are diagnosed (who, 2019). Correct diagnosis is crucial for treatment. The ICD is not only for mental health disorders but all disorders including physical ones. These works help us to keep track of all disorders and symptoms in order for a correct diagnosis.

CLASSIFICATION OF AUTISM:

There are different types of ASD, these different types also differ in severity. Some of these varieties include autistic disorder, sometimes called classic autism, common characteristics of this are communication difficulties, language delay and below average intelligence (Mandal, 2009). Another example is Asperger syndrome the symptoms of this are milder than those of classic autism, individuals struggle to understand humour and figures of speech

(Mandal, 2009). Pervasive developmental disorder is also another type of autism also known as “atypical autism” these individuals only meet some of the criteria for ASD, but the symptoms are much milder. There may be social and communication barriers (Mandal, 2009). This was the previous way autism was categorised.

The broad variations in how severe the symptoms in and across the groups of autism have made it difficult to discern one from the other (Sharma, Gonda and Tarazi, 2018). In aiming to get rid of this confusion the 5th edition of diagnostic and statistical manual of mental disorders made the move from put

ting all the disorders under the same umbrella of PDDs to viewing them all as members of a broader category known as autism spectrum disorder (Sharma, Gonda and Tarazi, 2018).

Currently autism is now classified as ASD 1, ASD 2 and ASD 3. These levels indicate the levels of care and support that the individual needs (Center, 2021). Level 1 ASD is the lowest classification, those on this level will require some support to help with their issues, they may have issues such as lack of social skills and poor organisational and planning skills. ASD level 2 is the mid-range individuals within this level require substantial, individuals also have issues which are more apparent to others. These individuals may struggle with verbal communication, have very restricted interests and they also exhibit frequent repetitive behaviours (Center, 2021). ASD level 3, this level is the most severe end of the spectrum, which requires significant support. The signs that are associated with both level 1 and 2 are still present however the severity is worse, and they are also accompanied by various complications (Center, 2021). Individuals with this level have severe lack of communication skills and social interactions.

The loss of Aspergers syndrome has been quite controversial however from a scientific perspective members of the DSM-5 working groups have argued that there are no distinguishable factors between autism and Asperger syndrome (Wright, 2013). The DSM 5 also combines the lack of language and social skills into one measure. To be diagnosed with autism an individual must show deficits in language and social skills and show repetitive and restrictive behaviours (Wright, 2013).

The old system did not recognise autism as a spectrum disorder, there were many overlaps and gray areas in determining which symptoms were most important in putting an individual into one category or the other (Mastroianni, 2018). Putting the different types into one category offered a more co-operative approach to the support of individuals with ASD. This new standard also makes it easier for more bespoke support to the individual, allowing the carers to consider the strengths and difficulties of the individual that they are working with (Mastroianni, 2018).

PROCESS AND PROCEDURE OF DIAGNOSING ASD:

Autism was initially described as being a form of child schizophrenia and the result of bad parenting, then as a set of related developmental disorders and finally as a spectrum condition with broad ranges of impairment (Zeldovich, 2018). Alongside these views the

diagnosis of autism has also changed. The view that autism was because of schizophrenia stemmed from an Austrian- American psychologist named Leo Kanner. Kanner described autism in 1943 as “extreme autistic aloneness”, “delayed echolalia” and the “anxiously obsessive desire for the maintenance of sameness”. He also described children as displaying great memory skills and being intelligent (Zeldovich, 2018). As a result of this Kanner viewed autism as an emotional disturbance which did not impact an individual's cognitive abilities.

In 1968 the DSM 2 saw autism as a psychiatric condition, a form of childhood schizophrenia. During the 1950s and the 1960s it was thought that individuals who had autism were brought up in households which had cold and emotionless mothers (Zeldovich, 2018). However, this concept was later disproved in the 1960s- 1970s, as more research and work into autism led to discoveries of there being biological factors, there are also issues rooted in brain development which could lead to an individual having autism. In 1980 autism was described as pervasive developmental disorder, which shifted from the perspective of autism being a form of schizophrenia (Zeldovich, 2018). It was viewed that to be diagnosed with autism an individual had to display a lack of interest in people, a significant inability to communicate with others and strange reactions to their environment within the first 30 months of life (Zeldovich, 2018).

However, in 1987 this changed as there was now a broader definition of what autism was, this included the more milder end of the spectrum (Zeldovich, 2018). Although, there was no such thing as a spectrum at this time it demonstrated an augmented understanding of what autism actually is. Autism is not just a singular condition however; it is an array of conditions on a spectrum. With one end of the spectrum being extreme and individuals on this end displaying more significant signs of autism such as severe lack of communication and lack in focus. Whereas the other end of the spectrum being less severe with individuals on this end of the spectrum demonstrating lesser significant signs of communication such as being uncomfortable in social settings.

Autism was first presented as a spectrum in 1994. In addition to autism and PDD-NOS, Aspergers was also added to the mild end of the spectrum. Autism was beginning to be conceptualised as being rooted in an individual's genetics. Throughout the 1990s researchers were hoping to find out which genes were responsible for autism (Zeldovich,

2018). The human genome project was completed in 2003, with many studies trying to find which genes were responsible for autism, hundred were found however none could be explicitly linked or stated to be responsible for autism.

Diagnosing ASD can be sometimes difficult as there is nothing apparent physically that doctors can look at to diagnose individuals. A doctor cannot run a medical test to diagnose children with ASD (CDC, 2020). Instead, doctors will look at a child's developmental history and behaviour analyse it and give a verdict on whether the child has autism or not. ASD can sometimes be detected at 18 months. By age 2 a diagnosis from a professional would be reliable, however, many children are not diagnosed until a lot older (CDC, 2020). Some individuals with ASD may not be diagnosed until they are adolescents or even adults. This is a problem within diagnosis as it means that individuals will not be able to receive the help that they need until much later in life.

There are different types of monitoring which help to detect if an individual has ASD or not. For example, developmental monitoring is an ongoing process which involves active conversations between providers and parents about their child's skills and abilities (CDC, 2020). Parents, grandparents, early childhood educators and other childcare providers can be included in developmental monitoring. Another example is developmental screening this takes a closer look into how a child is developing. Screening questionnaires and checklists are based on research that compares a child to another child their age (CDC, 2020). This can be done by a doctor, nurse or any other healthcare professional within the community or school environment.

CURRENT TREATMENT PROVISION:

The primary goals of treatment are to maximize the individual's functional independence and their quality of life. This is done through reducing the main attributes of ASD. This can be done through exercises which work on encouraging socialisation, facilitating learning and development, minimising maladaptive behaviours and educating and supporting family members (Shenoy, Indla and Reddy, 2017). As it stands there are no remedial therapies or treatments which can cure ASD, however, the recommended treatment involves a wide range of therapies which encompass applied behavioural analysis, sensory integration and speech therapy. Medications have also been used for behavioural symptoms of ASD.

Techniques such as hyperbaric oxygenation and stem cell therapy are also being tried (Shenoy, Indla and Reddy, 2017).

Although there have now been advancements made in diagnosing autism in order to treat individuals early on in life, there has been no therapy, technique or medication which has completely reversed the symptoms of ASD (Shenoy, Indla and Reddy, 2017). Nutritional intervention has also been utilised in order to minimise the behavioural symptoms of ASD, this type of intervention alongside alternative medicine is a highly utilised approach being used among over 70% of children who have been affected by ASD (Shenoy, Indla and Reddy, 2017). The only treatment which has proven to be effective and has minimised the core behavioural symptoms of ASD is, intense behavioural and educational intervention therapy at an early age. In order for individuals with ASD to be treated there needs to be a team of caring professionals who can provide the best service possible. Examples of these behavioural professionals include developmental paediatrician, behavioural and occupational therapist, psychologist, speech therapist, social worker and specialist teacher are all examples as to the examples of the type of individuals who are needed for the improvement to the quality of life of individuals with ASD.

It has been shown that there is an improvement in cognitive, communication, social functioning and reduction in inappropriate behavioural displays such as tantrums, aggression and hyperactivity after early intensive and behavioural therapy in autistic children (Shenoy, Indla and Reddy, 2017). Early refers to the child receiving this therapy before the age of 4. It was suggested that intensive applied behavioural analysis intervention at an early stage would lead to great outcomes, with almost half the children receiving this treatment gaining a significant increase in their IQ and being mainstreamed into regular classes (Shenoy, Indla and Reddy, 2017).

There are also psychopharmacological treatments for autism. The pharmacotherapy of autism involves treatment of targeted behavioural symptoms as opposed to one core autism features (Shenoy, Indla and Reddy, 2017). Examples of these targets include hyperactivity, inattention, repetitive thoughts and behaviours and aggressive behaviours towards their environment. Antipsychotics have been demonstrated to display improvements in symptoms related to aggression, social withdrawal and self-injurious behaviours. Risperidone was reported to ameliorate self-injury, aggression and agitation in 70% of the children and

adolescents compared to the placebo rate of response at 11% (Shenoy, Indla and Reddy, 2017). Selective serotonin reuptake inhibitors alongside second generation antipsychotics and mood stabilizers have been used for repetitive and stereotypic behaviour. Newer techniques include stem cell therapy and hyperbaric oxygenation however, there has been no conclusive evidence to suggest that these therapies work.

Since the treatment of autism is extremely complex and also needs to be bespoke to the individual receiving the care, it demonstrates as to why there needs to be a team of professional individuals who can tackle the situations effectively. The points made also emphasise the need for early diagnosis and how late diagnosis of autism can lead to major issues and big regrets for carers and families. Studies highlight how early treatments lead to there being a minimisation of the core symptoms of autism, allowing for a better quality of life and overall, more inclusivity into society for individuals with ASD.

HOW AUTISM IS MEASURED IN RELATION TO ITS MEANS:

Autism severity is defined in terms of the individual's language ability, their IQ, problematic and repetitive behaviours such as aggression all which have an impact on the individual's ability to function in society (Bernier, 2015). To measure the extent at which an individual's autism level is at we must base this on the core features these being mainly social and communication skills as well as their restricted interests and behaviours (Bernier, 2015). It is difficult to judge an individual's autism as it becomes unclear on whether judgement should be based on the symptoms that individuals display which are within the core domains or based on their ability to function within society. Ultimately whoever has more severe autism been it those individuals who display the most textbook autism symptoms? Or is it those who display a few core symptoms and challenging behaviours which intervene with their functioning throughout the day? These are the types of questions which are being put forward by professionals. Clinicians and researchers are also trying to answer these questions trying to quantify and define the severity of autism.

There are several ways in which autism is measured to quantify and judge the severity of autism. One of the ways in which researchers do this is by using scales, examples of these scales include: the childhood autism rating scale and the autism behaviour checklist (Bernier, 2015). There are also questionnaires which can be utilised to measure autistic traits and behaviours for example the autism spectrum quotient, the social responsiveness

scales (SRS) the autism diagnostic observation schedule (ADOS) and the autism diagnostic interview-revised (ADI-R), and measurements based on an individual's cognitive level, adaptive ability, their communication and language ability (Bernier, 2015). These approaches are all incredibly valuable and are utilised in quantifying autism granting researchers a better understanding and diagnosis.

However, there are also disadvantages to these approaches for example many of the rating scales have a strong correlation with an individual's IQ. This in turn takes the focus off the core symptoms individuals display with autism (Bernier, 2015). On the other hand, we also have the SRS is affected less by IQ, is more focused on social communication and does not include direct observation of child which is being measured (Bernier, 2015). Summary scores of the ADI-R have been used widely to measure the severity of autism however the ADI-R was not created to measure the extent to which an individual's autism level is at. Higher scores mean a greater level of impairment however, non-verbal children are not given this test therefore restricting the use of the communication domain. Scores also vary based on the child's age and IQ. Similar issues arise with the ADOS, which make it difficult to generalize results as individuals vary in IQ, age and other factors.

RECOMMENDATIONS:

Autism is a very difficult and complex topic to discuss as it is not a disorder that is physically seen however it is interpreted from an individual's behaviours and symptoms that they display. This is why when it comes to individuals with autism, they require expert help from professionals throughout their life for them to function within society. In the assignment the topic of early diagnosis was touched upon, how not having an early diagnosis can lead to future complications. A recommendation to healthcare professionals would be to diagnose autism early to the best of their ability, there also needs to be more advancements made in understanding autism through research a better understanding will give a greater insight allowing us to diagnose individuals with more ease as carers and professionals will know exactly what to look out for.

Adults have reported that they especially struggle with making appointments by telephone. With 62% of adults reporting difficulty of making appointments over the phone (Doherty et al., 2022). This is due to the lack of social cues as there is an absence of a physical individual. To overcome this, we must find alternative pathways for individuals to make

appointments with their GP. Adults have also reported there being barriers to primary care leading to poorer health outcomes. This can be overcome through identifying predictability, communication, and sensory processing as key domains under which such barriers fall.

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