

Diagnosis and Treatment of Autistic Spectrum Disorders
With a Focus on Homeopathic Prescribing

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Diagnosis and Treatment of Autistic Spectrum Disorders With a Focus on Homeopathic Prescribing

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ABSTRACT

A 6-year-old male presented to the clinic with a previous diagnosis of Autism. Onset of symptoms began after the birth of the patient's younger brother around 4 ½ years ago. Present treatments include ABA (Applied Behavior Analysis) therapy and a gluten-free, casein-free diet. Chelation using DMPS was attempted, but was discontinued due to side effects. The patient has difficulty with social interaction, maintaining attention on a task, sensory sensitivity, and ritualized behaviors. Patient also has bursts of running and screaming. Expressive language is very limited with no spontaneity and poor articulation of words. Based on symptoms, the diagnosis of autism disorder is appropriate according to the criteria of the DSM-IV. The mother has come to the clinic seeking homeopathic care. A single homeopathic remedy was given, and results will not be known until the follow-up visit.. Modification of treatment will depend on any future results of the remedy prescription. For this patient, positive results would include more appropriate social interactions, longer duration of maintaining attention on a task, less sensitivity to sensory input, and increased mastery of expressive language.

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Introduction:

Autism is a disorder of young children, and like any such disorder, it is very tragic and plucks on our heartstrings. The rate of autism is growing in industrialized countries all over the world—it is an epidemic affecting the minds and hearts of millions of people. In a personal interview with Irene Ingram, a pediatric occupational therapist in Hartsville, South Carolina, she reports that the number of autistic children in her practice has risen from just a few cases in the 1980's to a large percentage of her practice in the last decade. In addition, she has noted that more “normal” children have sensory integration difficulties and auditory processing difficulties, two common symptoms of autism. The question then arises: how do we stop more children from getting the disorder and how do we help those who have it? Naturopathic medicine has many theoretical answers, and many of these answers are proving correct on some level; naturopaths are getting results. As we learn more about the causes and pathophysiology of the disorder, we will likely continue to improve treatment and eventually learn how to prevent this terrible disorder.

A Case:

John, a 6yo male previously diagnosed with autism:
February 2, 2006

Subjective:

The first symptoms of autism started around 1 ½ years of age after being left alone with a nurse in the hospital during the birth of his younger brother (mother does not suspect that the nurse did anything wrong). He did not want to be touched and had fear being away from mom. He started getting sick a lot (flus, chest colds). Then he “sort of left” after several more months. He started losing language skills, calling dad “mom” and

vice versa, flapping arms and hands, and running up and down the hall screeching.

Spinning and deep pressure would calm him down.

Previous treatments:

Patient received IV DMPS chelation for several years, but began getting sick; this treatment was discontinued. He has been doing applied behavior analysis (ABA) and relationship development intervention (RDI) for 3 years now.

Behavior:

He does not relate to the world. He is hyper—jumping a lot, restless, and does not cuddle or seek attention for any length of time. He still has limited language ability although he can communicate now with ABA training. He cries a lot. It is difficult to engage with him; he is not able to focus and eye contact is difficult. He loves computer games. He lost his sense of humor for a while, but he is smiling and laughing some now. He sees things that are not obvious; he shows this in his drawing. He will play with his little brother some—chasing, wrestling. It is sporadic and he will not initiate the play.

He can hold his attention on things he loves for 15-17 minutes at the most. Mom has to constantly entertain him and keep changing activities. This is very exhausting for her.

He has fears of cats and dogs—he runs away. He is fearful in unknown environments. He is easily overstimulated by lights and noise—runs around panicky. Certain noises “drive him crazy” such as the vacuum cleaner and background talking. He reacts to overstimulation by covering his ears and screaming.

He has ritualistic behavior and things have to be done in a certain way. For example, he likes to cook and bake, but he has to put things into the bowl in a certain order. He gets upset if procedures are not done in that way. He repeats things like movie lines and things from school.

Physical symptoms:

He has chronic constipation; he only has a bowel movement every other day if he does not use Mg. He had difficulty sleeping through the night, but the gluten-free, casein-free (GFCF) diet helped that.

Food:

He loves Fritos corn chips.

Pregnancy:

Labor was long and difficult. He was born very early. He was unresponsive at birth with limp arms and legs. He had severe jaundice. Mother was averse to salmon and fish during pregnancy. Patient was frightened during his brother's birth. He was with a caregiver in another room away from his parents. (The circumstances and significance of this event are unclear. This may have more significance for the mother than the patient.)

Objective:

Interested in touch; touching Dr. Taylor's beard, apple on a computer. He pushes his brother when frustrated. He chews on his hand a lot. He likes shiny things (apple on computer). He needs a short run—only a minute—so that he can calm down. Sits still in chair for most of the visit but must get up and run every 10-15 minutes. These bursts of running are sudden.

Diagnosis:

Autism is one of five pervasive developmental disorders (PDD) listed in the DSM-IV, which also includes rett disorder, childhood disintegrative disorder, asperger disorder, and pervasive developmental disorder not otherwise specified. Diagnosis of a specific PDD can often be difficult and confusing as many of the developmental disorders are very similar. For example, in the DSM-IV, the only real difference between asperger disorder and autism is people with asperger usually have no difficulty with language or communication. See appendix for DSM-IV criteria for PDD.¹ There are so many arbitrary lines drawn between all of these disorders that it really makes sense to think of them as a continuum of disorders. For this reason, PDD's, excluding rett disorder, are often referred to as autistic spectrum disorders (ASD) or "the spectrum" rather than referring to a specific DSM-IV diagnosis.

Diagnosis of autistic spectrum disorders (ASD) is entirely based on observable behavior and the ruling out of organic causes of disease. Patients with ASD have a normal EEG unless seizures are a concomitant finding. MRI or CT results are being researched but are not conclusive and certainly cannot be used to diagnose ASD. They are more useful to rule out brain lesions as a reason for behavioral changes.²

Basic developmental screening should be done at every well-child visit so that early detection of ASD can be made. It has been found that early intervention can make a big difference in future success of the ASD child. Useful screening tools are the Ages and Stages questionnaire, BRIGANCE Screens, Child Development Inventories, and the Parents' Evaluation of Developmental Status. Any child who fails one of these exams or

is behind on well-established language development goals should be examined more closely (See Figure 1).³ The most important thing is to really learn to identify the common symptoms of autistic spectrum disorders. Then the practitioner must decide whether this is a phase that a child is going through or if these are symptoms indicating the presence of ASD. For example, in John's case, one of the first symptoms he developed was an aversion to being touched, a common symptom of ASD. In and of itself, this is not cause for alarm as any child can go through such a phase at some point in development. So a symptom must be viewed in the context of the case, and suspicion must be raised if a child loses skills that they had previously developed such as language or coordination.⁴

If there is high suspicion of ASD, a more advanced developmental examination should be done that is specific to ASD. The Checklist for Autism in Toddlers (CHAT) is useful at 18 months, but is often inadequate to detect high functioning autism, atypical autism, or Asperger syndrome. The Autism Screening Questionnaire is used at four years of age or more and will often detect those missed by the CHAT screening. Diagnosis before 4 years is optimal since early treatment has been shown to greatly improve prognosis. More effective screening tests are being developed, but are still in research or developmental stages.⁵

In addition to questionnaires, more testing should be done to rule out other causes of the presenting symptoms. Test for lead, especially if pica is present. Refer for an audiological assessment to rule out hearing loss, which is often a concomitant in autism.⁶ Audiological testing for children with PDD requires some modifications to traditional testing so an audiologist with experience working with PDD should be consulted. Genetic

testing may rule out Fragile X, Prader Willi, and Angelman’s syndrome, and metabolic testing may uncover inborn errors of metabolism.⁷

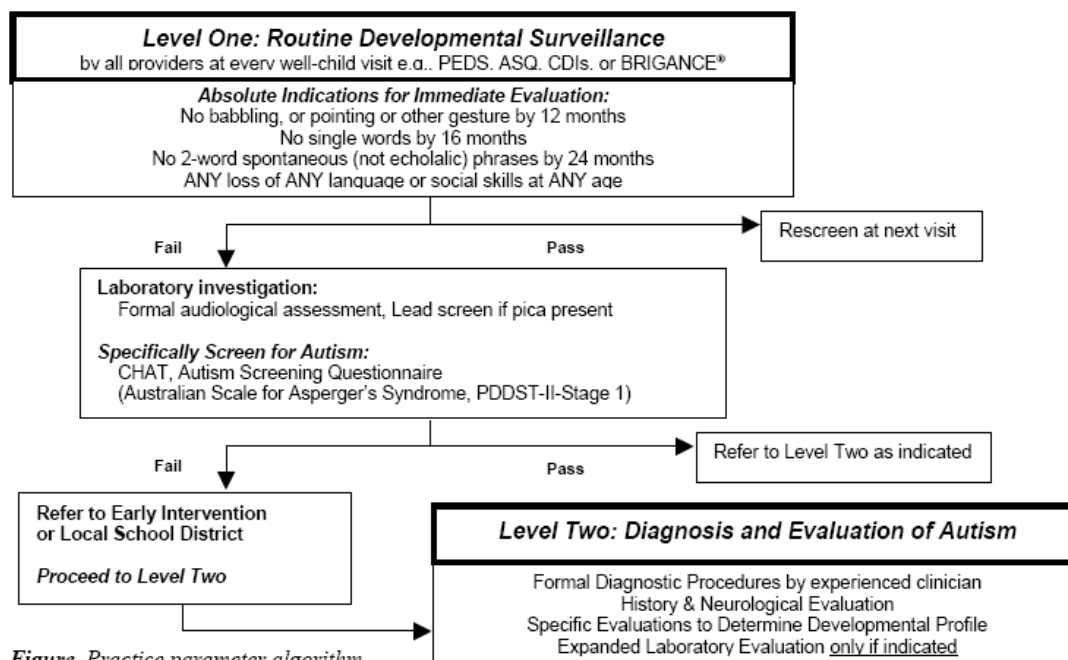


Figure. Practice parameter algorithm.

Figure 1: PDD Testing Algorithm⁸

The fact is that autism is not so much a “thing” as a functional syndrome. As Dr. Will Taylor said, “we are more impressed by the differences in these kids than the similarities.” There are certainly similarities as described by the DSM-IV, but there are so many differences even within the same diagnosis. ASD children often have difficulties in different areas. Many of the symptoms of autism are also seen in attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) such as hyperactivity, short attention span, sensory processing problems, and a lack of empathy or ability to express empathy. That is another reason some have adopted the term autistic spectrum disorder; it is truly more of a spectrum of behavior that merges with the “normal” population. Autistic children are generally very picky about food tastes and

textures, but so are most children at some point in development. Our therapies then need to focus on learning to function in their disorder, but also on improving their disorder.

In the case, John has already been diagnosed with autism. We did not get the details of the diagnostic workup. Upon reviewing the case, the patient literally meets all of the criteria for the diagnosis of autistic disorder. At this point in development, it is a relatively easy diagnosis to make because others his age are much more developmentally advanced. He does not meet criteria for asperger syndrome due to the delay in spoken language and communication. Onset of the disorder was before 2 years of age, which rules out childhood disintegrative disorder. Rett disorder is ruled out by normal head size and lack of characteristic hand movements such as wringing or washing.

Etiology:

The etiology and pathophysiology of autistic spectrum disorders (ASD) are still very much a mystery. There are many theories—most of which are very compelling, but none have been effectively proven and none account for all of the cases of autism. As of 2004, two large research projects, Childhood Autism Risks from Genetics and the Environment (CHARGE) and the Center for Disease Control's large-scale autism project, are working on finding environmental causes or triggers for autism.⁹ There are many others doing research as well. In particular, an organization that has gained power especially among parents of autistic children is the group Defeat Autism Now! (DAN). It is a group of people including many physicians who are very proactive in coming up with effective treatment and discovering the etiology of autism.¹⁰

Vaccinations have become a very controversial topic in the autism community. There are many angry parents and doctors, particularly in the DAN organization, that blame vaccines as a major cause or trigger of autism. Others are convinced that vaccines are not related at all. The two vaccines considered most problematic are the measles, mumps, rubella (MMR) vaccine and the diphtheria, pertussis, tetanus (DPT) vaccine. Reading the “facts” is not all that helpful at times especially with the addition of political, legal, and economic perspectives and agendas.

It is well beyond the scope of this thesis to cover the vaccine issue thoroughly. Little of the information out there is unbiased; the John Hopkins website¹¹ is one of the most unbiased sources of information.¹² Both sides of the vaccine debate continue to cite evidence and put their own opinions forward, yet neither side seems to be able to prove whether or not any vaccine causes pervasive developmental disorders or any other neurological disorder. There is enough evidence to be cautious, perhaps angry or afraid, but not enough to say whether or not the vaccines are causing autism. It is a debate steeped with politics and economics, but unfortunately the innocent people and children are paying the consequence no matter which side you believe.¹³ But vaccines certainly cannot be the only cause of autism. There are many children with autism who were never vaccinated and many who developed autism before receiving vaccination.

There is now some thought that infectious disease itself, such as measles or unknown childhood fevers, can trigger the development of autism. There are many instances where children develop autism just after one of these fevers. An amazing study by Vojdani et al found that children with autism have higher titers of antibodies to neural antigens such as those on myelin, sulfatide, chondroitin sulfate, and neurofilament

protein. They also found higher titers to three other proteins known to cross-react with neural tissue: Chlamydia pneumoniae antigen, Streptococcus group A antigen, and Butyrophilin (a milk antigen). This is good evidence to support that autism has an autoimmune component that could be triggered by childhood infectious disease, vaccination, environmental toxicity, and early milk introduction.¹⁴

Genetics is a strong etiological component; one study found a 92% concordance between monozygotic twins.¹⁵ Dr. Skowron, a naturopath having great success treating autism, questions genetics as a cause. He feels that ASD is not strictly inherited since the rate is increasing so quickly; there must be something such as environmental toxins that are affecting genetic expression or replication.¹⁶ Also, most children have no family history of ASD.

Environmental toxins have been implicated for good reason. There are so many more environmental toxins in our environment today. To make matters worse, the Centers for Disease Control found that mercury is selectively shunted to the fetus in utero. They found that mercury levels in umbilical cord blood is 1.7 times higher than in the mother's blood. So it only requires a level of 3.5 ppb in the mother's blood to reach a fetal blood level of 5.8 ppb, the EPA's minimum exposure of mercury for a fetus. It has been found that 16% of women have mercury levels higher than 3.5 ppb.¹⁷ There are many practitioners promoting detoxification as a main treatment for autism and many are getting really good results with a variety of detoxification methods.¹⁸

The fact remains that we do not know what really causes autism. Vaccines and infections may be triggers, but they are not the causes. Maybe autism is a spiritual disease of the industrialized world. Maybe it is Mother Nature's way of coping with

imbalances in our world. Maybe it is a combination of spiritual, environmental, and genetic factors. With the high rate of autism, we must find the causes and repair it. One in 166 children in industrialized countries have a pervasive developmental disorder.¹⁹ That is astounding. Whatever the causes are, they need to be dealt with as quickly as possible.

Pathophysiology:

The pathophysiology of autistic spectrum disorders is largely theoretical or unknown. One of the main theories with some therapeutic efficacy is the opioid-excess theory. This hypothesis was first reported by Panksepp in 1979. He noticed that animals given excess opiates would take on many of the common symptoms of autism especially the lack of social interest. This is especially true in the younger animals as older animals (including humans) have a different production of opiates. Young animals produce beta-endorphins which are longer lasting and stronger opiates. This may account for the calmness of infants before they are physically able to move around very much. As animals begin to mature, they produce less beta-endorphin and more enkephalin. Enkephalin is a much weaker and shorter-acting opiate. Many of the emotional and behavioral symptoms of autism such as lack of response to social cues, repetitive behavior, and lack of interest in socialization may be due at least in part to excess beta-endorphin production. Another interesting thing about the opiate pathways in the brain is that they can be turned on and off quickly depending on the situation. As we know, opiates have some addictive properties. Panksepp hypothesized that children with autistic disorders may be addicted to the opiates produced in their own body. Opiate

pathways are turned off when exposed to more novel situations; this may account for the need for routine and the panic states that are induced from changes in routine.²⁰

Environmental toxicity is another area of concern. There are many environmental toxins that are known to affect genes as well as the nervous system in a variety of ways. For instance, PCB's, lead, mercury, and bacterial enterotoxins can lead to increased adhesion of leukocytes on brain endothelial cells, activation of T-cells to antigens on oligodendrocytes and astrocytes, increased permeability of the blood-brain barrier, and then subsequent breakdown of myelin and other neural cells in the central nervous system.²¹ There are also many environmental toxins that are directly neurotoxic such as lead, mercury, vinyl chloride, arsenic, toluene, and tetrachloroethylene.²²

Treatment:

Allopathic medicine has very few treatments to offer a child diagnosed with an autistic spectrum disorder. Treatment is focused on management of secondary disorders such as seizures, gastrointestinal problems, and allergies; psychopharmaceuticals to manage behavioral difficulties; and referral for intensive behavioral therapy to improve behavioral and social functioning. The other major role of the pediatrician is to refer the parents to support groups and other resources that will be required some time in the management process.²³

Naturopathy has much to offer autistic children and their parents. Naturopaths have therapies that are particularly wonderful for treating functional problems where there is not necessarily a known organic "thing" to be treated. There are so many things that we can do to help with the secondary disorders of autism without the side effects of

conventional pharmaceuticals. We are experts at treating gastrointestinal disorders, and we have the ability to use energetic medicine such as homeopathy, botanicals, and craniosacral therapy to get things “unstuck.”

Naturopaths are not the only ones that should be involved in the treatment of ASD; a myriad of therapists of different types are needed to make the kind of changes that lead to optimal functioning in school settings and, more importantly, in every day life. Often the help of speech pathologists, occupational therapists, behavioral therapists, teachers, child psychiatrists, and others are needed depending on the difficulties of the child.²⁴

In this case, we worked strictly on homeopathic prescribing for this patient. They were already doing most of the common therapies including one-on-one therapy (specifically ABA), GFCF diet, and a detoxification program via chelation had been attempted. The detoxification program should have been modified or a different modality used to detoxify that would not cause so many side effects in the patient. This is an example of the need for flexibility especially when working with this population. Things that may work for other populations may not work in this one.

One-on-One Therapy:

One of the important treatment modalities for ASD is behavioral modification programs and tutoring programs. There are many different types that have been developed specifically to treat ASD and a few that are designed for a wider range of learning difficulties. Some of these programs are Applied Behavioral Analysis (ABA),^{25,26} Relationship Development Intervention (RDI),^{27,28} Greenspan’s Floor Time,^{29,30} and the Lindamood-Bell Program.³¹ These programs are very intense one-on-

one tutoring programs designed to maximize learning of language, communication, socialization, play, and appropriate behavior management. The intensity of these programs often demands that there be multiple therapists trained in these methods at the house and/or school for many hours a day—often as much as forty hours per week. These programs are very necessary to help parents learn to manage their children and to help children understand others around them. All of these therapies result in great benefits for ASD children especially in the areas of communication and socialization. The common theme in all of these therapies is intensity. Whatever program is chosen must be delivered for many hours with one-on-one attention. The parents should explore the programs that are in their area to find one that fits the child and the parent(s).

Sensory Management:

One of the difficulties with autism is a difficulty in managing sensory input. Occupational therapists who are experts in sensory integration should be consulted to provide what is often called a “sensory diet.” A sensory diet often includes deep massage, chewing on a necklace designed for the purpose, oral massage, a weighted vest, and any other interventions that are done at regular intervals throughout the day to help the ASD child regulate their level of stimulation. The sensory diet should be incorporated into the entire treatment regimen. It should especially be incorporated into therapy sessions and daily life. The naturopath in the office can help with this by creating a calm and safe environment in the office. This can be done with dimmer lighting, reduction of outside noise, good time management, and a pictorial schedule or story about what will happen during the visit.³²

A treatment option that is more in the realm of the naturopath involves regulation or balance of the neurotransmitters. This can be done by giving precursors to the calming neurotransmitters (theanine, tryptophan, and taurine) or with nervine botanicals such as holy basil.³³

Nutrition:

Nutrition is one of the areas where a naturopath is very suited to help. Two of the most commonly used diet interventions for autism are avoiding allergens and the gluten-free, casein-free (GFCF) diet.

Avoiding allergies or food sensitivities is often very helpful. There are many different tests including Elisa antibody testing, electrodermal testing, Carol testing, skin prick testing, and elimination trials. It is best to choose a testing method that the individual naturopath trusts and one that the parents can believe in.³⁴

The GFCF diet is based on the opiate-excess theory mentioned in the pathophysiology section. Gluten and casein are proteins that can be broken down into opiate-containing peptides that can contribute to the excess opiate stimulation that may already be plaguing the autistic patient.^{35,36} But treatment should not stop with simple elimination of these foods from the diet, though it is most likely necessary at the beginning of treatment. The opiate peptides are formed due to poor digestion that is often associated with ASD. So these digestive disturbances should be treated. Digestive disturbances seem to vary widely from leaky gut, allergies, ileal lymphoid nodular hyperplasia, and non-specific colitis.³⁷ Naturopathic treatment should be targeting these digestive disturbances so that patients no longer form opiate peptides and do not have to stay on such a restrictive diet for life.

No matter what diet changes are made, the most important thing is getting and providing support for the family in this difficult transition. Diet changes can be extremely difficult especially since ASD patients often have very limited diets anyway. There are support groups for the GFCF diet in many areas that can help.³⁸ An important thing for the naturopath to remember is that these families are often stretched to the maximum already. Sometimes adding the stress of transitioning into a difficult diet can do more harm than good. So there should be adequate preparation and planning before any diet change is begun. If there is a large treatment team, as is often the case, they should all be involved in this transition so that snacks that are to be avoided are not being given during therapy sessions. Also, therapists in the home can help with behavioral modification to ease the transition into this new diet. It would be very helpful for the naturopath to meet with and remain in communication with the entire treatment team involved. Supplementation can be difficult due to the hypersensitivity of these individuals—they will often only eat a few foods and will not swallow capsules. This problem should also be kept in mind when recommending dietary changes.

Homeopathy:

Homeopathy is a very effective approach in the treatment of ASD, and some homeopaths specialize in this area. Famous examples that have lectured and/or written on the subject are Paul Herscu,^{39,40} Amy Rothenburg, Judith Reichenburg-Ullman, and Dana Ullman.⁴¹ One of the advantages of homeopathy is that it adds very little to the already overfilled schedules of the families of ASD kids. The main difficulty in the homeopathic treatment of ASD kids is in taking a good case. If a good case can be had, then analysis is the same as with any other homeopathic case.

Taking the case of an ASD child may be similar to veterinary case taking in that these kids often cannot communicate very much quality information. The case is based mainly on observation of behaviors and reactions to stimuli. One of the first mistakes of many homeopaths is to go straight to the repertory without understanding the case first. Many of the common symptoms of autistic children are poorly described in the repertory. Also, these children often present with symptoms of several different remedies; even with a good understanding of these remedies, it can be difficult to choose the correct one. So it is very important to understand what is really the problem in the case and to understand the symptoms thoroughly.⁴²

Paul Herscu thoroughly explains the approach to taking the case of autistic children so that it is relatively simple. There should be a focus on the chief complaint or most important presenting symptom. The most important symptom is the one where the patient is expending the most energy. Remember that the symptom itself is an adaptation to something. So the key to the case is figuring out why the patient is expending so much energy. “No organism expends energy without a return on that energy expenditure.”⁴³ A plant spends a lot of energy in order to bend toward the sunlight; the plant would not do that if it did not receive enough increased energy from the sun to make it worth the effort. Often that reason can be found by finding the modalities or context of the symptoms. For example, in John’s case, he screams, covers his ears, and runs away when the vacuum cleaner is running and when there is a lot of background noise. The idea that is important here is the sensitivity to overstimulation and the need to reduce this stimulation. The screaming and covering ears are ways to reduce or avoid the excessive stimulation.

Care has to be taken not to jump to conclusions, though. A truly important symptom or theme should have what Herscu calls “redundancy”—it should come out in multiple places in the case and in more than one situation.⁴⁴ In this case, sensitivity is a theme that is very redundant.

It is also very important to maintain perspective. Often parents and practitioners alike forget that this is a three-year-old or a five-year-old. Sometimes similar behaviors or lack of development can be seen in “normal” peers and may actually be a very normal behavior for children without ASD. For example, sometimes behavior problems come after the seventh hour that day of intense tutoring. Any child—and I would wager any adult as well—will be exhibiting tantrums or other “adverse” behaviors at that point. Often, the important thing is not so much that they are having behavior problems, but how they exhibit their behaviors. Studying the child’s individual behavior patterns will lead to better understanding of the case and a more accurate prescription.⁴⁵

Herscu also explains that coping methods are useful in finding a remedy. Some children will need to flap hands and arms in order to cope with a long day. Others want to be covered or want deep pressure. Some kids want both. Some just want to be left alone in front of the television or computer.⁴⁶

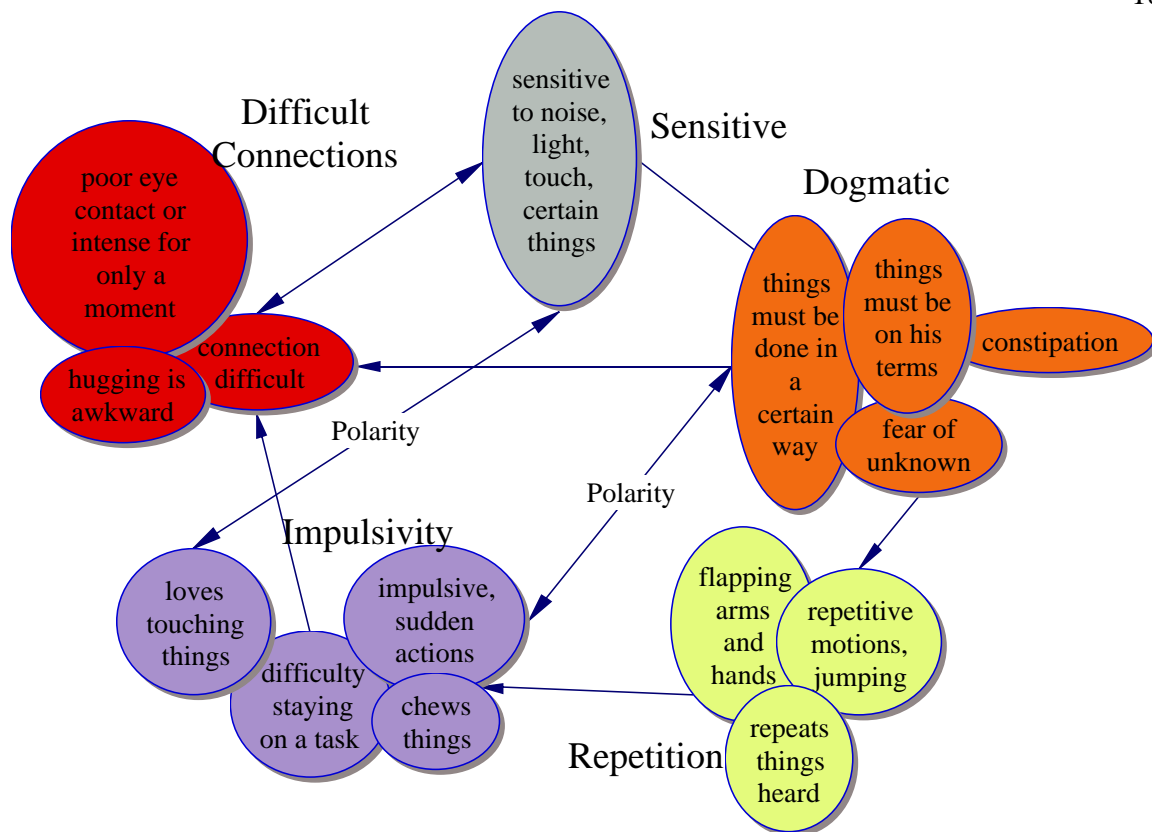


Figure 2: Organization and Assessment of John’s Symptoms (Using Inspiration software).

This is an organization of themes of the case using Paul Herscu’s cycles and segments. In this method, themes or “segments” are formed from the patient’s symptoms and linked together to form a cycle of connected segments in order to provide a cohesive understanding of the process of the pathology.

“Difficult Connections” seems connected to all of the other segments; it is probably his core issue. Most of the segments seem pretty directly connected to each other as shown in the diagram. “Sensitive” leads John to control things, to make sure things are on his terms. That then leads to “Dogmatic” and “Repetition.” As he focuses on doing these repetitive things, it seems his senses are overloaded and he must run

around in a very impulsive way in order to be calm again. This “impulsivity” and inability to stay on a task leads to “Difficult Connections” with people.

The final connection in John’s case is between “Difficult Connections” and “Sensitive.” There is a theory that people with ASD (as well as ADD) lack the mental filters for all of the “extraneous” information that is constantly coming in.⁴⁷ They have difficulty connecting to or concentrating on anything because they cannot exclude other things. So John becomes sensitive to all of the sensory information around him because he cannot keep it out of his active awareness; he cannot ignore the input. This may be similar to attempting to have a conversation while also attempting to watch a movie and work on a thesis at the same time. I do not have completely observable proof that this is what is actually happening, but I believe this works as a hypothesis to make a connection in this case.

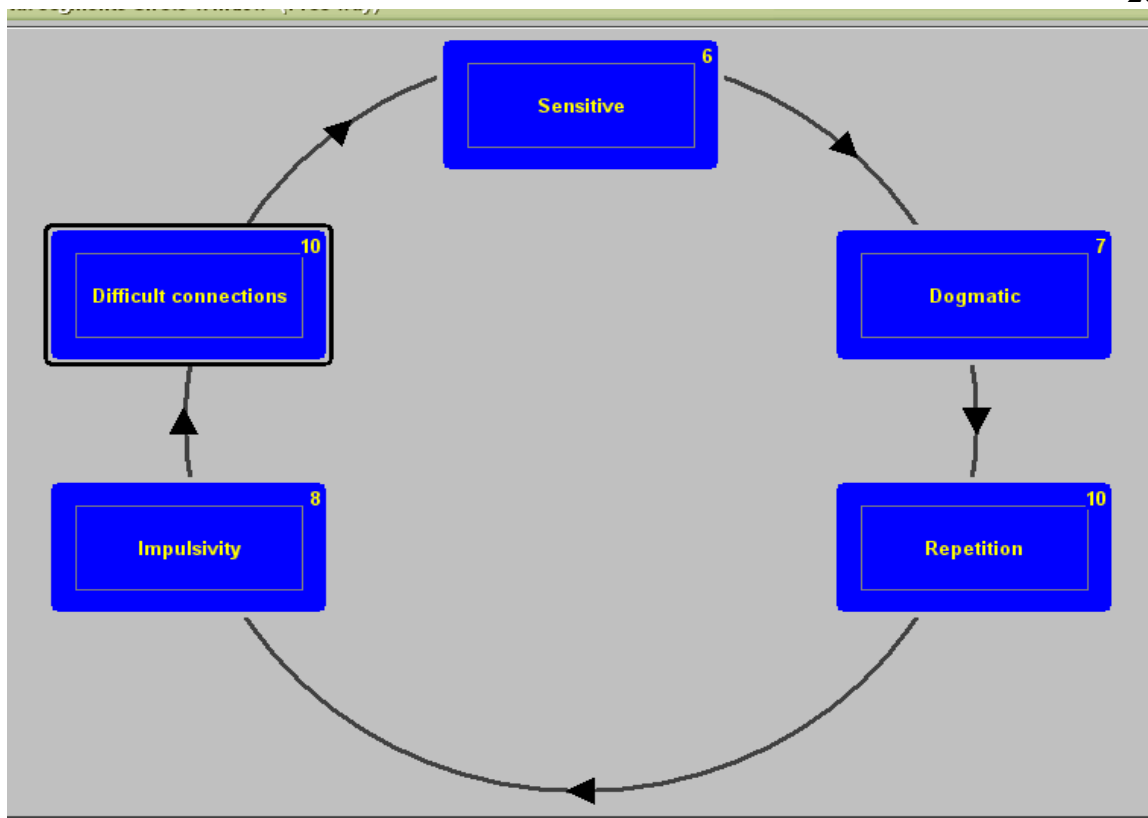


Figure 3: Cycle of Segments (Using RADAR homeopathic software).

A cycle of the process of this disharmony is created with all of the connections above. It is the “outwardly perceptible symptoms portraying the present malady, which are organized by the dynamis in the organism, form[ing] a whole”⁴⁸ The cycle shows how the patient reacts to the stress of having his particular disharmony, which we term autism.

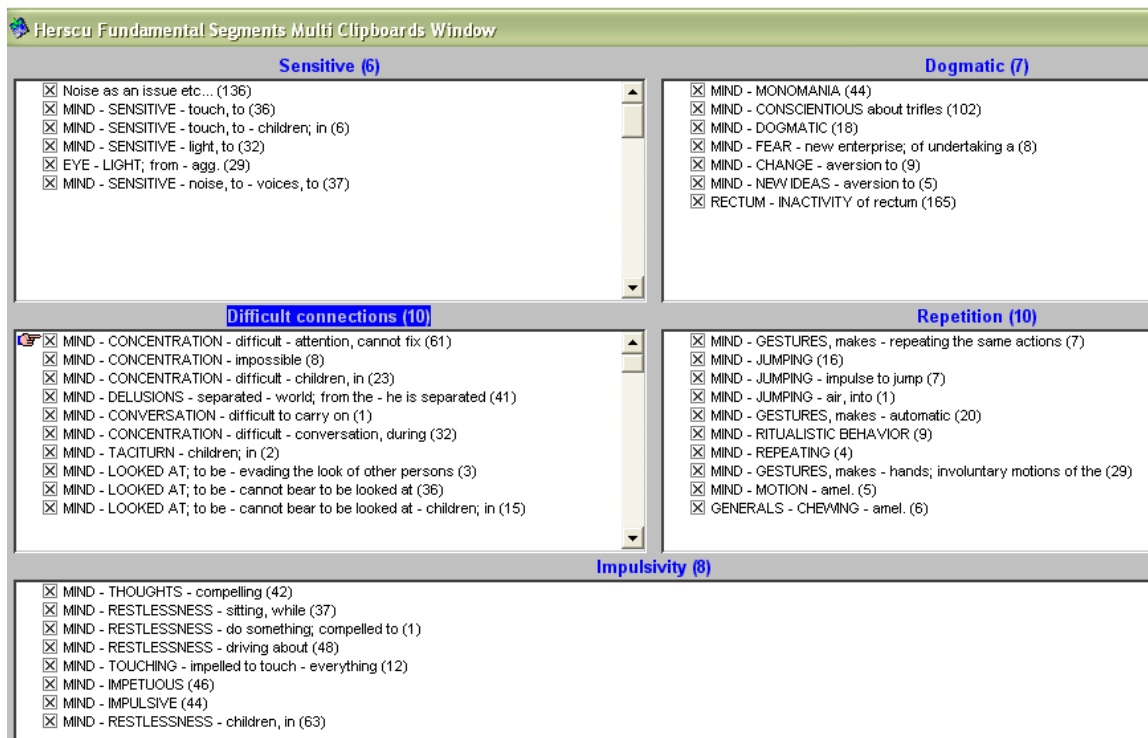


Figure 4: Rubrics in Each Segment (Using RADAR homeopathic software).⁴⁹

The rubrics chosen for each segment are those that represent or describe the segment in the way that it is expressed in the patient. As an example, the rubrics chosen for the “Sensitive” segment are ones that are actual symptoms of the patient (See Figure 4). All of the rubrics in a particular segment are then combined into one larger rubric. The idea is to have each segment represented well enough that the correct remedy for the patient is in at least one rubric in the segment so the remedies of interest should be present in all of the segments. The specific remedy is the one that best represents each segment and has similar connections within the cycle. So the “Law of Similars” is interpreted as finding the remedy that has a similar cycle as opposed to one that simply has similar symptoms. The symptoms are still very important, but the context of these symptoms is stressed more with this system of analysis.⁵⁰

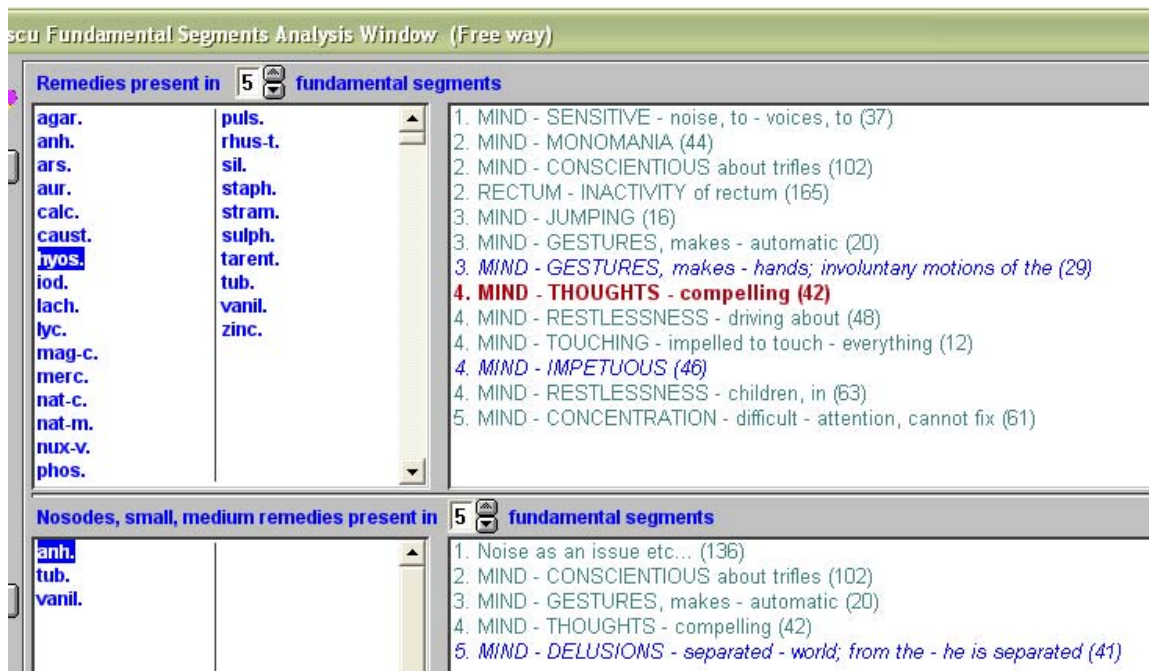


Figure 5: Remedies Present in All 5 Segments (Using RADAR homeopathic software).

This list of remedies is a little longer than is preferred using this model, but it is acceptable. The rubrics listed in the right column are those in which the highlighted remedy in the left column is present. To me, the most interesting remedies here are Anhalonium, Hyoscyamus, Lachesis, Phosphorus, Silica, Stramonium, Tarentula, and Tuberculinum.

George Vithoulkas describes Anhalonium as having the feeling of being separate from others and difficulty connecting to others. A person who needs Anhalonium feels pretty separate from everything in the environment yet also feels merged with everything in the environment. They have a sensitivity of vision, hearing, and touch; this lack of filtering that sounds very similar to ASD in general. There is “kaleidoscope hearing” where the patient hears all of these incomprehensible sounds. It has the gesturing and compelling thoughts. There is a lot in this remedy about spiritual or existential issues, but we cannot know that in John’s case. One of the things that does not come out in this

remedy is John's fears. We don't know the nature of his fears, but they are there. This remedy typically is not afraid or may even like all of the strange delusions or hallucinations that they experience. This remedy is also dominated by hallucinations, but we have no idea what John experiences in that realm. He may have hallucinations, or he may not have any at all.⁵¹ See Figure 5 for rubrics of the case in which Anhalonium is present.

Hyocyamus has strong connection difficulties,⁵² which is very applicable for this case. It has the awkwardness of communicating with others that is such an issue for John. The sensitivity is not there as strongly as would be preferred—it is there in only a few rubrics (especially in regards to sound⁵³), but it is also in rubrics speaking of insensitivity. That brings up some issues such as the fact that John is sensitive to input such as the vacuum or lights, but he is insensitive to other impressions such as the feelings of others and personal space. All of these sensitivities seem to have to be on his terms; if they are not, they are overwhelming. Hyoscyamus covers that very well. It covers the need to have things a certain way, the gestures, and the impulsiveness of the patient perfectly.⁵⁴ See Figure 5 for the rubrics of Hyoscyamus in this case.

The screenshot shows the 'Fundamental Segments Analysis Window (Free way)' in the RADAR software. It is divided into two main sections. The top section, titled 'Remedies present in 5 fundamental segments', lists various remedies in two columns. The first column includes: agar., anih., ars., aur., calc., caust., hyos., iod., lyc., mag-c., merc., nat-c., nat-m., nux-v., phos., puls. The second column includes: rhus-t., sil., staph., stram., sulph., tarent., tub., vanil., zinc. To the right of this list, five fundamental segments are listed: 1. MIND - SENSITIVE - light, to (23); 2. MIND - SENSITIVE - noise, to - voices, to (36); 2. MIND - MONOMANIA (38); 2. MIND - CONSCIENTIOUS about trifles (78); 2. RECTUM - INACTIVITY of rectum (156); 3. MIND - JUMPING (16); 3. MIND - JUMPING - impulse to jump (6); 3. MIND - GESTURES, makes - automatic (18); 3. MIND - GESTURES, makes - hands; involuntary motions of the (27); 4. MIND - RESTLESSNESS - children, in (56); 5. MIND - LOOKED AT; to be - evading the look of other persons (3); 5. MIND - LOOKED AT; to be - cannot bear to be looked at (31). The bottom section, titled 'Nosodes, small, medium remedies present in 5 fundamental segments', lists remedies: anih., tub., vanil. To the right, five fundamental segments are listed: 1. Noise as an issue etc... (115); 2. MIND - CONSCIENTIOUS about trifles (78); 3. MIND - GESTURES, makes - automatic (18); 4. MIND - THOUGHTS - compelling (31); 5. MIND - DELUSIONS - separated - world; from the - he is separated (8).

Figure 6: Rubrics for Stramonium (Using RADAR homeopathic software).

Stramonium is always considered when thinking of Hyoscyamus. They are both in the Solanaceae family and have many similarities. The connection piece is so prominent in this remedy; there is the feeling of being alone in the wilderness. But I'm not so sure that describes John's feeling. They do not have this difficulty communicating like Hyoscyamus. Stramonium's behaviors also seem more aggressive and perhaps random. Stramonium does have more sensitivity as this patient does. It definitely covers the flapping. The communication piece is a little different. Stramonium does not like to be looked at, but does not necessarily have the communication difficulties of Hyoscyamus. His fears are not nearly like those that are usually associated with Stramonium. His fears seem more like reactions to sensitivities or the unknown.⁵⁵

With Lachesis, Phosphorus, Tarentula, and Tuberculinum, we don't see difficulty connecting with others. They are the ones that are usually very communicative. All of these remedies are so charming in general. It can be in an awkward or over-the-top way,

but not so much difficulty with communication. It is hard to give lachesis without some kind of locquacity. There is not the wildness of Tuberculinum or Tarentula. His restlessness also seems more voluntary and with purpose than the way Tuberculinum and Tarentula usually exhibit their restlessness.^{56,57}

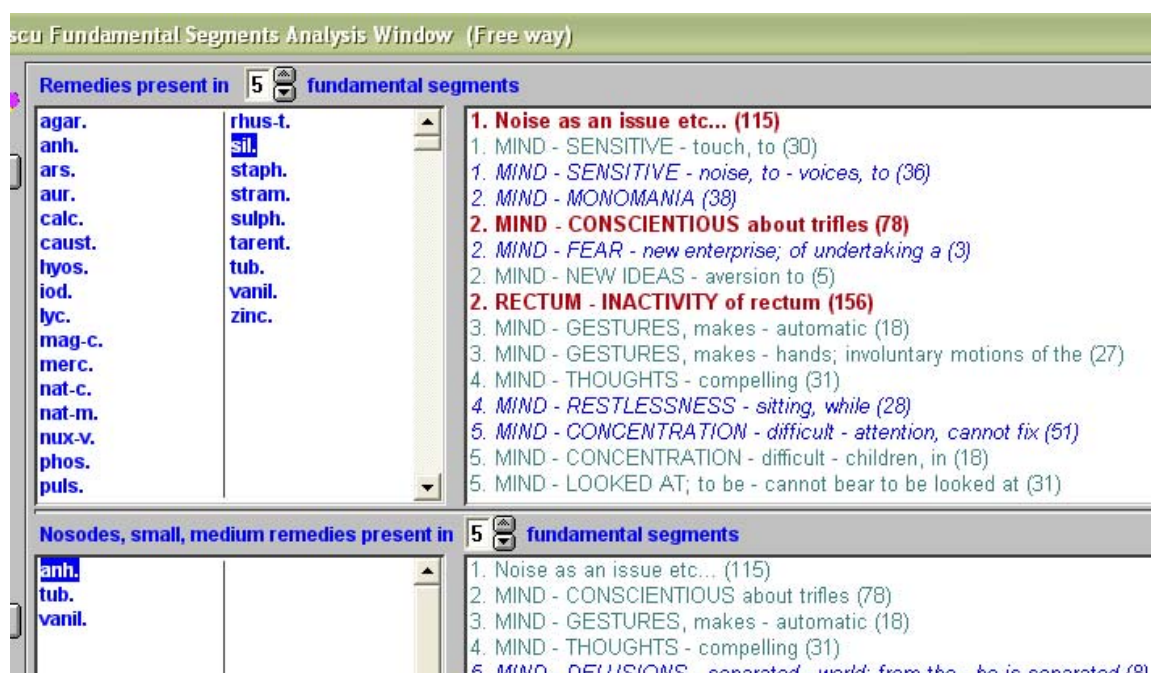


Figure 7: Rubrics for Silica (Using RADAR homeopathic software).

Silica is a very interesting remedy to consider for John. It covers all of the issues of the case really well. It has the sensitivity. Silica more often wants things to be their way, obstinacy. The story about baking and having to have things in a certain order does sound like something that silica could do, but I would not expect someone who needs Silica to impose that order on someone else. Silica has the fear of new things very strongly, but it seems more extreme in this case than Silica usually exhibits. There is none of the timidity of Silica, but there is mildness.⁵⁸

Hyoscyamus was chosen for this case and given in a single dose of 3 pellets in a 1M potency. It is beyond the scope of this thesis to talk about potency and reasons for dosing in this manner for this case.

Stramonium and Silica are the next choices for this case. These will be the next remedies attempted if Hyoscyamus does not act for John. Considering the long-standing pathology involved with this case, a few months should be allowed for the remedy to act before deciding on the next course of action. The main thing that should improve with treatment is the connection to others. With continued care, John should make excellent progress in the areas of behavior, social interactions, and ability to regulate sensory input. It is often difficult if not impossible to know the reaction of a remedy in a given patient. Only time will tell the results of this prescription.

Treating the Parents:

When treating kids, the parents are always a major consideration. The parents of autistic kids are stressed to their maximum. They are usually taking their child to many practitioners and specialists. Every activity can be a huge ordeal. Often these kids cannot play by themselves safely—they may require almost constant monitoring and entertainment. This quickly leads to overwhelmed parents. These difficulties are compounded by the fact that this is not a “stage” that the child is going through. This can go on for years with no sign of an end in sight. Parents feel that they are out of time, money, energy, and perhaps most importantly—hope. As holistic healers, we have to help these parents cope with the incredibly difficult situation that they are in. They need adrenal support, babysitters that can responsibly care for the child, time to themselves, help with their relationships, and some hope.

Conclusion:

Since the patient's mother came in for homeopathic care and many of the other treatment options that might be suggested were being utilized, there is little that I would add to the treatment plan at this time. One treatment option that could be addressed in this case is a more gentle detoxification program that is less likely to have too many side effects. This could be accomplished through increasing fiber in the diet or providing a fiber supplement such as ground flax seeds to improve gastrointestinal motility. Botanicals such as cilantro can also be effective for detoxification.

In researching the case and homeopathic analysis for children with autism, I have become much clearer about exactly what to look for while taking the case. I will probably be more efficient in analysis of future cases, but I would not have done anything different with the analysis of the present case.

In speaking with the mother, Dr. Taylor provided excellent counseling to the mother about taking time for herself. This will have to be a part of any treatment plan when working with this population as well as many other pediatric cases.

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³ Filipek PA, et al. "Practice Parameter: Screening and Diagnosis of Autism: Report of the Quality Standards Subcommittee of the American Academy of Neurology and the Child Neurology Society," Neurology 55 (2000): 470-471.

⁴ Collins, L. "Child Growth and Development," Child Growth and Development, Course Notes, National College of Naturopathic Medicine (Spring 2005): 13.

⁵ Filipek, 471.

⁶ Filipek, 472.

⁷ Filipek, 471-472.

⁸ Filipek, 471.

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¹¹ Institute for Vaccine Safety, John Hopkins Bloomberg School of Public Health. <<http://www.vaccinesafety.edu>>.

¹² Zwickey, H. and Andrews, H. "Vaccination Elective Course Notes," (Course notes, National College of Naturopathic Medicine, 2006), Appendix 8.

¹³ Zwickey, 47-48.

¹⁴ Vojdoni, A. et al, "Antibodies to Neuron-Specific Antigens in Children with Autism: Possible Cross-Reaction with Encephalitogenic Proteins from Milk, Chlamydia pneumoniae, and Streptococcus Group A," Journal of Neuroimmunology 129 (2002): 169-176.

¹⁵ Bailey, A. et al., "Autism As a Strongly Genetic disorder: Evidence From a British Twin Study," Psychological Medicine 25, no. 1 (1995): 63-77.

¹⁶ Skowron, JM. "Awakening Autism and the Theory of Increased Action Potentials," Grand Rounds Lecture, National College of Naturopathic Medicine. (April 12, 2006).

¹⁷ Zwickey, 49.

¹⁸ Skowron.

¹⁹ Fombonne, E, "Changing Epidemiology of Autism," Journal of Applied Research in Intellectual Abilities 18 (2005): 292.

²⁰ Panksepp, J, "A Neurochemical Theory of Autism," Trends in Neurosciences 2 (1979): 174-177.

²¹ Vojdoni, 176.

²² "Taking an Exposure History," United States Department of Health and Human Services, Agency for Toxic Substances and Disease Registry, Division of Health Education and Promotion. (June 2000), 8.

²³ Sandler, 1224.

²⁴ Sandler, 1224.

²⁵ Lovaas Institute <<http://www.lovaas.com>>, 2006.

²⁶ Carbone Website <<http://www.dr carbone.net/pages/Home.html>>.

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- ²⁹ Greenspan, S. Infancy and Early Childhood Training Course. Aril 2002.
- ³⁰ Floortime Foundation: Reaching Beyond Autism <<http://www.floortime.org/index.php>>.
- ³¹ Lindamood-Bell Learning Processes Programs. <<http://www.lindamoodbell.com/programs/programs.shtml>>.
- ³² Ingram, I. Personal Interview. March 2006.
- ³³ Skowron.
- ³⁴ Skowron
- ³⁵ White, JF, "Intestinal Pathophysiology in Autism," Experimental Biology and Medicine 228 (2003): 645-646.
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- ³⁸ GFCF Diet <<http://www.gfcfdiet.com>> April 2006.
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APPENDIX – DSM-IV DIAGNOSTIC CRITERIA OF PDD

DSM-IV Criteria, Pervasive Developmental Disorders

Diagnostic and Statistical Manual, 4th Edition, ©1994, American Psychiatric Association

299.00 Autistic Disorder

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

(1) qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

(b) failure to develop peer relationships appropriate to developmental level

(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

(d) lack of social or emotional reciprocity

(2) qualitative impairments in communication, as manifested by at least one of the following:

(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)

(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

(c) stereotyped and repetitive use of language or idiosyncratic language

(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3) restricted, repetitive, and stereotyped patterns of behavior, interests, and activities as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

(b) apparently inflexible adherence to specific, nonfunctional routines or rituals

(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole-body movements)

(d) persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's disorder or childhood disintegrative disorder.

299.80 Pervasive Developmental Disorder, Not Otherwise Specified

This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests, and activities are present, but the criteria are not met for a specific pervasive developmental disorder, schizophrenia, schizotypal personality disorder, or avoidant personality disorder. For example, this category includes "atypical autism" --presentations that do not meet the criteria for autistic disorder because of late age of onset, atypical symptomatology, or subthreshold symptomatology, or all of these.

299.80 Asperger's Disorder

A. Qualitative impairment in social interaction, as manifested by at least two of the following:

(1) marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

(2) failure to develop peer relationships appropriate to developmental level

(3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)

(4) lack of social or emotional reciprocity

B. Restricted, repetitive, and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus

(2) apparently inflexible adherence to specific, nonfunctional routines or rituals

(3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)

(4) persistent preoccupation with parts of objects

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

D. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).

E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.

F. Criteria are not met for another specific pervasive developmental disorder or schizophrenia.

299.80 Rett's Disorder

A. All of the following:

- (1) apparently normal prenatal and perinatal development
- (2) apparently normal psychomotor development through the first 5 months after birth
- (3) normal head circumference at birth

B. Onset of all of the following after the period of normal development:

- (1) deceleration of head growth between ages 5 and 48 months
- (2) loss of previously acquired purposeful hand skills between ages 5 and 30 months with the subsequent development of stereotyped hand movements (i.e., hand-wringing or hand washing)
- (3) loss of social engagement early in the course (although often social interaction develops later)
- (4) appearance of poorly coordinated gait or trunk movements
- (5) severely impaired expressive and receptive language development with severe psychomotor retardation

299.10 Childhood Disintegrative Disorder

A. Apparently normal development for at least the first 2 years after birth as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior.

B. Clinically significant loss of previously acquired skills (before age 10 years) in at least two of the following areas:

- (1) expressive or receptive language
- (2) social skills or adaptive behavior
- (3) bowel or bladder control
- (4) play
- (5) motor skills

C. Abnormalities of functioning in at least two of the following areas:

(1) qualitative impairment in social interaction (e.g., impairment in nonverbal behaviors, failure to develop peer relationships, lack of social or emotional reciprocity)

(2) qualitative impairments in communication (e.g., delay or lack of spoken language, inability to initiate or sustain a conversation, stereotyped and repetitive use of language, lack of varied make-believe play)

(3) restricted, repetitive, and stereotyped patterns of behavior, interests, and activities, including motor stereotypies and mannerisms

D. The disturbance is not better accounted for by another specific pervasive developmental disorder or by schizophrenia.

LIST OF ABBREVIATIONS

1M – 1 milligram potency

ABA – Applied Behavior Analysis

ADD – attention deficit disorder

ADHD – attention deficit hyperactivity disorder

ASD – autistic spectrum disorder

DAN – Defeat Autism Now!

DPT – diphtheria, pertussis, and tetanus vaccine

DSM-IV – Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition

GFCF – gluten free, casein free

MMR – measles, mumps, and rubella vaccine

PDD – pervasive developmental disorder

Ppb – parts per billion

RDI – Relationship Development Intervention