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Introduction

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This month's issue of the Residents' Journal focuses on early intervention in the treatment of psychiatric disorders. An interview with Robert Zipursky, M.D., a leader in the field of early intervention, discusses issues surrounding early intervention in psychiatry to help broaden residents' understanding and knowledge of this area. Jodi Marshall, M.D., details early intervention specific to psychosis and reviews the evidence base. Another article explores early intervention in autism spectrum disorders and underscores the importance of early diagnosis in children with these disorders. The area of early intervention in psychiatry is one that can help improve the quality of life for many of our patients and their families.

Back to School

Sarah B. Johnson, M.D.
Editor-in-Chief

I would like to take this opportunity to welcome everyone to the new academic year, with an update of exciting changes to the Residents' Journal. With the support of the editorial staff, Issue Editors, and contributing authors, our Journal is becoming more popular and receiving more attention in resident circles. At this year's APA annual meeting in San Francisco, we held a very productive focus group to set goals for the upcoming year. Some of the changes that you can expect to see are as follows:

The Residents' Journal will be nicknamed the Blue Journal;

The e-mail portion of each issue will be dramatically reduced for easier reading, with links to the current issue of AJP; and Residents are encouraged to submit their manuscripts online via Manuscript

Central to enhance their learning experience of online journal submission (<http://mc.manuscriptcentral.com/appi-ajp>).

Additionally, we will be soliciting manuscripts in a more formalized manner in order to increase the quality of our publication. We also hope to solicit contributions from a wide resident population through networking with resident groups and e-mail listservs.

The types of manuscripts that we are soliciting from residents for future editions are as follows:

Opinion and narrative articles (approx. 500 words).

Case presentations (approx. 750 words).

Brief research or review articles (approx. 1,000 words, with no more than 10 references).

We also hope to incorporate a teaching series modeled after the Treatment in Psychiatry feature in AJP, composed of a prompt related to a treatment issue or controversy, followed by a brief case vignette and discussion.

The Residents' Journal has been a huge success, and I hope that this year will be even better. We are off to a great start, and I encourage you to take part through contribution or spreading the word about our publication. Encourage fellow residents to sign up to receive the Blue Journal. Consider attending our focus group sessions at the annual meeting and other organizational meetings throughout the year. Without residents, the Residents' Journal would not be possible, and we appreciate your continued contribution and support!



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	Friday, October 9	9:30 a.m. - 12:00 p.m. 1:30 p.m. - 5:45 p.m.
	Saturday, October 10	9:30 a.m. - 12:00 p.m.

Interview with Dr. Robert Zipursky

Jennifer McLaren, M.D.
Dartmouth Hitchcock Medical Center

The following is an interview with Robert Zipursky, M.D., on “Early Interventions in Psychiatry,” conducted by Jennifer McLaren, M.D. Dr. Zipursky is Professor and Chair of the Department of Psychiatry and Behavioral Neurosciences at the Michael G. DeGroot School of Medicine, McMaster University. He is also Chief of Psychiatry at St. Joseph’s Healthcare Hamilton and Hamilton Health Sciences Hospitals in Hamilton, Ontario, Canada. His academic career has been focused on the study and treatment of schizophrenia, and he has a particular interest in early intervention. Dr. McLaren is a second-year resident in Child and Adolescent Psychiatry at Dartmouth Hitchcock Medical Center and the Editor for this issue.

Dr. McLaren: What is early intervention?

Dr. Zipursky: There has been a fair bit of confusion about what the term “early intervention” means, as it is used to refer to two different types of initiatives. Most frequently, it refers to interventions that are applied as soon as possible after a person first becomes ill. More recently, there has been another area of research and treatment that is also described as “early intervention.” This field involves developing interventions for those who are high risk of becoming ill before they have the onset of frank illness. Early intervention can refer to either approach. However, it is very important to be clear which of these areas of work we are discussing when we look at the risks and benefits of early intervention. Most of my comments relate to the field of early intervention that aims to identify patients as soon as possible after the onset of frank illness.

Dr. McLaren: Why is early intervention important?

Dr. Zipursky: In the past, most mental health services in North America have been devoted to people who have been chronically disabled with illnesses like schizophrenia. As a result, it has often been very difficult to get access to specialized care for individuals presenting for the first time with a mental illness. Most mental health systems are not designed to meet the needs of people when they first become ill; they are designed to meet the needs for people when they become very disabled. While it is very important to have excellent services for those who have become very disabled by a mental illness, it is also critical to ensure that the

first treatment that is provided at the beginning of a potentially chronic mental illness is also the best treatment.

While it has not yet been definitively established that earlier intervention leads to better outcomes, we need to keep in mind that our responsibility as physicians is not only to aim to achieve the best outcomes but to eliminate as much suffering for patients and families in the process. We should be striving for care that is both patient- and family-centered. If, for example, it turned out that treating people with schizophrenia early after the onset of illness does not lead to better outcomes, there are still compelling reasons to get patients engaged in treatment as soon as possible. Patients and their families may often go through horrific suffering in the months and years that the illness goes untreated. If you can get patients engaged, educated, and into treatment in the first few months after the onset of their illness, then the suffering experienced by patients and families may be relieved much sooner. We should not only be looking at outcome measures such as cost to the system or the ability to work and live independently. If you can get patients connected quickly with excellent services and get the symptoms under control in a few weeks to months as opposed to years, then you are doing a real service for people with mental illness and their families.

Dr. McLaren: In what disorders is early intervention most indicated?

Dr. Zipursky: In medicine, more broadly, you only want to apply early interventions for illnesses that are treatable—that is where your interventions will reduce

symptoms or improve outcomes. Most of the illnesses that psychiatrists treat would fall into that group.

I do think one of the reasons that mental health services have been focused on those with severe disability is related to the fact that we did not really have treatments that were effective for mental illnesses until the 1950s. The organization of our services and our models of care are often a better reflection of the history of our field than of our current reality. I think if we look at psychiatry today there are many illnesses for which early interventions are potentially important: schizophrenia, mood and anxiety disorders, eating disorders, and borderline personality disorder.

Dr. McLaren: What about the high-risk group for the onset of frank illness? Would you advocate for early intervention in that group?

Dr. Zipursky: My own view is that it is extremely important for researchers in the field to be pursuing the question of whether early intervention for those “at risk” is effective, but it is premature to suggest that such preventive treatment is indicated. The evidence is not yet in on the value of intervening at this stage of illness.

There are relatively few clinical programs in the United States that provide early intervention for people with psychosis, let alone the many other debilitating mental illnesses that afflict young people. I do not think that treating people at high risk for illnesses such as psychosis should be a public health priority at this time when you have huge numbers of people suffering from a broad range of mental

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disorders, including psychosis, who cannot get the care they need.

When you are treating people who are at high risk for illnesses like schizophrenia, the majority of the people identified will probably never develop the disease. The actual percentage will vary as a function of the criteria one uses to identify those at risk and the population to which these criteria are applied. The issues around the risk and benefits get much more complex when you are treating people who may never get the disorder. We have to make sure there are excellent services for young people and their families when illness is first diagnosable. Once a system has been put in place for those who are already ill, then it would be more reasonable to make intervening at even earlier stages a priority, assuming that the evidence supports early intervention for the illness in question. Supporting research to establish evidence to support early intervention should be a priority.

Dr. McLaren: With early interventions, is there a danger of overtreatment?

Dr. Zipursky: If we are using my first definition of early intervention—if we treat people who meet diagnostic criteria for an illness such as schizophrenia—I do not see a risk of overtreatment. If we start treating people who are at risk of developing mental illness, that is a very different story, as the majority of people at risk will probably never develop these disorders. For example, there are considerable risks of initiating treatment for individuals at high risk for developing schizophrenia. These include serious neurologic and metabolic side effects of typical and atypical antipsychotics. This is not to say that some people would not benefit greatly from treatment at this stage of illness. Rather, much more evidence is needed

to determine under what conditions the benefits outweigh the risks involved.

The other caveat I would add is that the treatment of young people who have a first episode of mental illness needs to be very different than the type of treatment that we provide to people who have an established chronic mental illness. Young people early in the course of illness have very different needs that call for different models of care. You could do a great deal of damage if you brought an 18-year-old with a first episode of schizophrenia into an ACT [assertive community treatment] team or a specialized program for people with chronic schizophrenia. If one assumes the type of treatment you are going to apply is tailored and specialized for young patients, I do not see overtreatment as one of the risks.

Dr. McLaren: What would the optimal early intervention team look like?

Dr. Zipursky: Generally speaking, these are multidisciplinary teams. There are a number of different models that are published, but certainly the teams would typically have psychiatrists, psychiatric nurses, social workers, occupational therapists, psychologists, and integrated substance abuse treatment expertise. These teams need to focus on ensuring rapid access, comprehensive assessment, intensive education and support for patients and families, and expert psychopharmacology. Many individuals will also benefit from cognitive behavioral therapy and family interventions. Young patients presenting with psychosis are very likely to return to work and school, so a team needs an appropriate supportive employment program. Of course, housing, income support, and medication benefits are also important. It is important that the focus of care be both on getting patients well and putting the strategies in place to help them stay well. After pa-

tients complete their treatment with an early intervention team, which is typically 1–5 years, they should be transitioned to a team that can provide the kind of maintenance treatment that they require. This will vary from case to case as a function of their degree of recovery and the complexity of their ongoing needs.

Dr. McLaren: What are the benefits of early intervention?

Dr. Zipursky: I do not think that our field has a very good appreciation of what the outcomes are for most of the mental illnesses that we treat. We often assume that outcomes are determined by the natural history of the illness. However, in an era where we have effective interventions for most mental illnesses, I think outcomes are more likely to be a function of the interventions provided, the level of adherence to these interventions, the model of care, and the extent to which other broader determinants of health are addressed. The development of tailored, specialized treatment programs for young people with a range of mental illnesses will allow us to define the outcomes. As we have better, more evidenced-based treatments, I think that we should assume that the outcomes we are aiming for are moving targets. They are probably much better now than we imagine them to be, but they may be even better in the future.

Dr. McLaren: Do you have any advice for residents and fellows in training?

Dr. Zipursky: I do think early intervention is a major trend that will take hold internationally, not only with schizophrenia but with all major psychiatric disorders. Those residents and fellows interested in this area should train in a program where these early intervention programs are established so they can see how effective teams work and how research aimed at improving and describing outcomes is integrated into their approach.



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Early Intervention in Psychosis

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Schizophrenia is a chronic disorder with a progressive, often deteriorating course. The illness usually presents in adolescence or early adulthood, and, over time, impairments in cognitive, social, and occupational functioning develop. It has been proposed that early intervention may alter the course of schizophrenia and improve outcomes in individuals with the disorder.

Much of the rationale for early intervention comes from the changing view of schizophrenia, supported by increased research in this area. It was once thought that a decline in functioning over time was inevitable. However, with current therapies, newer research suggests that outcomes for patients with schizophrenia are often heterogeneous, and many people can go on to live functional and productive lives. One factor that has been associated with worse outcomes is the duration of untreated psychosis. Numerous investigators have demonstrated that individuals with a shorter duration of untreated psychosis have better outcomes, making the duration of untreated psychosis a target for early intervention programs (1–3). Evidence suggests that psychosis may be neurotoxic by contributing to a decrease in gray matter volume, and thus limiting this exposure by early intervention may prevent these neuro-anatomical changes from occurring (4). Moreover, newer antipsychotics with improved side effect profiles are available and may be better tolerated by at-risk individuals earlier in the disease process than in the past.

Two types of early intervention programs for psychosis have been widely used. The more aggressive programs aim for early intervention during the prodromal phase of the illness and identify individuals at high risk for developing psychosis, engaging them in treatment with the goal of delaying or preventing the onset of psychosis. Slightly less aggressive early intervention programs focus on intervention after the onset of psychosis. These

programs attempt to move patients into treatment quickly, subsequently reducing the duration of untreated psychosis.

The success of early intervention programs focused on intervention during the prodromal period depends on the ability to identify youth who are at risk for schizophrenia. Often, these programs utilize psychoeducation to identify at-risk youth in the community, which requires a coordinated effort among caregivers, schools, physicians, and families to recognize prodromal symptoms. Once identified, these individuals can enter early intervention programs with the goal of delaying or preventing the onset of psychotic symptoms. However, due to the nonspecific nature of prodromal symptoms, it may be difficult to detect these individuals. The Scale of Prodromal Symptoms and the Structured Interview for Prodromal Symptoms have been used by clinicians to identify at-risk patients. Together, the Scale of Prodromal Symptoms and the Structured Interview for Prodromal Symptoms can identify more than 50% of those individuals who will go on to develop psychosis in the subsequent year (5).

Once at-risk individuals are identified and enrolled in early intervention programs, several different interpositions can be employed to prevent or delay the onset of psychosis. The most frequently studied interventions are medications and psychotherapy. In one study (6), patients in prodromal states were treated with risperidone plus cognitive-behavioral therapy (CBT) for 12 months, and the conversion rate to psychosis was significantly less among these individuals (12.5%) relative to individuals in a comparison group (36%) who received needs-based intervention. However, at the 6-month follow-up, the difference was no longer significant. In another study (7), high-risk individuals were treated with low-dose olanzapine for 12 months, and there was a nonsignificant decrease in the rate of transition to psychosis among these individuals relative to

individuals in a placebo group (16.1% vs. 37.9%). However, this difference was lost when treatment was discontinued. These studies suggest that pharmacologic intervention can successfully delay the onset of psychosis but not prevent it. Other strategies, such as psychotherapy, have been used to attempt to delay or prevent the onset of psychosis in prodromal patients. Morrison and colleagues (8) showed that at-risk individuals who received CBT for 6 months were less likely to transition to psychosis than at-risk individuals who received standard care. This effect was sustained at the 3-year follow-up (9).

The second type of early intervention program focuses on individuals for whom psychotic symptoms have already developed and aims to move these patients into treatment as soon as possible to decrease the duration of untreated psychosis. The mean duration of untreated psychosis for first-episode patients in many studies is 1 to 2 years, and this is often preceded by 1 to 2 years of prodromal symptoms. A prolonged duration of untreated psychosis is associated with poor clinical and functional outcomes, even when confounders, such as poor premorbid functioning, are considered (1, 3). Consequently, programs focused on providing both early detection and specialized treatment for early psychosis have been developed. Implementation of an Early Psychosis Prevention and Intervention Centre in Australia successfully decreased the duration of untreated psychosis in a group of patients by up to 21.5 weeks relative to a historical comparison group treated with a standard approach (10, 11). In the 1-year follow-up period, the Early Psychosis Prevention and Intervention Centre sample had significantly fewer hospital admissions, better quality of life, and fewer negative symptoms. In the early Treatment and Intervention of Psychosis study in Norway (12), an educational campaign to detect individuals with psychotic symptoms and

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enter them into treatment led to a non-significant decrease in the duration of untreated psychosis from 16 to 5 weeks relative to a historical comparison sample. In the 1-year follow-up, individuals with a shorter duration of untreated psychosis had fewer negative symptoms. These studies suggest that early intervention programs focused on early detection and treatment of patients in their first episode of psychosis may decrease the duration of untreated psychosis and subsequently improve outcomes.

Early intervention programs have not only been shown to decrease the rate of conversion to psychosis and the duration of untreated psychosis, but to improve other clinical outcomes as well. First-episode patients in early intervention programs are less likely to suffer a relapse and be re-hospitalized than their counterparts receiving standard care (13, 14). Preventing relapse in these patients is critically important, given that active psychosis is thought to be neurotoxic. Patients involved in early intervention programs also have a decreased rate of suicide (15, 16). Lastly, some of these programs have been shown to be cost effective, and this cost savings is related to decreased inpatient stays (17–20).

The present evidence base, although small, suggests that early intervention programs can be effective in delaying transition to psychosis, decreasing the duration of untreated psychosis, preventing relapses, decreasing suicide rates, and decreasing treatment costs. Early intervention in psychosis is a strategy that more mental health centers as well as national health services may begin to employ in order to improve the health of their communities. Hopefully, there will be additional research to further support the use of these programs and promote funding for community mental health centers to implement these strategies.

Dr. Marshall was awarded a grant from the American Psychiatric Institute for Research and Education and Janssen Pharmaceuticals in 2008, which provided funding for travel to the 2008 and 2009 APA Annual Meetings.

References

1. Marshall M, Lewis S, Lockwood A, Drake R, Jones P, Croudace T: Association between duration of untreated psychosis and outcome in cohorts of first-episode patients. *Am J Psychiatry* 2005; 62:975–983
2. Perkins DO, Gu H, Boteva K, Lieberman JA: Relationship between duration of untreated psychosis and outcome in first-episode schizophrenia: a critical review and meta-analysis. *Am J Psychiatry* 2005; 162:1785–1804
3. Singh SP: Outcome measures in early psychosis; relevance of duration of untreated psychosis. *Br J Psychiatry Suppl* 2007; 50:s58–s63
4. Zipursky RB, Lambe EK, Kapur S, Mikulis DJ: Cerebral gray matter volume deficits in first episode psychosis. *Arch Gen Psychiatry*. 1998; 55:540–546
5. Miller TJ, McGlashan TH, Rosen JL, Cadenhead K, Cannon T, Ventura J, McFarlane W, Perkins DO, Pearson GD, Woods SW: Prodromal assessment with the structured interview for prodromal syndromes and the scale of prodromal symptoms: predictive validity, interrater reliability, and training to reliability. *Schizophr Bull* 2003; 29:703–715
6. McGorry PD, Yung AR, Phillips LJ, Yuen HP, Francey S, Cosgrave EM, Germano D, Bravin J, McDonald T, Blair A, Adlard S, Jackson H: Randomized controlled trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. *Arch Gen Psychiatry* 2002; 59:921–928
7. McGlashan TH, Zipursky RB, Perkins D, Addington J, Miller T, Woods SW, Hawkins KA, Hoffman RE, Preda A, Epstein I, Addington D, Lindborg S, Trzaskoma Q, Tohen M, Breier A: Randomized, double-blind trial of olanzapine versus placebo in patients prodromally symptomatic for psychosis. *Am J Psychiatry* 2006; 163:790–799
8. Morrison AP, French P, Walford L, Lewis SW, Kilcommons A, Green J, Parker S, Bentall RP: Cognitive therapy for the prevention of psychosis in people at ultra-high risk: randomised controlled trial. *Br J Psychiatry* 2004; 185:291–297
9. Morrison AP, French P, Parker S, Roberts M, Stevens H, Bentall RP, Lewis SW: Three-year follow-up of a randomized controlled trial of cognitive therapy for the prevention of psychosis in people at ultra-high risk. *Schizophr Bull* 2007; 33:682–687
10. Carbone S, Harrigan S, McGorry PD, Curry C, Elkins K: Duration of untreated psychosis and 12-month outcome in first-episode psychosis: the impact of treatment approach. *Acta Psychiatr Scand* 1999; 100:96–104
11. McGorry PD, Edwards J, Mihalopoulos C, Harrigan SM, Jackson HJ: EPPIC: an evolving system of early detection and optimal management. *Schizophr Bull* 1996; 22:305–326
12. Larsen TK, Melle I, Auestad B, Friis S, Haahr U, Johannessen JO, Opjordsmoen S, Rund BR, Simonsen E, Vaglum P, McGlashan T: Early detection of first-episode psychosis: the effect on 1-year outcome. *Schizophr Bull*. 2006; 32:758–764
13. Agius M, Shah S, Ramkissoon R, Murphy S, Zaman R: Three year outcomes of an early intervention for psychosis service as compared with treatment as usual for first psychotic episodes in a standard community mental health team: final results. *Psychiatr Danub* 2007; 19:130–138
14. Goldberg K, Norman R, Hoch JS, Schmitz N, Windell D, Brown N, Malla A: Impact of a specialized early intervention service for psychotic disorders on patient characteristics, service use, and hospital costs in a defined catchment area. *Can J Psychiatry* 2006; 51:895–903
15. Addington J, Williams J, Young J, Addington D: Suicidal behaviour in early psychosis. *Acta Psychiatr Scand* 2004; 109:116–120
16. Melle I, Johannessen JO, Friis S, Haahr U, Joa I, Larsen TK, Opjordsmoen S, Rund BR, Simonsen E, Vaglum P, McGlashan T: Early detection of the first episode of schizophrenia and suicidal behavior. *Am J Psychiatry* 2006; 163:800–804
17. Cullberg J, Levander S, Holmqvist R, Mattsson M, Wieselgren IM: One-year outcome in first episode psychosis patients in the Swedish Parachute project. *Acta Psychiatr Scand* 2002; 106:276–285
18. Cullberg J, Mattsson M, Levander S, Holmqvist R, Tomsmark L, Elingfors C, Wieselgren IM: Treatment costs and clinical outcome for first episode schizophrenia patients: a 3-year follow-up of the Swedish “Parachute Project” and two comparison groups. *Acta Psychiatr Scand* 2006; 114:274–281
19. McGorry PD, Killackey E, Yung AR: Early intervention in psychotic disorders: detection and treatment of the first episode and the critical early stages. *Med J Aust* 2007; 187(suppl 7):S8–S10
20. Mihalopoulos C, McGorry PD, Carter RC: Is phase-specific, community-oriented treatment of early psychosis an economically viable method of improving outcome? *Acta Psychiatr Scand* 1999; 100:47–55

Autism Spectrum Disorders: Importance of Early Diagnosis and Interventions

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Autism spectrum disorders are multidimensional neurodevelopmental disorders that affect social skills, communication, and behavior, with signs and symptoms occurring before age 3 (1). The Centers for Disease Control and Prevention (CDC) estimates that approximately one out of every 150 children suffers from an autism spectrum disorder (autism, Asperger's syndrome, and pervasive developmental disorder not otherwise specified); making autism spectrum disorders a widespread public health problem (2).

Children with an autism spectrum disorder exhibit phenotypic differences as early as 1 year of age (3). Osterling and Dawson (3) examined home videotapes of first birthday parties of children who were later diagnosed with autism spectrum disorders and found that these children differed—in several ways—from typically developing children as well as from children later diagnosed with mental retardation. One-year-old children who were later diagnosed with an autism spectrum disorder were less likely to look at others and orient to their names relative to their typically developing peers and children later diagnosed with mental retardation. There are multiple other studies documenting the ability to screen for signs and symptoms of autism in the first 1 to 2 years of life, including another study analyzing home videotapes, retrospective reports from parents, case studies, and a systematic analysis (4–7). Despite the evidence that children with autism demonstrate signs and symptoms in their early months and years of life, most are not diagnosed until after age 4. The obstacles to early diagnosis are not completely clear. Certainly, some issues are related to the failure of clinicians to recognize the early signs and symptoms of autism spectrum disorders. Another barrier is children presenting to care late. However, Lord and Luyster (8) noted that there has been a large expansion of

our understanding of autism spectrum disorders over the past decade, and these studies show that appropriately trained clinicians may be able to diagnose children with autism spectrum disorders before age 2.

Many clinicians have advocated for early diagnosis and intervention for children with autism spectrum disorders, and it is widely recognized that early treatment increases the likelihood of improved outcomes (9–14). Early recognition allows for an earlier understanding of a child's behavior by his or her parents, teachers and school counselors, daycare providers, and clinicians. Early intervention also allows for a child to receive an individualized, interdisciplinary core plan of treatment during early childhood, which is a critical period for neurodevelopment. The goal of early intervention is to minimize the effects of autism spectrum disorders at the earliest period possible in order to limit sequelae throughout the child's life. Early intervention is typically an intensive, comprehensive, individualized treatment over several hours per week (usually 20), focusing on all areas of development, particularly a child's weakness.

Early intervention has been shown to improve language skills in children with autism spectrum disorders (11, 12). Language development is a strong predictor of positive adult outcomes for these children, and thus any improvement in language skills is crucial. In addition, it has been found that early intervention may reduce behavioral disturbances and improve gross and fine motor skills, responsiveness of the child to his or her parents, and IQ scores (11–14). Furthermore, it allows families time to cope with the diagnosis, decreasing family stress (10), and enables parents and caretakers to establish an individual, informed, and compassionate relationship with the child. An earlier diagnosis gives families

the opportunity to better understand autism spectrum disorders and to access support systems and resources in their community,

Children with autism spectrum disorders are seen by psychiatrists not only for initial diagnosis, but also for management of disruptive behaviors and other comorbid psychiatric conditions, since these children have a high prevalence rate of psychiatric comorbidities. Psychiatrists as well as psychiatry residents can play an integral role on behalf of children with autism spectrum disorders by serving as educators, informing families, advocates, psychopharmacologists, and therapists. Our field should not only serve these children and their families, but other healthcare professionals, such as pediatricians and family physicians. Moreover, children with autism spectrum disorders will not only be seen by child and adolescent psychiatrists, but they will most likely need services from adult psychiatrists as they mature. Thus, it is important for all psychiatrists to understand and be well versed in the needs of this population, improving the quality of life for patients and families.

Dr. McLaren received a travel grant from APA and Shire Pharmaceuticals, which provided funding to attend the 2007 and 2008 APA Annual Meetings.

References

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed. Washington, DC, American Psychiatric Publishing, 2000
2. Centers for Disease Control and Prevention: CDC Releases New Data on Autism Spectrum Disorders (ASDs) From Multiple Communities in the United States Atlanta, Department of Health and Human Services, 2007. http://www.cdc.gov/media/pressrel/2007/r070208.htm?s_cid=mediarel_r070208_x

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3. Osterling J, Dawson G: Early recognition of children with autism: a study of first birthday home video tapes. *J Autism Dev Disord* 1994; 24:247-257
4. Baraneck GT: Autism during infancy: a retrospective video analysis of sensory-motor and social behaviors at 9-12 months of age. *J Autism Dev Disord* 1999; 29:213-224
5. Gillberg C, Ehlers S, Schaumann H, Jakobsson G, Dahlgren SO, Lindblom R, Bågenholm A, Tjuus T, Blidner E: Autism under age 3 years: a clinical study of 28 cases referred for autistic symptoms in infancy. *J Child Psychol Psychiatry* 1990; 31:931-934
6. Baron-Cohen S, Allen J, Gillberg C: Can autism be detected at 18 months? The needle, the haystack and the CHAT. *Br J Psychiatry* 1992; 161: 839-943
7. Dawson G, Osterling J, Meltzoff AN: Case study of the development of an infant with autism from birth to 2 years of age. *J Appl Develop Psychol* 2000; 21:299-313
8. Lord C, Luyster R: Early Diagnosis and Screening of Autism Spectrum Disorders: Early Diagnosis of ASD. Medscape Psychiatry and Mental Health website. <http://www.medscape.com/viewarticle/518834>
9. Dawson G, Osterling J: Early intervention in autism, in *The Effectiveness of Early Intervention*. Edited by Guralnick MJ. Baltimore, Paul H. Brookes Publishing, 1997
10. Charman T, Baron-Cohen S: *Screening for Autism Spectrum Disorders in Populations: Progress, Challenges, and Questions for Future Research and Practice*. New York, Guilford Press, 2006
11. Mays RM, Gillon JE: Autism in young children: an update. *J Pediatr Health Care* 1993; 7:17-23
12. Rogers SJ, Herbison J, Lewis H, Pantone J, Reis K: An approach for enhancing the symbolic, communicative, and interpersonal functioning of young children with autism and severe emotional handicaps. *J Div Early Childhood* 1986; 10:135-148
13. Ozonoff S, Cathcart K: Effectiveness of a home program intervention for young children with autism. *J Autism Dev Disord* 1998; 28:25-32
14. McEachin JJ, Smith T, Lovaas IO: Long-term outcome for children with autism who received early intensive behavioral treatment. *Am J Ment Retard* 1993; 97:359-372

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