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Preschool and school-age autism

INVITERT KOMMENTAR

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The author has completed the ICMJE form and declares the following conflicts of interest: She is the project manager of the clinical ENACT study on autism in children. One of the authors of the articles discussed (A.L. Høyland) is clinical lead for one of the centres included in this study.

Children who are of school-age when they receive an autism diagnosis differ in many ways from children who are of preschool age when they receive the diagnosis.

The current edition of the Journal of the Norwegian Medical Association publishes a study by Røe et al. on 10 to 16-year-olds with an autism diagnosis (1). The review of medical records showed no overrepresentation of mothers with a non-Norwegian background, unlike the findings of an earlier study of preschool children in the same area and period (2).

In the study of preschool children, 42 % were diagnosed with childhood autism and only 4 % with Asperger syndrome. Most of the preschool children were diagnosed by the Habilitation Unit, while more than half of the children in the study of school-age children were diagnosed by the Child and Adolescent Mental Health Services (BUP). In that study, no children were diagnosed with childhood autism, and the dominant diagnoses were Asperger syndrome and unspecified pervasive developmental disorder. Less than 2 % had a comorbid intellectual disability, but there was a high prevalence of psychiatric comorbidity, with ADHD being the most common diagnosis.

As we transition to DSM-5 and ICD-11 classification, we leave behind the subgroups of childhood autism, Asperger syndrome and pervasive developmental disorder in favour of the more generic term of autism spectrum

disorders (3, 4). This is because current thinking suggests there are no fundamental differences between the subgroups. However, ICD-11 requires the clinician to actively identify whether there are also comorbid language disorders and/or intellectual disabilities (4). A delay in language development is often the reason why a child receives a specialist referral at an early age. This is why language difficulties and intellectual disabilities accompany autism spectrum disorders more frequently in younger children. Children without these challenges receive their specialist referral only once their social challenges become more evident. At that point, they have tended to be diagnosed with Asperger syndrome because their difficulties were less prominent at a younger age. The findings of the two studies from Trøndelag illustrate these age-related differences.

But why is there a difference between the preschool children and the school-age children when it comes to the proportion of mothers of a non-Norwegian national background? As I have already pointed out, the two groups have different characteristics in that there is a higher proportion with learning disabilities among the preschool children with an autism diagnosis while there are more cases of psychiatric comorbidity among the school-age children. The authors discuss whether risk factors may be impacted by age and severity, because children of mothers with a different national background also had a higher prevalence of autism symptoms in the preschool study. They also point out that there may be a type 2 error at play, because there was also a slightly higher prevalence of mothers with a different national background among the school age children, although this was not significant. If the number of participants had been larger, the slight association may have been significant, but it would nevertheless be considerably less pronounced than the difference identified among the preschool children.

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Demographic changes may be a contributing cause, as well as changes in the clinical understanding and awareness surrounding the autism diagnosis. Although the two studies from southern Trøndelag reviewed patients' medical journals from the same period (2016–2019), the children in the preschool study were born in 2010–2017, while the school-age children were born in the period 2000–2009. Consequently, they represent, in principle, two entirely different cohorts. Developments in diagnostic practice, autism knowledge in primary services and immigration are all factors that have changed considerably over a short period of time. The number of immigrants and the number of children born in Norway to immigrant parents have almost doubled between 2000 and 2010 (5). The number of preschool children who receive an autism diagnosis has also multiplied in the period 2012–2022 (6).

In their article, Eig et al. discuss whether the later diagnosis at school age is part of the reason why there is such a high prevalence of accompanying mental disorders. It has been observed that an early autism diagnosis appears to reduce the risk of psychiatric comorbidity later in life (7). It may be that early adaptations and other interventions have a preventive effect. With this in mind, and considering the great change in the prevalence of autism in Norway, it would be interesting to review more recent data. The preschool children in the first study are now 10–16 years old, and differences between the two studied cohorts may have evened out, partly or completely. It would be interesting to investigate whether we can find that early diagnosis of autism spectrum disorders may have a preventive effect in relation to other psychiatric disorders. Such knowledge would also inform how we plan for the provision of health services to meet future demand.

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