

Child with intellectual disability misdiagnosed as autism: A case study

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Abstract

Misdiagnosis has become a public health crisis and it is unavoidable in all health care systems. This case study is about a nine year old boy, referred by the special school teacher presenting with the complaints of Autism and slow learning. Contrary to his complaints, the developmental assessment showed that the child had no symptoms of Autism, whereas moderate symptoms of Intellectual Disability were made known. The brief therapeutic plan focused on enhancing his functional level of adaptive behaviour. This case report holds its implication to drift attention of stakeholders working in different health care systems towards the issue of misdiagnosis.

Keywords: Misdiagnosis, Autism, Intellectual Disability.

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Introduction

Diagnosis is the most crucial phase in the field of medicine and psychiatry, and this process seems to have been largely overlooked even in the modern era, where efforts have been made to improve healthcare quality.¹

Misdiagnosis may delay the initiation of adequate therapeutic treatment and increase the risk of a severe outcome. A lot of harm can be done to a person who is taking therapy about a mental disorder from which he is not suffering. The cases of negligence are also rising.²

An enlargement of the heart or a high blood pressure is not overlooked but signs and side effects of mental issues are frequently dismissed due to their non-location, improper medicines and misdiagnosis.³ Thus, increasingly genuine mental cases are disregarded or managed by utilising measures that overly represent the symptoms.⁴

The prevalence of autism spectrum disorder in Pakistan is not known. However, 345 of 600 people in Pakistan are estimated to be diagnosed with autism spectrum. Issues (consequences) of misdiagnosis, incomplete information, and negative social repercussions result in gross underestimation of the actual number.⁵ Various health

professionals, including general psychiatrists, child psychiatrists, neurologists, paediatricians, psychologists, and speech and language therapists, make the diagnosis of autism in Pakistan. Alongside these experts, there are solid social convictions in getting treatment from customary healers.⁶ No formal indigenous screening tools are available for the assessment of autism spectrum disorder.³ Few signs of autism seem similar to other developmental conditions. The presence of intellectual Disability (ID) further entangles the indicative picture.⁷ ID refers to the problem of general mental abilities that affects an individual's intellectual and adaptive skill functioning.⁸

As a result, some social or other developmental symptoms can be mistaken for autism. This results in a problem because using autism treatment on an individual who does not have the disorder probably will not help the way it should. Therefore, the purpose of the current study is to highlight the dire need of a correct diagnosis by a relevant and authorised professional.

Case Report

The child of the present case report was a nine year old boy admitted in National special education school of city Lahore during the time period of 5th December, 2019-8th February, 2020. The school administration referred him with features of autism and issues of forgetting. Before pursuing psychotherapeutic process ethical considerations were followed which involved consent by the administration to apply therapeutic intervention and ensuring anonymity of the child. An interview with the teacher showed that the child belonged to a lower socio-economic status. At the time of the admission at school, he was diagnosed with autism spectrum disorder. His file revealed that this diagnosis was made by a medical doctor.

The child was born healthy and had age- appropriate milestones such as social smile, neck holding, crawling, and walking; but his speech was delayed. No family history of any serious physical or psychiatric illness was reported, except that his mother sometimes experienced high blood pressure during pregnancy. At the age of 4 years, the parents noticed that their child is behind in performance and skills as compared to other children. A little information about treatment was available as a prescription of the year 2015 was attached, in which the diagnosis to child's problem was given by a physician and that was autism

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spectrum disorder. (in which the child’s problem was diagnosed by a physician as Autism Spectrum disorder) On his report, complaints mentioned were, aggressive behaviour, stubbornness, hitting behaviour, and self-talking. The same diagnosis had been followed at the school and no psychological test to verify this diagnosis was administered by the school authorities.

His diagnosis, along with his other problems, hindered him to study in a mainstream school, therefore, he got admission in a special school of education. Initial assessment revealed contradiction between the child’s complaints, his behaviours, and the diagnosis given by the physician (Table 1) There, the child was assessed using developmental skill measure (Portage Guide to Early Education) and the results revealed 5-6 years of discrepancy between functional level and chronological age of the child (Table 2). The summary of assessment showed cognitive deficiency and the child was suspected to have the problem of Intellectual Disability (Moderate level).

The outcome was found to be satisfactory as he was able to perform many behavioural tasks on his own, such as he could identify four colours without aid, learn to tie shoe laces, solve 8-12 piece puzzles without any assistance and started using social conventions (sorry, please, thank you) with his fellows with minimal reminders. After a three weeks follow-up the child could repeat the tasks as the teacher kept on working on the same goals. Children with moderate ID levels take time to learn things however individual attention, repetition, and practice of the task support a favourable outcome.⁹ To verify his diagnosis, Autism, the Childhood Autism Rating Scale¹⁰ was administered. The child’s raw score on CARS was 16 which falls in the non-autistic category. No evidence of difficulty in relating to people, in emotional responses and in body use was noticed. His both verbal and non-verbal

Table-1: Child’s Complaints in Favour and Against of Autism Diagnosis.

Factors in favor	Factors in against
Sometimes talks irrelevant to topic.	Speech is developed and reciprocal speech is also present.
	Initiates social interactions.
	No stereotypical behaviour is found.

Table-2: Areas, Functional Level and Discrepancy of Child between Functional and Chronological Age on Portage Guide to Early Education.

Areas of PGEE	Current Functional Age of Child (years)	Discrepancy (years)
Socialization	5-6 years	3-4
Motor	5-6 years	3-4
Self help	4-5 years	4-5
Language	4-5 years	4-5
Cognitive	3-4 years	5-6

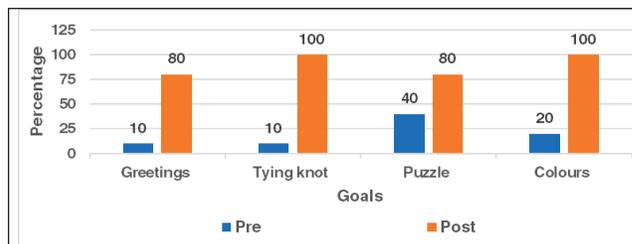


Figure: Pre and Post Assessment of Goals.

communication was age and situation appropriate, therefore, it was concluded that child showed none of the symptom characteristics of autism.

On the basis of above mentioned points it was hypothesised that the child is having moderate level of intellectual disability.

Discussion

In the current case, such neglected factors which caused the child to remain misdiagnosed were discussed. The observation of the child in different settings revealed that he was a social, talkative and inquisitive child. The therapeutic process consisting of 12 sessions was planned in which assessment procedures of a single case design were employed. It also highlighted that the reasons underlying the excessive and deficient behaviour patterns is often unknown.¹¹ It has been found that a diagnosis given by the doctor remained associated with the subject for 7 years. Parents, practitioners and other stakeholders needed to be aware to stand against the faulty belief that “once a diagnosis is always a diagnosis”. The intervention plan of the present case was aimed to enhance socialisation, self-help and cognition which ended with effective results. Therapist (or Therapists) focused on different behaviour modification techniques like reinforcement, prompting, modelling and shaping to achieve the goals in said areas (Figure 1).

Conclusion

It is concluded that childhood behaviours mimicking a particular disorder needed to be normalised rather than pathologized. Malpractice of giving a diagnosis for a problem for which someone is not a specialist should be discouraged. Moreover, there is a need to select multidimensional and multidisciplinary screening techniques to determine developmental diagnosis in children.

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Conflict of Interest: None

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