A possible contra-indication for early diagnosis of Autistic Spectrum Conditions: Impact on parenting stress

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ABSTRACT

The current study investigated the impact of diagnosis of Autistic Spectrum Conditions (ASCs) in children on parenting stress. While there is increasing pressure to provide early diagnosis of ASC, there is a lack of evidence relating to the impact of early diagnosis on the parents. The parents of 85 children with ASC completed measures of their parenting stress, and gave a brief history of their child and their diagnosis. The children were assessed for autistic severity and behavioral functioning. Autistic severity predicted their parents' first noticing a problem, and the speed of the latter, rather than the child's autistic severity, predicted obtaining an earlier diagnosis. The autistic severity of a child was related directly to parenting stress. However, earlier diagnosis may be detrimental to levels of parenting stress. While parenting stress declined over time from the point at which the parents had first noticed a problem in their child, it failed to change by any significant degree once the diagnosis of ASC had been received. Given this possible contra-indication for early diagnosis of ASC, it warrants caution and further investigation.

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Early diagnosis is a common goal in the management of many conditions, and the associated early treatment leads to enhanced outcomes, and better long-term prognosis. The same is true for the diagnosis of Autistic Spectrum Conditions (ASCs) in children. It is often suggested that intervention for ASC is more effective if offered early, rather than remedially later (Lovaas, 1987), and such suggestions produce pressure for earlier diagnosis of the condition. Certainly, an early diagnosis of ASC can...
facilitate access to services (Gillman, Heyman, & Swain, 2000), and would seem to enhance the treatment prognosis for the child.

However, while there may well be benefits of an early diagnosis for the child with ASC, it is known that the diagnosis of mental problems can have dichotomous and paradoxical effects. For example, people diagnosed with schizophrenia can have poorer probability of remission than those with no such label (Bentall, 1990). In pediatric cases, such as ASC, the impact of diagnosis is also often seen in the parents. For example, the diagnostic processes concerning ASC can produce extreme levels of stress in the parents (Goin-Kochel, Mackintosh, & Myers, 2006; Osborne & Reed, 2008). It is known that high levels of stress in the parents can have detrimental impacts on the children, in terms of treatment outcomes (e.g., Osborne, McHugh, Saunders, & Reed, 2008a; Robbins, Dunlap, & Plenis, 1991), and behavior problems (e.g., Lecavalier, Leone, & Wiltz, 2006). Given the above, the current report sought to explore whether there were any potentially detrimental aspects of the diagnosis of ASC for the parents of the diagnosed child, and to try to tentatively identify the predictors of any adverse parental reactions.

It appeared important to focus on parenting stress for a number of reasons. In terms of treatment outcomes for children with ASC, Robbins et al. (1991; see also Osborne et al., 2008a) noted a strong relationship between parenting stress and later child progress in young children undergoing intervention programs. It is also well established that there is a strong association between parenting stress and child behavior problems (Baxter, Cummins, & Yioulitis, 2000; Hodapp, Fidler, & Smith, 1998; Lecavalier et al., 2006; Stores, Stores, Fellows, & Buckley, 1998). Recent evidence suggests that high initial levels of parenting stress can lead to subsequent worsening of child behavior problems (Lecavalier et al., 2006). In order to explain such findings, it has been proposed that high levels of parenting stress can have an impact on subsequent parenting behaviors, which, in turn, impact on a child’s behavior problems, and outcomes. For example, Osborne, McHugh, Saunders, & Reed (2008b) noted that, in a longitudinal study over a 9–10-month period of time, parenting stress and certain parenting behaviors, namely, limit setting for the child, closely interacted bi-directionally with one another over time, and poor limit setting impacted negatively on child behavior problems.

Contact with professionals concerning diagnosis of ASC often comes prior to engagement with treatment programs. If the contact has been stressful, this may lead to subsequent treatment being less successful, and behavior problems being more pronounced. The limited research to date concerning ASC diagnosis suggests that this process has a high capacity for producing stress in parents of children with ASC (Goin-Kochel et al., 2006; Howlin & Moore, 1997). Mansell and Morris (2004; see also Midence & O’Neil, 1999) found that parents thought that the diagnostic process was slow, chaotic, and badly handled. Parent satisfaction with the diagnostic process has been noted to increase with the fewer professionals that they need to see in order to obtain a diagnosis for their child (Goin-Kochel et al., 2006). Finally, Osborne and Reed (2008) noted that many parents felt that they were given no help and advice following diagnosis. Thus, issues such as the speed of diagnosis, the chain and coherence of referral through the system, and the help offered to parents at the time of diagnosis, may all be implicated in the development of stress in parents during the diagnostic process.

Thus, a picture emerges in which it is acknowledged that the parent plays a pivotal role in the prospects for the child with ASC, and that those parents suffer from high levels of stress, which have, in turn, a negative impact on the prospective outcomes of the child with ASC. Many of these early stressors appear revolve around communication and contact with professionals over the critical period of time in which a diagnosis of ASC is sought and obtained. However, there has been relatively little research effort devoted to discovering the effect of a child’s ASC diagnosis on the parents, especially the impact of these experiences on their levels of stress as pressure increases to gain earlier diagnosis.

The current research represents a first attempt to establish some relationships between key aspects of the diagnosis, such as its speed, and parenting stress. Given the practical difficulties in establishing these relationships using a prospective study (which would involve identifying parents of children with ADVC prior to the diagnosis), the current study used a retrospective approach. Obviously, such a retrospective approach cannot provide evidence as solid about such relationships as a prospective longitudinal study, but, given the paucity of findings on this topic, it was thought appropriate to use such an approach initially to establish some tentative findings that may form the basis of subsequent work.
1. Method

1.1. Participants

A total of 149 children with ASC (135 male and 14 female) were identified in conjunction with Local Education Authorities in the South East of England. All of the parents of these children were contacted, and they provided parental consent for their, and their child’s, participation in the research. Ethical approval for this study was granted by the University College London Hospital Trust Ethics Committee.

Of these 149 parents who agreed and consented to participate, 85 (83 male and 2 female) parents completed the study (57%). The children who participated were between 3 and 16 years of age (mean = 8.8) at the time of the study, and previously had been independently diagnosed with ASC by specialist pediatricians, following initial referral from an independent general medical practitioner. All diagnoses were made prior to participating in, and the commencement of, this study. In addition to these independent diagnoses of ASC, all of these children had a statement of Special Educational Needs related to their ASC from their Local Education Authorities.

1.2. Measures

1.2.1. Gilliam Autism rating scale

The GARS (Gilliam, 1995) comprises four sub-scales, each describing behaviors that are symptomatic of ASC (Stereotyped Behaviors, Communication, Social Interaction, and Developmental Disturbances). The raw scores from these sub-scales can be converted into standard scores (mean = 10, standard deviation = 3). These sub-scales combine to give an overall Autism Quotient; higher scores meaning greater autistic severity (mean = 100 (average autistic severity), standard deviation = 15). In terms of assessing the probability that an individual has ASC, an Autism Quotient score of between 90 and 110 means an ‘average’ probability of ASC, a score below 89 means that there is a ‘below average’ probability of ASC, and a score below 79 means that there is a ‘low’ probability that the individual has ASC (Gilliam, 1995). The scale is appropriate for persons aged 3–22-years old, and is completed by parents or professionals in about 10 min. Its internal reliability is 0.96, and it has high criterion validity with the Autism Behavior Checklist (0.94).

1.2.2. Vineland adaptive behavior scale

The VABS (Sparrow, Balla, & Cicchetti, 1990) is a semi-structured interview, administered to a parent, or other caregiver, of the child. It can be used from birth to 18:11 years, making it suitable for the present cohort. The VABS assesses children’s day-to-day adaptive functioning. Scores from three domains of adaptive behavior were used in the present study (Communication, Daily Living Skills, and Socialization). The raw scores can be converted to standard scores, and a Composite Overall score can be derived, based on the sum of the sub-scale standard scores (mean = 100; standard deviation = 15). The internal reliability of the Overall Composite score is 0.93.

1.2.3. Questionnaire on resources and stress

The Friedrich short-form of the QRS (Friedrich, Greenberg, & Crnic, 1983) is a 52-item, self-administered, true or false, tool, designed to measure parental perceptions of the impact of a developmentally delayed, or chronically ill, child on other family members. The QRS-F consists of four sub-scales, which assess parental perceptions about: Parent and Family Problems (total possible = 20)—dealing with the impact that the disability has on family activities or relationships; Pessimism (total possible = 12)—related to parent depression; Child Characteristics (total possible = 14)—dealing with the impact of the child’s problems on the family; and Physical Incapacity (total possible = 6)—which examines the family problems produced by the child not being able to perform certain activities for themselves. Higher scores are indicative of greater perceived stress within the family, as perceived and indicated by the parents (but not, it should be noted, of a greater degree or number of actual stressors, see Dyson, Edgar, & Crnic, 1989). The internal reliability of the sub-scales ranges from 0.77 (Physical Incapacity) to 0.85 (Child Characteristics). This tool has previously been employed for samples with ASC in assessing stress in parents (e.g., Hastings & Johnson, 2001).
1.3. Procedure

The children were identified by the Local Education Authorities, were contacted by the researchers, and, on choosing to participate, parental consent was obtained. Autistic severity (GARS), and adaptive behavioral and social functioning (VABS) were measured for all children. In addition, measures of self-reported parenting stress (QRS-F) were collected.

The children were visited by an Educational Psychologist, who was blind to the levels of parenting stress, and the child measures were taken (GARS and VABS). Parents were contacted, at this time, and asked to complete the QRS-F, and to give some background regarding their child. In particular, they were asked about the age of their child when they first noticed a problem, and the age of their child at diagnosis, as well as a brief history of their child’s provision, which they did independently from the researchers.

The questionnaires were sent out by post to the parents, along with an information letter, and a pre-paid, addressed return envelope. The information letter provided contact details, offering parents the opportunity to seek help and guidance, if required, regarding the completion of the questionnaires, however, it was extremely rare that any parents contacted the researchers in order to ask advice about answering specific questions. On completion, the parents used this pre-paid envelope to return the questionnaires to the researchers. As an added incentive for returning this information, the parents were automatically entered into a prize draw, the winner of which received £50 for toys or books for their child. This incentive was specified in the information letter. If parents had not returned the questionnaires after a period of time, they were contacted by a researcher, via telephone, and reminded, and given the opportunity to return the completed questionnaires.

2. Results

Table 1 displays the mean (and standard deviation) for the children’s levels of autistic severity (GARS), and adaptive behavioral functioning (VABS), along with the mean age (in months) at which the parents first noticed that their child had problems, and the mean age (in months) that the diagnosis was received. From these data, it can be seen that the autistic severity of the children was slightly milder than average (but within the range that suggests ASC is present), and that their behavioral functioning was very low (in the bottom 1% of the general population). The mean age at which the parents reported first noticing a problem was about 21 months (range birth to 72 months), and the mean age at which a diagnosis was received was about 45 months (range 16–192 months), with an average period between noticing and diagnosis of 24.3 months (±27.7; range 1–144 months).

Table 1 also shows the mean levels of parenting stress, reported by the parents, and the correlations between these parenting stress levels and the child, and diagnosis, characteristics, as noted above. From these correlations, it can be seen that autistic severity had statistically significant correlations with all parenting stress sub-scales, except for the Parent and Family Problems sub-scale. The greater the autistic severity, the greater the parenting stress. However, only the parenting stress relating to Child Characteristics, and the child’s Physical Incapacity, had statistically significant correlations with the age at which the child was diagnosed. The younger the child at diagnosis, the higher the parenting stress levels. No stress sub-scale was related to the age of the child at which their parents first noticed any problems.

Table 1

<table>
<thead>
<tr>
<th>QRS stress</th>
<th>Mean</th>
<th>GARS 89.5 (15.7)</th>
<th>VABS 55.2 (14.0)</th>
<th>Noticing 21.4 (11.1)</th>
<th>Diagnosis 45.6 (31.8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>8.4</td>
<td>0.180</td>
<td>0.027</td>
<td>−0.041</td>
<td>0.011</td>
</tr>
<tr>
<td>Pessimism</td>
<td>7.1</td>
<td>0.230***</td>
<td>0.037</td>
<td>−0.076</td>
<td>0.050</td>
</tr>
<tr>
<td>Child</td>
<td>7.9</td>
<td>0.353***</td>
<td>−0.062</td>
<td>−0.056</td>
<td>−0.227*</td>
</tr>
<tr>
<td>Incapacity</td>
<td>2.0</td>
<td>0.285***</td>
<td>0.033</td>
<td>−0.092</td>
<td>−0.285**</td>
</tr>
</tbody>
</table>

*p < 0.05, **p < 0.01, ***p < 0.001.
Table 2 shows the standardized beta coefficients from a series of multiple regressions. These attempted to identify the independent contributions of the child’s autistic severity, the child’s behavioral functioning, and the age of the child at which the parents first noticed a problem to the diagnostic process, and to the resulting parenting stress. Only the parenting stress relating to Child Characteristics, and the child’s Physical Incapacity, were studied, as these were the only sub-scales that had statistically significant correlations with the other measures in this study. Both the analysis using parenting stress relating to Child Characteristics, and the analysis using parenting stress relating to the child’s Physical Incapacity, showed highly similar results to one another (and a schematic representation of these results is shown in Fig. 1).

The only statistically significant independent predictor of the age of the child at which the parents first noticed a problem was autistic severity; the greater the autistic severity, the younger the child was when a problem was first noticed. The behavioral functioning of the child, and parenting stress, made no statistically significant contributions to the age of the child at which a problem was first noticed.

The only statistically significant independent predictor of age at which the child was diagnosed with ASC was the age of the child at which the parents first noticed any problems. The younger the child when the parents first noticed a problem, the younger the child at diagnosis. The child’s autistic severity, level of behavioral functioning, and the level of parenting stress made no statistically significant contribution to predicting the age of the child at diagnosis.

When parenting stress was the variable to be predicted, both the autistic severity of the child (the greater the autistic severity, the greater the parenting stress), and the child’s age at diagnosis (the younger the child at diagnosis, the greater the parenting stress), made statistically significant independent contributions to the level of parenting stress. The child’s behavioral functioning, and the age of the child when the parents first noticed a problem, did not predict parenting stress.

Table 2
Standardized beta coefficients for the predictions of the children’s ages at the time of parents’ first noticing a problem in their child, at the time of diagnosis, and for parenting stress levels

<table>
<thead>
<tr>
<th>Prediction</th>
<th>Noticing</th>
<th>Diagnosis</th>
<th>Child characteristics stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>GARS</td>
<td>−0.300**</td>
<td>GARS</td>
<td>0.367***</td>
</tr>
<tr>
<td>VABS</td>
<td>−0.025</td>
<td>VABS</td>
<td>0.024</td>
</tr>
<tr>
<td>Child</td>
<td>0.054</td>
<td>Child</td>
<td>0.170</td>
</tr>
<tr>
<td></td>
<td>Noticing</td>
<td>Notice</td>
<td>−0.237**</td>
</tr>
<tr>
<td>GARS</td>
<td>−0.283**</td>
<td>GARS</td>
<td>0.011</td>
</tr>
<tr>
<td>VABS</td>
<td>−0.023</td>
<td>VABS</td>
<td>0.133</td>
</tr>
<tr>
<td>Incapacity</td>
<td>0.008</td>
<td>Incapacity</td>
<td>0.140</td>
</tr>
<tr>
<td></td>
<td>Noticing</td>
<td>Notice</td>
<td>−0.262**</td>
</tr>
<tr>
<td>VABS</td>
<td>0.190</td>
<td>Notice</td>
<td></td>
</tr>
<tr>
<td>Inability</td>
<td>0.808</td>
<td>Incapacity</td>
<td>0.214**</td>
</tr>
<tr>
<td></td>
<td>Notice</td>
<td>Diagnosis</td>
<td></td>
</tr>
<tr>
<td>VABS</td>
<td>0.514***</td>
<td>Diagnosis</td>
<td></td>
</tr>
</tbody>
</table>

*p < 0.05; **p < 0.01; ***p < 0.001.

Fig. 1. Schematic representation of the interaction between autistic severity, parents’ first noticing a problem in their child, receiving a diagnosis, and parenting stress.
Table 3 shows the independent effects of the children’s autistic severity, the passage of time from the parents’ first noticing a problem, and the passage of time from the diagnosis of ASC, on the current levels of parenting stress. As the children’s behavioral functioning showed no statistically significant relationship to any other variable in the preceding analyses, it was not included in this analysis. The mean length of time between parents’ first noticing a problem in their child, and the time at which their parenting stress levels were measured, was 53.6 months (±45.6; range 1–144 months). The mean length of time between receiving the diagnosis, and parenting stress levels being measured, was 29.4 months (±32.7; range 1–132 months).

The standardized beta coefficients from the multiple regressions reveal that autistic severity predicted levels of both types of parenting stress; the higher the autistic severity, the higher the parenting stress. There was a statistically significant negative relationship between the passage of time from the parents’ first noticing a problem to their current levels of parenting stress. The longer the period of time since any problems were first noticed, the lower the parenting stress. However, the length of time since receiving the diagnosis bore no relationship to the current levels of parenting stress.

The above pattern of results implies that, the shorter the period of time between parents first noticing a problem in their child and receiving the diagnosis, the higher will be the current parenting stress levels. This implication was confirmed by two separate correlations, which showed statistically significant negative correlations between the noticing to diagnosis time period and current levels of parenting stress relating to Child Characteristics, \( r(83) = -0.239, p < 0.05 \), and parenting stress relating to the child’s Physical Incapacity, \( r(83) = -0.291, p < 0.01 \).

3. Discussion

The current study investigated the impact on parenting stress of a diagnosis of ASC in children. Parenting stress has been implicated as a factor important in managing this condition. Moreover, there is increasing pressure to provide early diagnosis of ASC, despite a lack of evidence relating to the impact of such an early diagnosis on the parents. The present study noted a clear route to getting a diagnosis, in that the child’s autistic severity, unsurprisingly, predicted the parents’ first noticing a problem. It was the age of the child at which the parents first noticed a problem, rather than the child’s autistic severity, that subsequently predicted getting an earlier diagnosis.

In terms of parenting stress, the autistic severity of the child was related directly to this factor, a finding which has been noted previously (Eisenhower, Baker, & Blacher, 2005). However, a novel finding to emerge from this study is that earlier diagnosis was associated with greater current levels of parenting stress, which subsequently can have a negative effect on children’s behavior problems (Lecavalier et al., 2006), and treatment outcomes (Osborne et al., 2008a; Robbins et al., 1991). Moreover, it was noted that, while parenting stress was smaller the further in time from the point at which they first noticed a problem in their child, it bore no relationship to the time since the diagnosis. Although care must be taken with such findings, one explanation that requires careful consideration by professionals is that levels of parenting stress appear to be fluid until the point of diagnosis, which appears to have the effect of crystallizing these levels of parenting stress, in that they did not systematically decline over time, once the diagnosis had been received.

It was also found that shorter periods of time between initially noticing a problem in their child, and receiving an ASC diagnosis, were associated with higher levels of parenting stress. Thus, the longer the period of time between initially noticing a problem and receiving a diagnosis of ASC, the lower the

<table>
<thead>
<tr>
<th></th>
<th>Child characteristics</th>
<th>Physical incapacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>GARS</td>
<td>0.307**</td>
<td>0.266**</td>
</tr>
<tr>
<td>Noticing—test</td>
<td>−0.290*</td>
<td>−0.370**</td>
</tr>
<tr>
<td>Diagnosis—test</td>
<td>0.021</td>
<td>0.008</td>
</tr>
</tbody>
</table>

*p < 0.05; **p < 0.01; ***p < 0.001.
levels of parenting stress. Again, a tentative explanation that requires serious consideration, is that parenting stress levels may have had an opportunity to decrease from the point at which the parents had first noticed a problem in their child, before diagnosis occurred. The implication of this finding is that parents may require a longer period of time to elapse, during which their initial parenting stress levels can decrease, before they receive a diagnosis of ASC for their child. Given the current findings that give a potential contra-indication for early diagnosis of ASC, this is an issue that warrants caution, and further investigation.

Of course, many qualitative reports in this area have noted that, when asked directly, parents of children with ASC often say that they want an early and speedy diagnosis (Goin-Kochel et al., 2006; Osborne & Reed, 2008). However, it may be that what parents are implying is that they want to be reassured that they are not ‘bad’ parents (Williams, 2006), and to be supported and assured that they are not alone (Osborne & Reed, 2008), as well as gaining access to services for practical help that a formal diagnosis facilitates (Gillman et al., 2000). However, there is no reason why a formal diagnosis should have to precede access to such support and services for parents and their children. For instance, it is recognized by the Welsh Assembly Government (2007), in their recent document, The Autistic Spectrum Disorder Strategic Action Plan for Wales, that there should be no requirement of a formal diagnosis of ASC in order for parents to receive help and support, as well as services, in managing the problems experienced by their children. If the current findings can be confirmed, then this approach may well alleviate much of the parenting stress, which the formal diagnosis appears to do little, in itself, to reduce.

The reason why parenting stress is important is that it impacts on the management of the child’s condition (Lecavalier et al., 2006; Osborne et al., 2008a; Robbins et al., 1991). Given this, enhanced management of parenting stress has also been an increasing feature of many interventions for ASC. For example, Baker-Ericzen, Brookman-Frazee, and Stahmer (2005) suggest such modifications as increasing family support, and incorporating parental interventions, for those parents with elevated levels of stress, in early intervention programs for children with ASC. Findings related to these various interventions suggest that improved parent–child interactions occur through promoting low parenting stress (e.g., Koegel, Bimbella, & Schreibman, 1996). Thus, interventions that target the problems experienced by the parents of children with ASC have been developed with some success. The impact of early diagnosis on parenting stress may be offset of such parent-focused interventions are included in the help offered at diagnosis.

It must be acknowledged that early diagnosis is not the only factor responsible for parenting stress. For example, individuals without access to rich social networks tend to report more stress than individuals with good social support, which may be mediated by parent-perceived expertise of those providing the assistance and respite (Factor, Perry, & Freeman, 1990; Gill & Harris, 1991; Konstantareas & Homatidis, 1989; Sharpley, Bisika, & Efremidis, 1997; Weiss, 2002). Lack of ‘hardiness’, and low levels of social support, are predictive of poor adaptation and worse coping with stress, leading to ‘burnout’ (Weiss, 2002), and these factors predict depression and anxiety (Boyd, 2002). Likewise, individuals who employ avoidant coping strategies in response to stress tend to report more feelings of stress and mental health difficulties, compared to those who utilize positive reframing strategies (Dunn, Burbine, Bowers, & Tantleff-Dunn, 2001; Hastings & Johnson, 2001). Maternal- and paternal-stress are associated with the depression of their partner (Hastings et al., 2005), and parenting stress levels may rise due to a temporary loss of support from their partner (Hastings, 2003).

Hence, there are many factors that arguably could impact on the levels of post-diagnosis parenting stress. However, it should be noted that these same factors would also impact on the levels of post-noticing parenting stress, but parenting stress levels still decline from the time of noticing a problem, but do not systematically reduce after the diagnosis is received. Moreover, it is unlikely that the passage of time, in itself, is responsible for these results. For instance, it could be claimed that parenting stress levels would reduce naturally to a floor over time after parents have initially noticed a problem in their child, and this would happen irrespective of whether or not a formal diagnosis is received. However, this is unlikely for two reasons: first, parenting stress does not reach a floor, and remains exceptionally elevated in parents of children with ASC (Blacher & McIntyre, 2006); and secondly, there was a wide range of temporal intervals between noticing and
diagnosis in the current study, making appeal to ‘natural’ processes in the reduction of parenting stress levels less convincing.

As noted in the Introduction to this report, the current study represents a first step in identifying the impact of a child’s ASC diagnosis on parents, and should be treated with caution. The use of retrospective reports for some of the variables, albeit ones that are not subjective (such as age at diagnosis) is a limitation. It would also be very helpful to be able to see how stress changes over the period of noticing a problem, and the process of getting a diagnosis, rather than relating these events to current parenting stress. However, there are severe practical restrictions on the ability to conduct such research, not least being able to identify parents prior to them first noticing a problem with their child, and then following them through a long process, perhaps lasting for years, which may make such a prospective approach impractical. Thus, the current report, while acknowledging several limitations, attempts to offer a feasible and practical approach to studying an important aspect of this topic, and suggests some potentially concerning issues for parents and professionals that warrant further investigation.

In summary, the current findings suggest that, in itself, early diagnosis may not be helpful to parents of children with ASC, unless it is coupled with support for those parents. At the very least, this contra-indication requires further investigation. In terms of policy, the present results imply that early access to services and provision for individual problems, and early emerging difficulties, are much more important (and indeed potentially less harmful) than an early formal diagnosis of ASC, without accompanying support for children and parents alike.

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