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age of three years old. While autism-like conditions may have always existed, autism has only recently been featured in diagnostic nomenclatures such as the Diagnostic and Statistical Manual of Mental Disorders (DSM). According to a review on the history of ideas surrounding autism, a child with symptoms akin to autism was previously perceived as a “soulless mass of flesh possessed by the devil”.

As with any condition that is culturally devalued, the societal perception of children with autism is often akin to ‘madness’ and demonic possession. In recent history, various studies have explored the ignorance (knowledge), prejudice (attitude) and discrimination (behaviour) of the general public towards those with autism. Many studies have indicated that the general public regard children with autism as less affable. However, those who have previously had contact with autism sufferers—such as family members or those who provide them with social, education or medical care—have a less pervasively negative attitude towards such children. On the whole, attitudes towards any culturally-devalued condition tends to be greatly influenced by the prevailing Zeitgeist. Despite the increased awareness that autism is marked by both maladaptive behaviour as well as proficiency, there is little evidence that the concept of autism has not suffered effects of the ‘euphemism treadmill’ as in the case of those with marked intellectual disabilities.

Although it has been widely broadcast that ASD, like other neurodevelopmental disorders, are debilitating and impervious to available medical interventions, there is a strong indication that early diagnosis, coupled with early intervention, can be good prognostic indicators. Against such a background, the focus has been on lessening the associated impairments and disabilities of those with ASD while improving their quality of life and facilitating functional independence and psychosocial skills. This means that early recognition is essential, if not paramount, in order to safeguard the path of such children to a meaningful and comfortable future. Furthermore, in order to improve the educational, social and medical remedial services for these children, it is essential to quantify the magnitude of the problem in order to allocate appropriate resources. It is well known that an incentive for establishing services for those affected by ASD will stem from the recognition that there is an increasing number of children with ASD in Oman. Thus, quantifying the rate of ASD in the community is crucial for ensuring the welfare of this patient population.

The aim of the present discourse, therefore, is to highlight some of the factors that could contribute to a lower prevalence of ASD in Oman.
Saharan children diagnosed with ASD.23 This means, as has been shown in other psychiatric conditions, that distress, disability or illness are often expressed within sociocultural contexts.21 It has been well-established that applying Euro-American expectations of human nature to people in other parts of the world constitutes a ‘category of fallacy’ or, simply put, like using the same yardstick to measure two different situations.21 This is an example of the pan-human predisposition to neurogenetic determinism that is often applied to such developmental disorders. The argument that ASD should display a similar degree of prevalence worldwide stems from the misconception that these disorders are rooted in biology.24 Another view is that the phenotypical features of ASD stem from pathoplastic cultural factors and individual idiosyncrasies.25 Therefore, the high variability of the rate of ASD in different populations suggests that both sociocultural and ecological factors play a substantial role in shaping the features of ASD, while existing evidence points to complex interactions between the nature versus nurture dichotomy.26

**RELIABILITY OF DIAGNOSTIC TOOLS**

Diagnosing ASD is challenging as there are no biochemical tests or neuro-imaging techniques that can be reliably employed to establish the presence of autism. There are, however, many symptom checklists that are largely accepted as accurate in ensuring improved diagnoses of ASD.27 One important point about these available checklists is their tendency not to detect higher-functioning individuals with autism, as opposed to moderate and severe cases.24 In such cases, the experience and skills of the clinician are the sole influential factors in determining the accuracy of the diagnosis. There is a dearth of studies examining the psychometric properties of these symptom checklists.28,29 It is possible, therefore, that there is be a conceptual issue in adopting verbal or non-verbal scales from Euro-American populations for cross-cultural populations. This issue is relevant for studies examining the epidemiology of ASD. Related to this, estimating the ‘true’ prevalence of ASD is likely to be hampered by the fact that the ‘true’ signs and symptoms of ASD may be submerged by their resemblance to other childhood conditions. The very fact that some of the hallmark symptoms of ASD are without central features means that diagnoses of ASD are often confused with mental retardation. The difficulty of distinguishing between ‘true’ mental retardation and ASD is compounded by the fact that a significant number of children with autism are also likely to have mental retardation.25

Similarly, many psychiatric disorders have been reported as the ‘twin sisters’ of ASD, including social anxiety disorder, oppositional defiant disorder, childhood-onset schizophrenia and social communication disorder, as well as those child disorders characterised by inattention and hyperactivity.15,16 One way to circumvent such a problem is to establish a genetic marker for ASD. As yet, identifying a genetic signature for ASD has remained an elusive search. Most experts agree that biological markers for autism are likely to owe their origin to spontaneous mutation.26 Therefore, without a validated genotype, diagnoses of ASD often hinge on a phenotypical presentation such as the symptom checklist which is featured in some of the common nomenclatures, including the DSM and the International Statistical Classification of Diseases (ICD). It is worth noting that some critics have indicated that both DSM and ICD fail to recognise that disease, distress and disability is often expressed in a sociocultural context. In the available literature, there is a lack of discussion on how sociocultural context may shape the ‘content’ of ASD.30 Such issues are likely to contribute to the disparity in reported rates of ASD in different parts of the world.

**SERVICE MISDISTRIBUTION AND SOCIETAL COPING**

Ideally, appropriate developmental evaluation an early intervention by a team of dedicated multidisciplinary professionals can aid in providing services to children with special needs. In Oman, however, services for children with special needs generally do not exist or are only rudimentary. Despite the fact that Oman has a geographical area of 310,000 km² and a population of 3.5 million, to date, there is only one child and adolescent mental health service unit in the country (located in a tertiary care setting in an urban area of Oman).31 In the rest of the country, there are no dedicated centres for diagnosing children with developmental disorders. This is likely to contribute both to the under-diagnosis and to the under-reporting of ASD cases.

With no one to address affected children’s symptoms, ‘doctor-shopping’ is a common method for parents to find a ‘cure’ for their children.32 Since the modern healthcare system often cannot meet their needs, alternative or traditional healing systems are filling the vacuum. There is evidence to suggest that pathways to care for people with behavioural and emotional disorders in Oman are often seen as the prerogative of traditional healers.14,19 In the Omani community, emotional and cognitive impairments are often perceived as a manifestation of possession
by spirits or supernatural forces, such as hassad (contemptuous envy), sihr (sorcery) or the ‘evil eye’. Little documentation exists regarding the role of traditional healing processes in families caring for children with ASD. In reference to other conditions, the traditional healing system tends to allay the ‘guilt’ often found among caregivers of children with intractable conditions. The family caregiver may resort to any means at their disposal to find a ‘cure’ for their autistic child. The use of traditional healers may also result from the frequent lack of mental healthcare services available in most Omani communities. Given this situation, it is difficult to quantify the true prevalence of children with ASD in the country.

**Conclusion**

In the available literature on ASD in populations from North America and Western Europe, there is debate regarding whether the rising tide of children with ASD is because there are more children affected or more cases detected Others have pointed out that the recent increase may stem from a broadening of the diagnostic criteria, greater service availability and an increased awareness among both professionals and the general public. On the other hand, although conditions akin to ASD have been reported in different parts of the world, including Oman, the prevalence of ASD varies from culture to culture. In Oman, the lower reported rate of ASD could be directly related to various sociocultural factors. This potential discrepancy in the prevalence rate of ASD may stem from cross-cultural variations in the manifestation of behavioural and emotional disorders. If the current, apparently low prevalence in Oman is in fact just a consequence of under-diagnosis and under-reporting, a concerted effort is needed to increase public awareness of ASD. Additionally, an attempt should be made to institute services for the welfare of such children. This would require training healthcare practitioners to provide the necessary services and remedial interventions for children with ASD.

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**References**


