

Letters to the Editor

To the Editor:

I would like to make the following comments and observations in response to your editorial regarding "candida-caused autism," which appeared in ARRI Vol. 2, No. 2:

1. Not one case of candida in autism or "candida autism" has been reported in the scientific, peer reviewed literature.

2. Not one case of any type of autism has been reported in the scientific peer reviewed literature to have improved with anti-candida medication.

3. I know over 25 parents who gave their autistic children Nystatin with no beneficial effects at all. I know of at least six parents who gave their children Nystatin and felt it made them "worse."

4. Hopefully, no physicians (not just less than one in 20 or 30) will consider giving autistic children anti-candida medication for their autism. Only patients with clinically proven candida infections should be given anti-candida medication—and then only for the infection.

5. Nystatin treatment for autism is non-scientific and unproven. Like other such treatments touted by their practitioners and in the lay press (e.g., options therapy, mineral therapy after hair analysis, homeopathic treatment, vitamin injections into bone marrow) it should be, in my opinion, strictly avoided by all parents of autistic children.

"Candida autism" and "psychogenic autism" are birds of a feather. The sooner and further they fly away the better.

Edward R. Ritvo
Professor, UCLA School of Medicine
Chairman, Professional Advisory Board,
Autism Society of America

Editor's Reply:

Dr. Ritvo and I have had friendly disagreements on almost every proposed treatment for autism since the late 1960s, when Dr. Ritvo advocated psychotherapy and opposed behavior modification while I argued the opposite. Dr. Ritvo's comments on candida are similar to those he made at the Autism Society of America conference in New Orleans in July, 1988. During his talk he asserted that he had seen hundreds of cases of autism and in none of those cases was the autism caused by candida. He was critical of our article discussing the possibility that a small percentage of cases of autism may be caused or aggravated by candida infection. Not having had an opportunity to respond to Dr. Ritvo at the conference, I will use this one to respond to both his spoken and written criticisms. I disagree with Dr. Ritvo for several reasons:

1. Dr. Ritvo's claim that he has seen hundreds of cases of autism, not one of which was caused by candida, is surprising. No one, including Dr. Ritvo, knows what causes autism, or more specifically, why any individual child is autistic. Therefore, his comment that none of the cases he has seen

had candida-caused autism cannot be defended.

2. It is true, as Dr. Ritvo says, that there have been no cases of candida-caused autism as yet reported in the "peer-reviewed scientific literature" (although candida has been linked to other behavioral disturbances in Japanese studies reported in the medical literature). That is to be expected when one is dealing with new information, just beginning the process of scientific verification and validation. That was true in 1982 when Dr. Ritvo and several colleagues published a brief report in the New England Journal of Medicine claiming that fenfluramine had produced remarkable improvement in three cases, in an uncontrolled study. My editorial on candida-caused autism mentioned at least ten cases of autistic children who had improved on candida treatment. This is at least three times the number of cases on which Dr. Ritvo and his colleagues based their widely-publicized report, which resulted in a large number of autistic children being tried on this dangerous drug (see page 2). Nystatin, the drug most often used for treating candida, is, on the other hand, extraordinarily safe. Unlike fenfluramine, it has never caused a death or serious illness.

The observant reader may ask, "If Nystatin is so safe, why did Dr. Ritvo report that six autistic children known to him had gotten worse on Nystatin?" Good question. Nystatin is so safe that it almost never causes adverse reactions except when the patient does have a significant candida infection. Dr. Ritvo may be unaware of the Herxheimer reaction, which occurs when a patient heavily loaded with candida is given Nystatin. The Nystatin begins to kill off large numbers of the candida organisms and it is the temporary adverse effects of these dead and dying organisms during the early stages of Nystatin treatment which causes the Herxheimer reaction. If the parents of the six children Dr. Ritvo spoke of reinstated their treatment with Nystatin, it is quite possible that these children would show the significant improvement observed in Duffy Mayo and the small percentage of other autistic children whose problems appear to be caused, at least in large part, by infection with the candida albicans yeast.

—B.R.

To the Editor:

I was very interested in the article in the recent ARRI on "Aversives: Are they needed? Are they ethical?"

In your "Readers Comment" column, a letter by a psychologist stated, "All-out non-aversive treatment is seldom applied—this would involve massive environmental restructuring combined with intensive intervention by a highly proficient staff. Until this is done, it's hard to say that non-aversive methods fail."

I submit that this is a perfect description of Boston Higashi School!

Our son, Kevin, aged 12, has been a student there for one year. His extremely violent behavior has been reduced to almost nothing, his response to us has increased, and he is learning to read and write for the first time!

It seems to us that Higashi School bears watching—as the perfect "test-case" for non-aversive effectiveness!

Kathleen Herceg

To the Editor:

I would like to make a few comments about methods to prevent self-injury or aggressive behavior. Lorna King in Phoenix, Arizona, has found that sensory stimulation such as a vibrator applied to the hands or head will often stop head-banging or hand-biting. McGimsey and Favell (1988) reported in the *Journal of Autism and Developmental Disorders* that two daily 45-minute exercise periods greatly reduced disruptive, hyperactive or aggressive behavior in eight out of ten retarded persons. The exercise was relatively unstructured and consisted of jogging, jumping on a trampoline, or basketball.

A combination of positive behavioral methods, exercise and sensory treatment will probably be more effective than behavioral methods alone for controlling self-injurious or aggressive behavior. These three methods should be used together before one resorts to aversives.

Temple Grandin

Editor's Reply:

ARRI heartily agrees with both the content and philosophy of Temple Grandin's letter (see editorial on page 3). ARRI will continue to seek and publish information on non-aversive methods of controlling severe behavior problems. As Ms. Grandin says, such approaches should be used before aversives are employed.

However, when non-aversives fail—and they sometimes do—the use of aversives is often the most humanitarian alternative. To fail to use aversives under such circumstances constitutes abuse, in our opinion.

—B.R.

To the Editor:

You have surely achieved the most balanced review of the "aversives" controversy I've read in any newsletter. It should be sent to every legislator in states considering a ban.

Beatrice H. Barrett, Ph.D.