Deconstructing the DSM-5

By Jason H. King

Assessment and diagnosis of autism spectrum disorder

For this month's topic, I am excited to share my recent experience using the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to confirm a DSM-IV Asperger's disorder diagnosis (assigned in 2004) for a 22-year old male.

"David" was referred to me by the Utah State Office of Rehabilitation for career and vocational assistance, with a special focus on his mental health needs. Before I talk about my experience diagnosing David, I want to provide readers with a solid background on the DSM-5's approach to autism spectrum disorder (ASD).

Background

According to Susan Swedo, M.D., chair of the American Psychiatric Association DSM-5 Neurodevelopmental Disorders Work Group, her members spent a great deal of time evaluating the reliability and validity of the separate DSM-IV diagnoses (autistic disorder, Asperger's disorder, childhood disintegrative disorder, Rett's disorder and pervasive developmental disorder-not otherwise specified).

The work group concluded there was no evidence to support continued separation of the diagnoses. For example, the pervasive developmental disorder (PDD) field had already moved to using single ASD as the preferred title (over Asperger's and PDD-not otherwise specified) with 95 percent of publications in the past five years.

Other reasons for the DSM-5 diagnostic structure for PDDs:
• Qualitative differences between them are inconsequential.
• The DSM-IV resulted in a high prevalence (sometimes up to 30 percent) of diagnoses being in the PDD-not otherwise specified classification, which led to inconsistent treatment protocols and impaired research activities.
• The DSM-IV was skewing Autism diagnoses toward children with social and communication difficulties, even though delays in language are neither unique to nor universal in PDDs.

To eliminate the misdiagnosis of communication disorders as autism-based disorders, the DSM-5 has a new mutually exclusive diagnosis: social (pragmatic) communication disorder (SCD). Symptoms of this disorder include difficulty in the acquisition and use of spoken and written language and problems with inappropriate responses in conversation. Symptoms must be present in early childhood even if they are not recognized until a later time when speech, language or communication demands exceed abilities.

Most important, ASD must be ruled out for SCD to be diagnosed. Moreover, SCD includes persistent difficulties in the social uses of verbal and nonverbal communication that cannot

be explained by low cognitive ability. The disorder limits effective communication, social relationships, academic achievement or occupational performance.

Previous editions of the DSM did not provide an appropriate diagnosis for people with such symptoms, leading to inconsistent treatment across clinics and treatment centers. For these individuals, SCD brings their social and communication deficits out of the shadows of a "not otherwise specified" label to help them get the services and treatment they need. (See DSM-5 pages 47-49 for more details on SCD.)

The new landscape

The DSM-5 collapses the DSM-IV three-factor model (qualitative impairment in social interaction, qualitative impairments in communication, and restricted repetitive and stereotyped patterns of behavior, interests and activities) of PDDs into a two-factor model:
1) Deficits in social communication and social interaction (notice this is really criterion A and criterion B from DSM-IV combined)
2) Restricted repetitive behaviors, interests and activities

In 2012, researchers W.P.L. Mandy, T. Charman and D. Skus published an article stating that the draft DSM-5 diagnostic criteria for ASD were supported by research. Their study methods analyzed 708 individuals, ages 2 to 21, who had completed a comprehensive diagnostic assessment. Their results indicated that the DSM-IV-TR three-factor diagnostic model, which was consistent with the DSM–IV diagnostic criteria, was not supported by the data.

On the other hand, the DSM-5's two-factor model, comprising social communication and restricted/repetitive behavior dimensions, was supported by data. Their results also indicated that stereotyped/repetitive language adequately fit on the restricted/repetitive behavior domain, as proposed in the DSM-5, but covaried strongly with items measuring social communication. Overall, the two-dimension model fit well for ASD and broader autism phenotype participants, suggesting appropriateness across the range of symptom severity.

Within this two-factor model, ASD is characterized by three of three criteria addressing deficits in social-emotional reciprocity, nonverbal communicative behaviors used for social interaction, and developing, maintaining and understanding relationships. It further includes two of four restricted repetitive behaviors criteria (overly dependent on routines, highly sensitive to changes in their environment, intensely focused on inappropriate items or sensory input sensitivity).

Though both the DSM-IV and DSM-5 contain a five-symptom minimum threshold to qualify for the diagnosis, the DSM-5 is more restrictive by using criterion language, such as "persistent," "across multiple contexts" and "clinically significant impairment." The DSM-5 also streamlines the 12 potential symptoms found in the DSM-IV to seven potential symptoms to promote clinical utility, because "if the disorder does not usefully inform that

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person's diagnosis, treatment or prognosis, then the diagnosis is considered inappropriate."

In the DSM-5, individuals with ASD must show symptoms from early childhood, even if those symptoms are not recognized until later. The DSM-5 also revised the DSM-IV's age requirement of three years because research indicates a valid and reliable ASD diagnosis can occur as early as age 2. Anyone diagnosed with one of the five PDDs from the DSM-IV should still meet the criteria for ASD in the DSM-5 or another, more accurate DSM-5 diagnosis. Finally, the DSM-5 includes a number of specifiers to provide a rich degree of information about the patient.

ASD descriptive specifiers, which convey additional information that can inform treatment planning, now include the following:
• With or without accompanying intellectual impairment
• With or without accompanying language impairment
• Associated with a known medical or genetic condition or environmental factor
• Associated with another neurodevelopmental, mental or behavioral disorder
• With catatonia (in the DSM-5, this can be used as a specifier for neurodevelopmental, depressive, bipolar and psychotic disorders)

ASD severity specifiers, which guide clinicians in rating the intensity, frequency, duration or symptom count, now include the following:
• Level 1(mild): "requiring support"
• Level 2 (moderate): "requiring substantial support"
• Level 3 (severe): "requiring very substantial support"

These specifiers assist with the DSM-5's new dimensional classification procedures that replaced the DSM-IV's multiaxial classification procedures. I encourage you to use these specifiers in your clinical practice because they provide you "with an opportunity to individualize the diagnosis and communicate a richer clinical description of the affected individuals" (DSM-5, page 32). See DSM-5 pages 51-52 for more details on use of these specifiers.

Latest research

The current scientific literature evaluating the DSM-5 ASD clinical formulation is compelling. In 2012, M. Huerta and colleagues published "Application of DSM-5 criteria for autism spectrum disorder to three samples of children with DSM-IV diagnoses of pervasive developmental disorders." They used three data sets that included 4,453 children with DSM-IV clinical PDD diagnoses and 690 with non-PDD diagnoses (for example, language disorder).

Their results found that, on the basis of just parent data, the DSM-5 criteria identified 91 percent of children with clinical DSM-IV PDD diagnoses (the remaining 9 percent would qualify for a more accurate diagnosis, such as SCD). They also reported that DSM-5 sensitivity (validity) remained high in specific subgroups, including female children younger than 4.

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The specificity of DSM-5 ASD was 0.53 overall, while the specificity of DSM-IV ranged from 0.24 for clinically diagnosed PDD-not otherwise specified to 0.53 for autistic disorder. When data were required from both parent and clinical observation, the specificity of the DSM-5 criteria increased to 0.63. In conclusion, Huerta and colleagues found that compared with the DSM-IV criteria for Asperger's disorder and PDD-not otherwise specified, the DSM-5 ASD criteria have greater specificity, particularly when abnormalities are evident from both parents and clinical observation.

This year, Stephanie Reszka and colleagues published "Brief Report: Concurrent Validity of Autism Symptom Severity Measures." Their purpose was to examine whether symptom severity and/or diagnostic status of 201 preschool-aged children with ASD categorized similarly on commonly used assessment measures: the Autism Diagnostic and Observation Schedule (ADOS), the Childhood Autism Rating Scale (CARS) and the Social Responsiveness Scale (SRS) – teacher and parent versions.

Their results revealed that for half of the sample, children were similarly classified across the four measures, and scores on most measures were correlated, with the exception of the ADOS and SRS-P. Although the ADOS, CARS and SRS are reliable and valid measures, there is some disagreement between measures regarding child classification and the categorization of autism symptom severity.

Also this year, C.A. Mazefsky and colleagues published "Brief Report: Comparability of DSM-IV and DSM-5 ASD Research Samples." Their methods investigated the impact of the DSM-5 on the diagnostic status of 498 high-functioning participants with ASD. Results indicated the percentage of participants satisfying all DSM-5 requirements varied significantly, with reliance on data from the ADOS at 33 percent and the Autism Diagnostic Interview-Revised (ADI-R) at 83 percent.

In conclusion, these researchers annotated that in utilizing combined ADOS/ADI-R data, 93 percent of participants met DSM-5 criteria. This suggests likely continuity between DSM-IV and DSM-5 diagnosis as characterized with these instruments in combination and highlights the impact of diagnostic methodology on ability to document DSM-5 symptoms.

If you work with this population, I suggest you keep Frederick Coolidge and colleagues' "Psychometric Properties of a New Measure to Assess Autism Spectrum Disorder in DSM-5" on your clinical assessment radar for future use after the instrument is validated.

With this background, let us now return to my client, David.

David

I used the following assessment procedures to diagnose my client:
• Biopsychosocial clinical interview of David with his mother as an additional informant
• Level 1 cross-cutting symptom measures (see DSM-5 pages 733-744; see also psychiatry.org/dsm5)

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• Dimensional screening tools (see K. Dayle Jones' article, "Dimensional and Cross-Cutting Assessment in the DSM-5," published in the October 2012 Journal of Counseling & Development)
• The American Psychiatric Association's Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders
• Historical evaluations
• Collateral reports from the referring vocational rehabilitation counselor
• Simon Baron-Cohen's Autism Spectrum Quotient (AQ)
Adhering to DSM-5 dimensional rather than DSM-IV multiaxial classification, I diagnosed David using this format:
• Autism Spectrum Disorder, Without Accompanying Intellectual Impairment, Without Accompanying Language Impairment, Requiring Support for Social Communication and Social Interaction, Requiring Substantial Support for Restricted Repetitive Behaviors, Interests and Activities.

Notice the diagnostic precision offered by the DSM-5 in comparison with how David would be listed by the DSM-IV:
• Asperger's Disorder
Also notice how that diagnosis does not promote clinical utility.

For ASD, severity ratings are listed independently for social communication and restricted repetitive behaviors rather than giving a global rating that covers both. So for David, his mild severity rating of "requiring support" for social communication means "without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions" (DSM-5, page 52).

His moderate severity rating of "requiring substantial support" for restricted repetitive behaviors (RRBs) means "RRBs and/or preoccupations and/or fixated interests appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress or frustration is apparent when RRBs are interrupted; difficult to redirect from fixated interest" (DSM-5, page 52).

I love how the DSM-5 helps to drive comprehensive treatment planning. It goes beyond the established diagnosis and requires me to communicate the level of support — at a dimensional level instead of a categorical level — that David needs from me, his family, his community, social services and educational institutions. I also welcome the DSM-5's expanded language and text on the diagnostic features of ASD for the adult population. Discussion on adult presentations of PDDs was absent from the DSM-IV.

I strongly encourage you to go beyond the diagnostic criterion and read the DSM-5 textual narrative on this disorder that discusses recording procedures, specifiers, diagnostic features, associated features supporting diagnosis, prevalence, development and course, risk and prognostic factors, culture- and gender-related diagnostic issues, functional consequences, differential diagnosis and comorbidity. In comparison with the DSM-IV, the

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DSM-5 enhances the textual narrative about diagnostic features, development and course of ASD. This description greatly informed my clinical evaluation and diagnosis of David.

I learned from the new manual that adults with ASD:
• Have difficulties processing and responding to complex social cues
• Consciously are calculating what is socially intuitive for most individuals
• Struggle to understand what behavior is considered appropriate in one situation but not another
• Desire to establish friendship but do not possess a complete or realistic idea of what a friendship entails
• Learn how to suppress repetitive behavior in public
My hope is that our discussion on assessment and diagnosis of ASD will help you to have more confidence — and excitement — in using the DSM-5 in your counseling or academic practice. Until next month, be well.

Bio

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