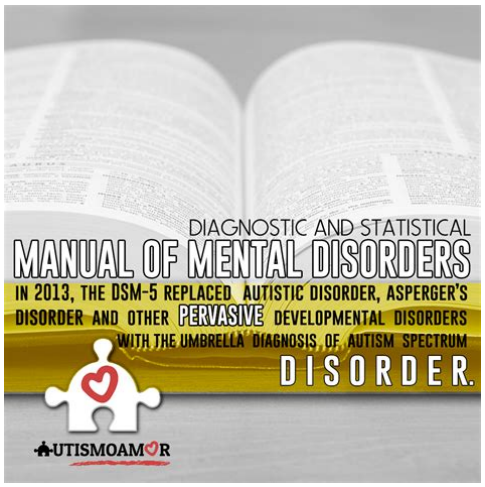

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Diagnostic And Statistical Manual Of Mental Disorders Autistic Disorder

CDC twenty four seven. Saving Lives, Protecting People Intellectual disability and autism spectrum disorder frequently cooccur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social pragmatic communication disorder. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA American Psychiatric Association; 2013. Intellectual disability and autism spectrum disorder frequently cooccur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social pragmatic communication disorder. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to andfro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful. Difficulty switching between activities. Problems of organization and planning hamper inde.http://www.neline.nl/userfiles/breville-urn-manual.xml

- **diagnostic and statistical manual of mental disorders autism spectrum disorder, diagnostic and statistical manual of mental disorders autistic disorder.**

Abstract The fifth edition of the diagnostic and statistical manual of mental disorders DSM5 introduced significant changes in the classification of autism spectrum disorders ASD, including the abolition of the diagnostic subcategories proposed by DSMIVText Revision. DSM5 describes three levels of increasing severity of ASD. The authors report two explanatory cases with ASD verbal boys, aged about 7 and a half years, without intellectual disability. According to DSM5, both cases fall into the lowest severity level of ASD. However, their neuropsychological and neurobehavioral profile varies significantly. While the first boy showed a prevalent impairment of visuoconstructional and visuoperceptual abilities, the second one presented a predominant involvement of verbal functions, with qualitative impairments in communication. A further step forward in the definition and classification of ASD, taking into account both intensity and quality of symptoms, is recommended in order to formulate a reliable prognosis, plan an individualized treatment and monitor the clinical course over time. Keywords Autism, autism spectrum disorders, diagnostic and statistical manual of mental disorders 5 th edition, diagnostic and statistical manual of mental disordersIVText Revision Introduction Autism spectrum disorders ASD are lifelong conditions severely impairing social skills and autonomy. In the diagnostic criteria, language abilities not employed in social communication have been deemphasized. Further, the diagnostic subcategories, that is, autistic disorder, Asperger disorder, Rett disorder, childhood disintegrative disorder, and pervasive developmental disorder PDD not otherwise specified, have been abolished. Case Reports Case 1 Male, aged 7 years 5 months. Family history was positive for schizophrenia in a maternal

greatgrandmother.http://m-isc.com/userfiles/breville-urn6-manual.xml

The maternal grandfather was a very skilled electronics technician, but he lacked empathy and had difficulties relating to others; as a child, he selftaught himself four languages. The boy was born at full term; pregnancy and delivery were uncomplicated, psychomotor development was normal. Since 18 months of age he appeared isolated, wanted things to be placed in a certain order, played along with water and looked at books for hours. He began to read letters and numbers at 20 months. His language was polished and characterized by some neologisms. He made nasty comments aloud in the presence of concerned persons. His face expressions were very serious. Understanding of others' feelings based on facial expressions was lacking. Eye contact was inconstant. Unusual interests for sinks, toilets, pipes, switches, lights were present. The boy was very afraid that the bulbs could explode. His behavior was often oppositional and hyperactive. He showed great ability to design projects, e.g., a new home or railway line and was frustrated by not being able to get the highest grade in maths. Applied behavior analysis ABA intervention was conducted. At school, he had a special needs teacher. Neurological examination was normal. The first five from the left are the verbal subtests, the other five are the performance subtests Open in a separate window According to DSM5 criteria, this case had an ASD diagnosis with severity level 1. Case 2 Male, aged 7 years 5 months. Family history was positive for Learning disorder in the older sister, ASD in the younger brother. During pregnancy, threatened abortions treated pharmacologically occurred. He was born at 37 weeks of gestation by induced labor due to preeclampsia. Apgar scores were normal. Psychomotor development was normal except for language as the child began to speak sentences with a slight delay. He was very attracted by numbers and puzzles. Hypersensitivity to visual, auditory and tactile stimuli was present.

Already from kindergarten he appeared isolated both at home and school. He had intolerance for what was new and frustrations. His behavior was often hyperactive and attention was lacking. Imagination seemed rather poor, with the need for scientific explanations for everything. Spontaneous play appeared limited to some materials and rather schematic. He liked to collect stones from the sea. The boy tended to verbally interact with others without looking at them. Socialemotional reciprocity was lacking He often followed the course of his thoughts and conversational exchanges remained limited. Comprehension of verbal messages tended to be literal, leading to difficulties in understanding the meaning of metaphors, jokes, and slang expressions. Language was fluent even if sentences were often incomplete. Prosody was slightly mechanical. Neologisms were present. Narration of event sequences was hard for him. First speech therapy and psychomotricity were conducted, then ABA intervention. At school, he had the special needs teacher. ADOS module 3 showed a result above the cutoff for autism both in language and communication, and in reciprocal social interaction; consequently also the overall result was above the cutoff for autism. CARS2HF showed the presence of mild to moderate symptoms of ASD. KADI was compatible with an extremely low probability of Aspergers disorder diagnosis. According to DSM5 criteria, this case had an ASD diagnosis with severity level 1. Discussion The description of these two explanatory cases underlines some critical points of the current setting of DSM5 classification for ASD. According to DSM5 criteria, both cases fall under ASD, due to a significant impairment in social communication and interaction, and to restricted interests and activities.

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At the same time, both cases verbal boys, aged about 7 and a half years, without intellectual disability, based on DSM5 description, fall into the lowest severity level of ASD level 1, which by definition requires support. However, their respective neuropsychological and neurobehavioral profiles were notably different. While the first boy showed a prevalent impairment of visuoconstructional and visuoperceptual abilities, with language functions even overdeveloped in some respects, the second boy presented an almost specular profile characterized by a predominant

involvement of verbal functions, with qualitative impairments in communication, and a preservation of nonverbal functions, some of which particularly visual analysis were the strength of his development. These differences have been objectified by standardized assessment tools. Admittedly, a detailed neuropsychological and neurobehavioral profile represents a basic prerequisite for the treatment of patients with ASD. Further, we could observe a cognitive profile characterized by strengths in verbal skills e.g., vocabulary and weakness in nonverbal skills e.g., visuospatial and visuomotor abilities. The description of these two cases is indicative of this lack. Our report is not meant to suggest a return to the past, but rather to give a cue to improve the current DSM classification. We believe that a further step forward in ASD definition and classification is necessary in order to meet the needs of affected individuals from the rehabilitation perspective. In our view it is important to take into account not only the intensity of symptoms, but also their quality, in order to formulate a reliable prognosis, plan an individualized treatment, and monitor the clinical course over time. In addition, description of detailed behavioral phenotypes, allowing the creation of homogeneous subgroups of patients with ASD, may be useful also for genetic research.

Acknowledgment The authors would like to thank Cecilia Baroncini for linguistic support. Footnotes Source of Support Nil. Conflict of Interest None declared. References 1. DSM5. 5th Edition. Washington, DC American Psychiatric Association; 2013. American Psychiatric Association. Washington, DC American Psychiatric Association; 2000. Validity and neuropsychological characterization of Asperger syndrome Convergence with nonverbal learning disabilities syndrome. Comparison of clinical symptoms in autism and Aspergers disorder. Changes in the diagnostic criteria for autism in DSM5 Controversies and concerns. Update on diagnostic classification in autism. Author manuscript; available in PMC 2019 Aug 28. Abstract Purpose The criteria for autism spectrum disorder ASD were revised in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders DSM. The objective of this study was to compare the sensitivity and specificity of DSMIVText Revision DSMIVTR and DSM5 definitions of ASD in a communitybased sample of preschool children. Methods Children between 2 and 5 years of age were enrolled in the Study to Explore Early DevelopmentPhase 2 SEED2 and received a comprehensive developmental evaluation. The clinicians who evaluated the child completed two diagnostic checklists that indicated the presence and severity of DSMIVTR and DSM5 criteria. Definitions for DSM5 ASD, DSMIVTR autistic disorder, and DSMIVTR Pervasive Developmental Disorder Not Otherwise Specified PDDNOS were created from the diagnostic checklists. Results 773 children met SEED2 criteria for ASD and 288 met criteria for another developmental disorder DD. Sensitivity and specificity were best balanced with DSM5 ASD criteria 0.95 and 0.78, respectively. Conclusions The DSM5 definition of ASD maximizes diagnostic sensitivity and specificity in the SEED2 sample. These findings support the DSM5 conceptualization of ASD in preschool children.

The early detection of ASD is an important public health priority that may address immediate and longterm needs of children and families. The criteria used to diagnose ASD are outlined in the Diagnostic and Statistical Manual of Mental Disorders DSM published by the American Psychiatric Association APA0. A diagnosis of autistic disorder required the presence of at least six of 12 total symptoms from three domains two social, at least one communication, and at least one behavioral, and onset before 36 months of age. A diagnosis of Asperger disorder specified qualitative impairments in social interaction and presence of restricted interests and repetitive behaviors, but no cognitive, language, or nonsocial adaptive delays noted in early development. Diagnoses of PDDNOS were described as a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal and nonverbal communication skills, or the presence of stereotyped behavior, interests, and activities, but criteria not met for another

ASD. Children with PDDNOS, therefore, had to meet at least two diagnostic criteria with one from the social domain. In its publication of the DSM5 in 2013, the APA made considerable changes to ASD diagnostic criteria in an effort to maintain diagnostic sensitivity and continue to improve diagnostic specificity. In DSM5, ASD no longer includes subtypes but represents one singular condition defined by level of functional support required by the individual. Consequently, diagnostic sensitivity may suffer with improved diagnostic specificity and impact the early detection and treatment of children with ASD. Previous studies that compared the sensitivity and specificity of DSMIVTR to DSM5 criteria utilized retrospective data collection methods and older populations of children e.g.

, identifying DSM5 symptoms in records of those evaluated with DSMIVTR criteria and employing a research algorithm applied to previously collected diagnostic instruments. To our knowledge, no study has examined concurrent coding of DSMIVTR and DSM5 criteria for ASD by a clinician who evaluated the child at a developmental period when symptoms may be first recognized by a parent or healthcare professional. In its second phase of data collection SEED2, study clinicians were asked to complete DSM checklists for both DSMIVTR and DSM5 criteria utilizing all available information on the child. The objectives of this analysis were to 1 report the sensitivity and specificity of DSMIVTR and DSM5 definitions of ASD compared to SEED2 final classification criteria, 2 examine agreement between DSMIVTR and DSM5 definitions of ASD, and 3 evaluate differences between characteristics of children who met DSMIVTR but not DSM5 definitions of ASD, and vice versa. The SEED2 protocol was approved by Institutional Review Boards at each site and adhered to ethical standards. Children eligible for data collection were born between January 1, 2008 and December 31, 2011, enrolled between 2 and 5 years of age, resided in one of the study areas, and lived with a knowledgeable caregiver who was competent to communicate in English or in California and Colorado, in English or Spanish. Three groups of children were recruited from each site 1 those with known ASD, 2 those with known developmental delays DD identified from multiple educational and health providers or family or physician referral, and 3 those from the general population identified from state vital records. Children in the DD group were later defined as those with ASD symptoms i.e., those who had ASD risk noted on an ASD screen, received an ASD evaluation, and did not meet study criteria for ASD and those without ASD symptoms i.e., those who did not have ASD risk noted on an ASD screen and, therefore, received a more limited evaluation.

Caregivers of enrolled children gave written consent to participate in the study. Clinicians who administered the ADOS and ADIR had at least a Master’s degree in psychology or related field and were deemed field ready once they established administration fidelity and research reliability with a supervising clinician at their site. These clinicians were monitored by the supervising clinician for administration fidelity at least once per year and for coding reliability at least once per quarter or every 10th ASD assessment. Firstpass coding reliability for field clinicians was 92% for the ADOS and 97% for the ADIR. Supervising clinicians had a doctorate degree in psychology, medicine, or related field and established research reliability with a certified ADOS and ADIR trainer. Supervising clinicians were monitored by each other for administration fidelity once during the study period and for coding reliability at least once per quarter. Checklists were completed by both clinicians in collaboration when the ADOS and ADIR were completed by two qualified staff members. Checklists were completed by one clinician when the ADOS and ADIR were administered by the same person. The DSMIVTR checklist was administered before the DSM5 checklist in the SEED2 study. A definition of Asperger disorder was not specified because only 30 children with ASD in the SEED2 sample did not have a cognitive or language delay noted on the MSEL and there were less than five of these children in some cells used to calculate sensitivity and specificity. Definitions of Childhood Disintegrative Disorder and Rett Syndrome were not created due to the low prevalence of these conditions. We did not create DSMIVTR PDDNOS definitions independent of DSMIV autistic disorder i.e., the same child could meet all definitions. This method allowed assessment of clinical definitions

independent of others with maximal sample size.

The clinicians who completed DSMIVTR and DSM5 checklists was also asked to rate severity of ASD symptoms categorized for this analysis as mild, moderate, severe, or symptoms accounted for by another disorder, and certainty the child had ASD categorized for this analysis as certain or uncertain. Briefly, children classified as ASD were those who met ASD criteria on both the ADIR and ADOS, or who met ASD criteria on the ADOS and one of three alternate criteria on the ADIR i.e., met criteria on the social domain and was within two points on the communication domain, met criteria on the communication domain and was within two points on the social domain, or met criteria on the social domain and had two points noted on the behavioral domain. Thus, if results of the ADOS and ADIR were discrepant, the child could still be defined as an ASD case if ADOS criteria were met and one of the three alternate ADIR criteria were met. We recognize that diagnostic instruments alone cannot replace informed clinical judgment when diagnosing children with ASD. However, scores from the ADIR and ADOS are both sensitive and specific in detecting children with ASD when used in combination, and offer several advantages to classify children with ASD in large epidemiologic studies. First, ADIR and ADOS scores are assigned by experienced and reliable clinicians and offer a uniform method of characterizing ASD symptoms in large cohorts of children that can be replicated in other studies. Consequently, using the ADIR and ADOS to classify children with ASD may be advantageous when welldefined groups of children are an important clinical or research outcome. Moreover, kappa agreement between SEED2 final classification status and clinical judgment was 0.71, reflecting substantial agreement. Sensitivity was the number of true positives i.e., those defined as ASD by both the DSM checklist and SEED2 criteria divided by the number of those defined as ASD by SEED2 criteria.

Specificity was the number of true negatives i.e., those defined as nonASD by both the DSM checklist and SEED2 criteria divided by the number of children defined as nonASD based on SEED2 criteria. PPV was the number of true positives divided by the number of children who were defined as ASD by a DSM checklist definition; NPV was the number of true negatives divided by the number of children who were defined as nonASD by a DSM checklist definition. The kappa statistic examined agreement between DSMIVTR and DSM5 definitions of ASD, and chi square examined differences in characteristics of children who met DSMIVTR but not DSM5 definitions of ASD, and vice versa. Due to multiple comparisons, significance for p was set at 0.01. Results A total of 773 children met SEED2 criteria for ASD and 288 met criteria for another DD after a comprehensive evaluation. Sensitivity, specificity, PPV, and NPV for each of these DSM definitions are shown in Table 3. DSM5 ASD had a better balance of sensitivity and specificity compared to the SEED2 classification than DSMIVTR autistic disorder, PDDNOS1, or PDDNOS2. Characteristics of these children compared to those who did not have conflicting DSMIVTR and DSM5 definitions are shown in Table 4. Results suggest that the DSM5 definition of ASD maximizes diagnostic sensitivity and specificity in the SEED2 sample of young children. Moreover, agreement between DSM5 and DSMIVTR definitions of ASD were good for autistic disorder and moderate for PDDNOS. Children who met DSMIVTR autistic disorder, but not DSM5 ASD were more likely to have mild ASD symptoms, or their symptoms were accounted for by another disorder. Children who met PDDNOS but not DSM5 ASD, or vice versa, were less likely to have ID and more likely to be female. Consequently, creating boundaries for clinical diagnosis or research classification inherently includes some children with ASD symptoms and excludes others with milder symptoms or subthreshold presentation.

The goal of categorical diagnostic systems is to maximize diagnostic sensitivity accurate inclusion of true positives as well as diagnostic specificity accurate exclusion of true negatives. Results presented herein suggest that DSM5 criteria for ASD achieves this goal within a large communitybased sample of preschool children. These results should be replicated in other large and geographically diverse samples that incorporate concurrent coding of DSMIVTR and DSM5 criteria

in a clinic setting. Some children in the SEED2 sample had a developmental profile defined by mild ASD symptoms and symptoms that were better accounted for by another disorder. These children were more likely to meet DSMIVTR autistic disorder, but not DSM5 ASD, or either of the DSMIVTR PDDNOS definitions but not DSM5 ASD. Additionally, children who met PDDNOS1 or PDDNOS2 but not DSM5 ASD, or vice versa, were less likely to have ID and more likely to be female. These children may be those seen in clinic settings to differentiate from children with ASD, and likely face developmental challenges that warrant professional attention. Service delivery may, therefore, be more effective if based on the strengths and challenges of the individual child rather than inclusion in one categorical diagnosis. More research is needed on the developmental status of children with DD with ASD symptoms, and how they are recognized, diagnosed, and treated. These results imply that higherfunctioning females and those without ID may be missed by current diagnostic systems. Results of this study add to this dialogue by providing evidence that females who meet DSMIVTR autistic disorder are as likely as males to meet DSM5 ASD; however, they are more likely than males to shift between DSMIVTR PDDNOS and DSM5 ASD. DSMIVTR definitions of autistic disorder and PDDNOS1 and PDDNOS2 had an adequate balance of sensitivity and specificity.

In fact, diagnostic specificity for PDDNOS1 and PDDNOS2 was higher in these analyses than previous reports. One possible reason for the improvement in PDDNOS specificity seen in this paper is that we considered severity rather than mere presence of social deficits in our PDDNOS definition. If only presence of any of the social deficits were required, in addition to presence of any of the communication or behavioral deficits, specificity would have dropped from 0.75 to 0.06 for PDDNOS1 and 0.78 to 0.16 for PDDNOS2 data not shown. Consequently, considering the severity of social deficits among those with subthreshold DSM5 ASD presentation may help guide decisions to monitor the ASD symptoms over time, especially among females and those without ID. There are limitations associated with this study. First, evaluation instruments were administered in SEED2 as part of a research protocol so clinicians did not have a choice in the information collected to assess diagnostic symptoms. However, the instruments that were administered in SEED2 are considered goldstandard diagnostic instruments, and elicit valid and reliable information on ASD symptoms and other areas of development. Second, information collected during the child observation ADOS and parent interview ADIR were considered in the diagnostic checklist, so the SEED final classification criteria and DSM definitions were not completely independent of one another. Nonetheless, this process reflects clinical practice and, therefore, may generalize to realworld clinic settings. Third, SEED2 did not systematically collect criteria for Social Communication Disorder SCD, which was introduced in DSM5 and thought to capture some children formerly defined as PDDNOS. The closest definition of SCD in this study is PDDNOS1, which had an adequate balance of sensitivity and specificity for ASD classification.

Sample characteristics undoubtedly influence measures of sensitivity and specificity so precaution must be taken when interpreting results. For instance, estimates of specificity i.e., the number of true negatives may have been reduced because only children with some social and communication difficulties—rather than children from the general population—were included the sample. Again, these sample characteristics may reflect clinical practice of distinguishing children with ASD from children with other DD, but must be considered nonetheless. In sum, these results are best generalized to samples with a similar age and developmental profile and may look different in sample of younger or older children or those with few social and communication concerns. Finally, this study was conducted many years after the publication of DSM5 in 2013 although it is novel in the approach and sample used to compare the sensitivity and specificity of DSMIVTR and DSM5 definitions of ASD. The strengths of our analyses outweigh these limitations. This is the first study to present concurrent coding of DSMIVTR and DSM5 criteria for ASD by a clinician who evaluated preschool children with goldstandard diagnostic instruments. The sample was large and ascertained from clinic and nonclinic sources in multiple geographic areas throughout the United States. Results

contribute to an important body of literature on how diagnostic criteria distinguish children with varied ASD symptoms, and highlights the need to learn more about those with mild ASD symptoms and the ASD phenotype in females. In conclusion, these findings support the DSM5 conceptualization of ASD in preschool children and highlight areas for future research. Acknowledgements The investigators acknowledge the contributions made to this study by project staff and enrolled families. The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the CDC.

Footnotes Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest. References 1. American Psychiatric Association 2013 Diagnostic and statistical manual of mental disorders, 5th edn. JAMA Pediatrics. Dis Heal J. J Dev Phys Disabil. J Earl Intervent. Inf Youn Children. Pediatrics. American Psychiatric Association, text revision; . Psych Serv. Volkmar FR, Shaffer D, First M 2000 PDDNOS in DSMIV. J Autism Dev Disord. Levy SE, Giarelli E, Lee LC, Schieve L, Kirby R, Cunniff CJ Dev Beh Pediatrics. Zwaigenbaum L, Bauman ML, Stone WL, Yirmiya N, Estes A, Harman RPediatrics J Amer Acad Child Adoles Psychiatry. Maenner MJ, Rice CE, Arneson CL, Cunniff C, Schieve LA, Carpenter LAJAMA Psychiatry. Mattila ML, Kielinen M, Linna SL, Jussila K, Ebeling H, Bloigu RJ Am Acad Child Adoles Psychiatry. Tsai LY 2014 Impact of DSM5 on epidemiology of autism spectrum disorder. Res Aut Spec Disorders. Schendel D, DiGuiseppi C, Croen L, Fallin D, Reed P, Schieve LJ Autism Dev Disord. DiGuiseppi C, Daniels J, Fallin D, Rosenberg S, Schieve L, Thomas K. Rutter MA, Bailey A, Lord C 2003 The social communication questionnaire. Mullen E 1995 Mullen Scales of early learning. Lord C, Rutter M, Le Couteur AL 1994 Autism diagnostic interviewrevised a revised version of a diagnostic interview for caregivers of individuals with possible pervasive developmental disorders. J Aut Dev Disord. Gotham K, Risi S, Pickles A, Lord C 2007 The autism diagnostic observation schedule revised algorithms for improved diagnostic validity. Lord C, Rutter M, DiLavore PC, Risi S 1999 Autism diagnostic observation schedule. Sparrow S, Balla D, Cicchetti D 2005 Vineland adaptive behavior scales, 2nd edn. Gray K, Tonge B, Sweeney D 2008 Using the autism diagnostic interviewrevised and the autism diagnostic observation schedule with young children with developmental delay evaluating diagnostic validity.