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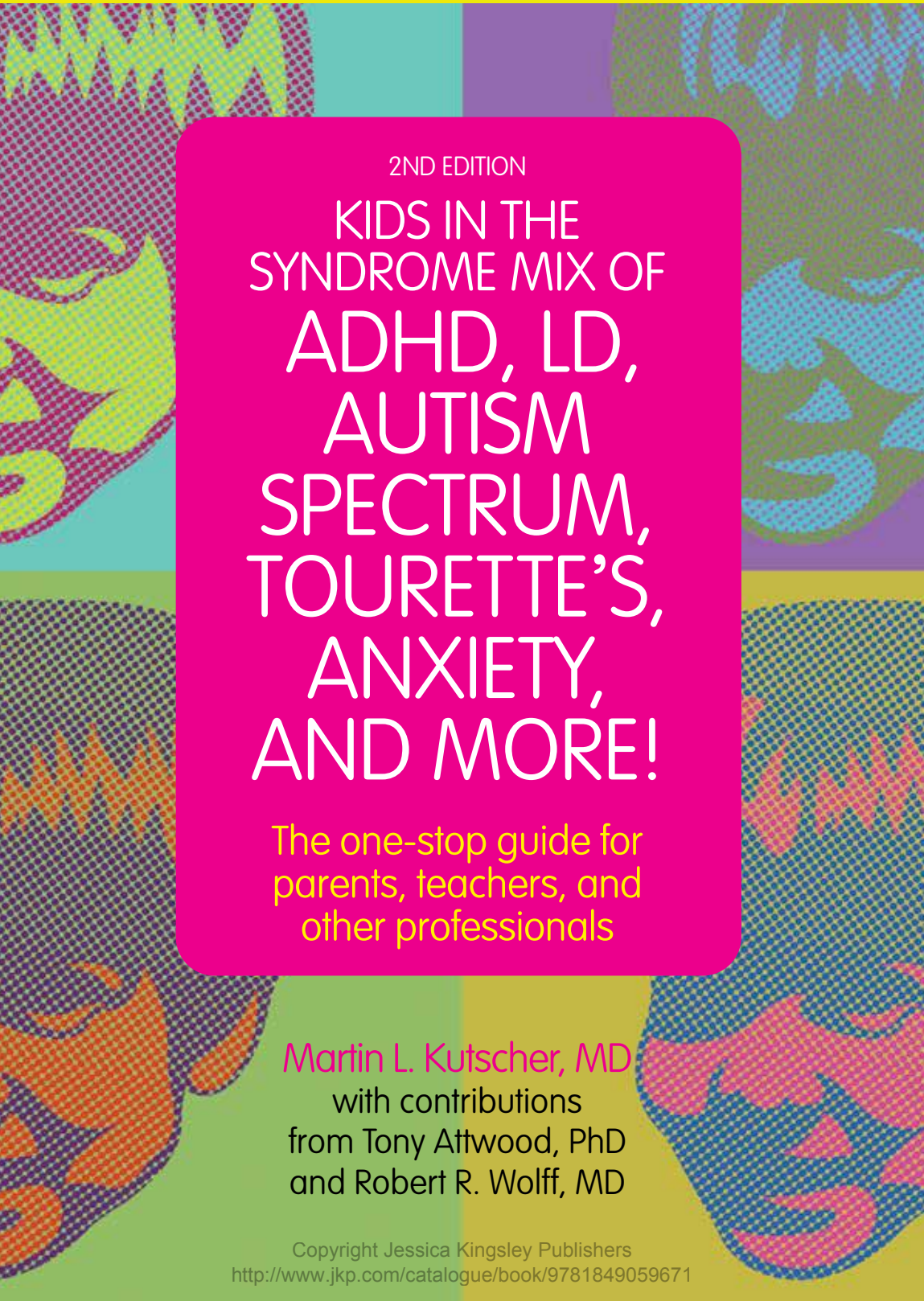

2ND EDITION

KIDS IN THE SYNDROME MIX OF ADHD, LD, AUTISM SPECTRUM, TOURETTE'S, ANXIETY, AND MORE!

The one-stop guide for parents, teachers, and other professionals

Martin L. Kutscher, MD
with contributions
from Tony Attwood, PhD
and Robert R. Wolff, MD

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DSM-5 and ASD

The old criteria of DSM-IV just weren't working out. Most importantly, scientific consensus has reached the conclusion that all of the different DSM-IV PDD disorders (except Rett's syndrome, which never should have been put in a psychiatric classification, anyway) were all manifestations of a single disorder with varying degrees of severity in the areas of social communication and restricted/repetitive behaviors. Thus, in DSM-5, all of the variants discussed above have been placed into a single condition entitled "Autism Spectrum Disorder."

DSM-5 criteria for ASD

Two basic criteria need to be fulfilled in the new DSM-5 criteria for ASD: problems in the area of social communication; and problems with repetitive, narrow, restricted, or odd behaviors or interests.

1. *Problems with social interaction and social communication* are delineated into three closely related areas, simplified as follows.

    a. *Problems with social and emotional reciprocity*, i.e., the ability, "to engage with others and share thoughts and feelings" in a back-and-forth fashion (APA 2013, p.53).

    b. *Problems with the non-verbal communication skills* required for the ability to carry out those social interactions. These diminished skills include body language, eye contact, and other non-verbal skills (such as comprehending subtext or hidden messages).

    c. *Problems with understanding, forming, and sustaining relationships*, ranging from trouble figuring out how to

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act in different social settings, to shared pretend play, to lack of urge to form bonds.

2. *Narrow, repetitive range of interests or behaviors* (at least two of the following):

    a. *Stereotypical or repeated behaviors*, such as flapping, use of repetitive phrases, echoing back what was just said, or lining up objects.

    b. *Inflexible need for sameness or routine*, such as becoming unraveled if the bus takes a different route to school today.

    c. *Unusually deep fascination with topics or objects*, such as memorizing the New York City subway map, or knowing everything about insects, or fixation with unusual objects, such as carrying around a spoon.

    d. *Increased and/or decreased sensitivity to stimuli*, such as fascination with spinning objects, sniffing objects, or avoidance/seeking of certain tastes or textures or other sensations. (This sounds awfully like sensory integration dysfunction. See Chapter 8.)

Once again, there are the usual qualifiers: the symptoms must begin (although not necessarily be recognized) in early childhood, must interfere with the quality of life, and must not be better explained by something else.

Although many people have been distressed that DSM-5 lumps everything together under the single ASD umbrella, it actually allows a number of "specifiers" that indeed allow for a better description of an individual on the spectrum—certainly better than the old non-specific term PDD-NOS. These include specifiers as follows:

- *Each of the two main categories above—social communication and restricted/repetitive behaviors—are each rated independently as either: Level 1 ("requiring support"), Level 2 ("requiring substantial support"), or Level 3 ("requiring very*

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substantial support"). Note that "the descriptive severity categories should not be used to determine eligibility for and provision of services; these can only be developed at an individual level and through discussion of personal priorities and targets" (APA 2013, p.51).

- *With or without accompanying intellectual impairment* (give brief description of level).
- *With or without accompanying language impairment* (give brief description of level).
- *Specify if an associated neurobehavioral disorder exists* (such as ADHD, Tourette's, etc.).
- *Specify if associated with a known medical/genetic condition* (such as Rett's syndrome or epilepsy).

See Chapter 6 for additional discussion of DSM-5 naming conventions regarding the ASDs—particularly regarding Asperger's syndrome.

Social (pragmatic) communication disorder

To meet DSM-5 criteria for autism communication disorder, a child must meet both criteria above of social communication and restricted/repetitive behaviors. If the person meets criteria for the socialization criteria above, but there is no evidence (now or from past history) of the narrow/repetitive criteria, then the correct diagnosis would probably be the newly created "Social (Pragmatic) Communication Disorder."

Simplified criteria from DSM-5 include all of the following problems in the social use of verbal and non-verbal communication.

- Using communication for social ends.
- Matching communication style to the needs of the listener (e.g., speaking differently to a child versus an adult).

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- Following the rules of give-and-take conversation and of narrating a story.
- Deducing what isn't explicitly said, such as inference and subtext.

Importantly, note that this social (pragmatic) communication disorder does not even mention trouble with the *urge* to socialize. In fact, DSM-5 places this disorder under the heading of "Communication Disorders" and is not in the ASD section. These are the kids who have the urge, but not the ability, to fit in socially (and, to repeat, never had the problem with restricted/repetitive behaviors). The condition is not usually diagnosable until the child is four to five years of age, but may not be apparent until early adolescence.

Notice that DSM-5 now actually makes clear that "communication" is a means to the end of "socialization" in both ASD and social communication disorder.

Treatment of ASD

The treatment of the less severe form of ASD is discussed in depth in Dr. Attwood's following chapter. More severely affected children require more intensive treatment. General rules of intensive treatment include the following (Myers 2007):

- Start as early as the diagnosis is seriously considered.
- Carry out the treatment for 25 hours per week for 12 months/year.
- The treatment should be of long duration (years).
- It should utilize a great deal of 1:1 attention.
- It should include a parent training component.
- It should utilize close, specific monitoring of progress.

These principles apply to such programs as Applied Behavioral Analysis (ABA), where the rewards that motivate the child are

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analyzed and then applied in discrete educational trials to teach one small behavior or skill after another. A recent meta-analysis of the literature of ABA programs found a dose-related response on both language and adaptive skills with respect to hours/week and duration in months or years (Maglione *et al*. 2012), i.e., the more, the better. Further information on these treatments can be found at www.nationalautismcenter.org/learning/parent_manual.php or in the Further Reading section of this book.

Also, we must be sure to look for other associated conditions of the syndrome mix, as around 70% of people on the autism spectrum have one other mental disorder, and 40% have two or more (APA 2013, p.58). Precautions against a spectrum child's wandering or running away (with all of the risks including drowning) can be found at www.awaare.org. See Chapter 14 for information on medical and complementary treatments.

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