Richard Woods @Richard_Autism

Sep 26 · 36 tweets · Richard_Autism/status/1574526228945461250

If you want an idea of how stress/ mental distress is present autistic people as a demographic are under. Worth considering looking at DSM-5 Cross-Cutting Symptom Measure & reflecting upon how a typical autistic person would score on it. Link to it below: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Level-1-Measure-Adult.pdf

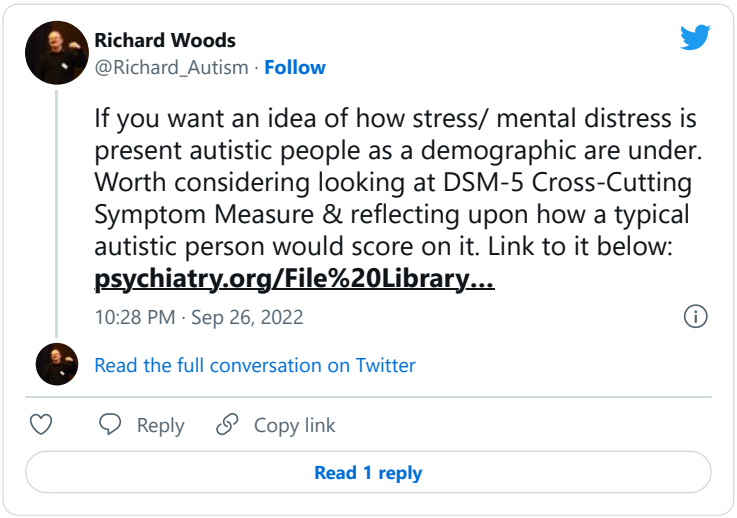
The DSM-5 Cross-Cutting Symptom Measure tool was created as features of human distress typically are heterogeneous spectrums, that most Disorders have features which are seen in other Disorders. So APA created transdiagnostic measures for adults & Children-young persons.

DSM-5 states that a transdiagnostic approach is needed for both clinical & research purposes. I wonder why (rhetorical)?

Looking at the child version of the Cross-Cutting Symptom Measure. I think how high many autistic CYP would score. Also just how CYP believed to have PDA should score highly on many of its items.

Link below to the caregiver rated version of the Cross-Cutting Symptom Measure: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Level-1-Measure-Parent-Or-Guardian-Of-Child-Age-6-to-17.pdf

Perhaps, might be better to reflect upon, how many autistic persons would likely score on the measure.



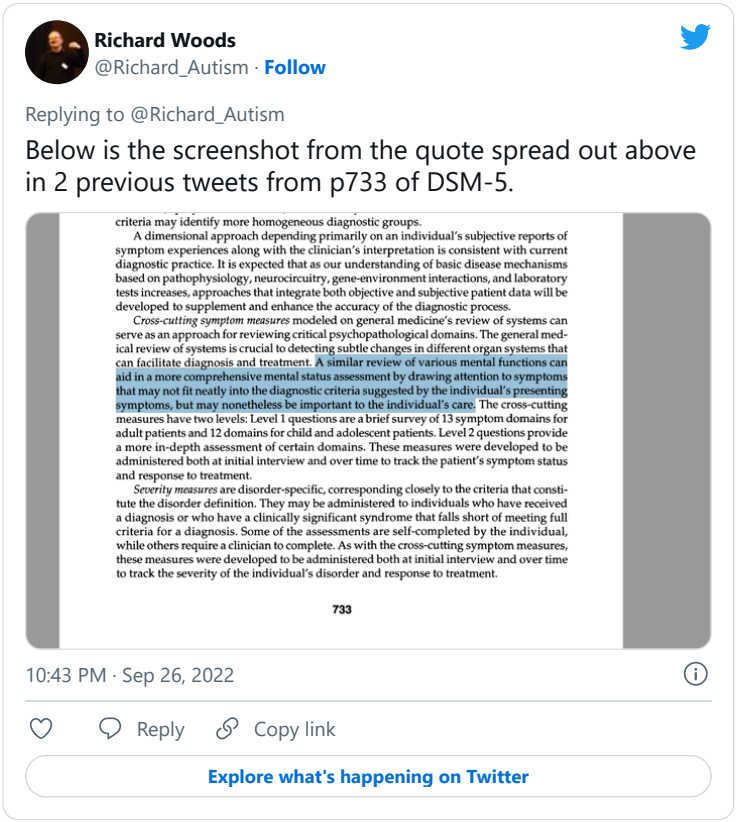
"A growing body of scientific evidence favors dimensional concepts in the diagnosis of mental disorders. The limitations of a categorical approach to diagnosis include the failure to find zones of rarity between diagnoses (i.e., delineation of mental disorders from one...

... another by natural boundaries), the need for intermediate categories like schizoaffective disorder, high rates of comorbidity, frequent not-otherwise specified (NOS) diagnoses, relative lack of utility in furthering the identification of unique antecedent validators for...

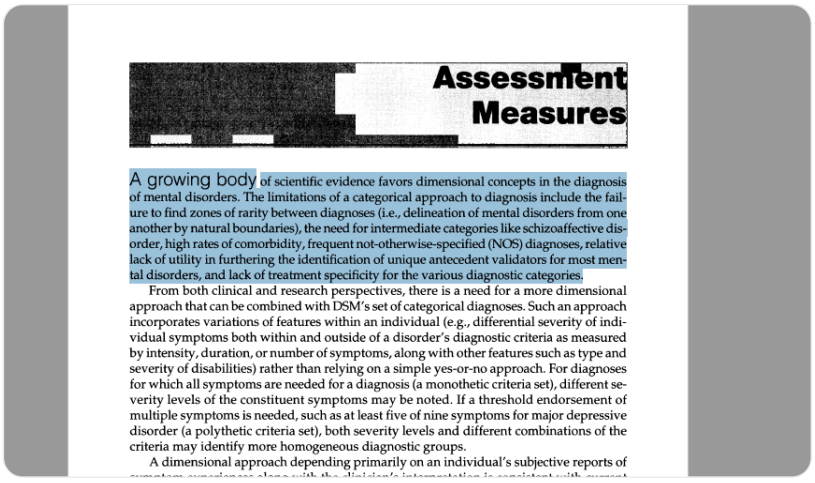
... most mental disorders, and lack of treatment specificity for the various diagnostic categories." APA 2013, p733.

"A similar review of various mental functions can aid in a more comprehensive mental status assessment by drawing attention to symptoms that may not fit neatly into the diagnostic criteria suggested by the individual's presenting symptoms,...

... but may nonetheless be important to the individual's care." APA 2013, p733.



Below is image of quoted paragraph mentioned in earlier tweets. Again from p733 of DSM-5.



I know say a lot stuff & frequently repeat it. There are good reasons why I when I do so.

This is an example, as I strongly recommend people read the front of the DSM-5 as there is a lot of important information in there. The book is clear about its limitations!

In this case the highlighted sections are quite clear about the problems with a category based diagnostic system DSM-5 presently uses. Including that APA needed to create transdiagnostic tools as using category based approach can fail assist to help people!

The point above is that ALL people have spikey profiles, so it is common for people to have characteristics which are NOT covered by a diagnosis based upon a categorical approach as used in DSM-5.

There are some important points in the first paragraph relating towards PDA.

"the failure to find zones of rarity between diagnoses (i.e., delineation of mental disorders from one another by natural boundaries), the need for intermediate categories" APA 2013, p733.

This means when constructed as a Disorder/ syndrome PDA should be a heterogeneous continuum, which overlaps many accepted Disorders & that is difficult (hard) to identify boundaries between PDA & accepted difficulties/ Disorders.

So this raises concerns about validity of some clinical reports surrounding PDA suggesting PDA can be easily distinguished, i.e., something else must explain those reports. I suspect confirmation bias would be a good candidate to explain that occurrence...

I would suggest more damning is this part:

"and lack of treatment specificity for the various diagnostic categories." APA 2013, p733.

I.e., treatment/ strategies generally are NOT diagnostic category specific. PDA should NOT have specific approaches/ strategies!

Why is this more damning Richard?

One of two main justifications for PDA's clinical need is that it has specific strategies/ approaches which are different to autism/ accepted difficulties-Disorders. Simultaneusly, some take a narrow approach to PDA, like "PDA Profile of ASD".

An example of this approach is this highly biased research report, which pretends to be clinical guidance, by the PDA Society.
https://www.pdasociety.org.uk/wp-content/uploads/2022/01/Identifying-Assessing-a-PDA-profile-Practice-Guidance.pdf

Many contest that PDA strategies should only be used with PDA, but instead they should be practiced much more broadly, especially with autistic persons (such arguments are part of debates contesting PDA's clinical need). I discuss this debate here:
https://www.researchgate.net/publication/337146735_Demand_avoidance_phenomena_circularity_integrity_and_validity_-a_commentary_on_the_2018_National_Autistic_Society_PDA_Conference

The point is that it is atypical clinical practice to suggest that PDA has specific strategies/ approaches compared to other autistic persons, let alone with accepted difficulties-Disorders. As strategies/ treatment tends to be issues-problem specific.

Strategies/ treatment being tied to specific issues-problems explains why there is a lack of specific "treatment specificity", is because most Disorders have features that overlap many other Disorders. I.e., Disorders continua nature leads to lack of "treatment specificity".

What does this matter for PDA?

That is one wants PDA to comply with existing clinical practice & associate PDA with certain strategies; PDA would need to be constructed into a broad continua to be inclusive of many persons, to ensure they also received PDA strategies.

PDA can easily be constructed to be broad & inclusive of many persons, as I suggest here:

https://www.youtube.com/embed/7cCYoHV4Ii8

I would also say this inclusive approach is already happening by some clinicians. I am specifically referring to those PDA Society & others consider to be over identifying PDA...

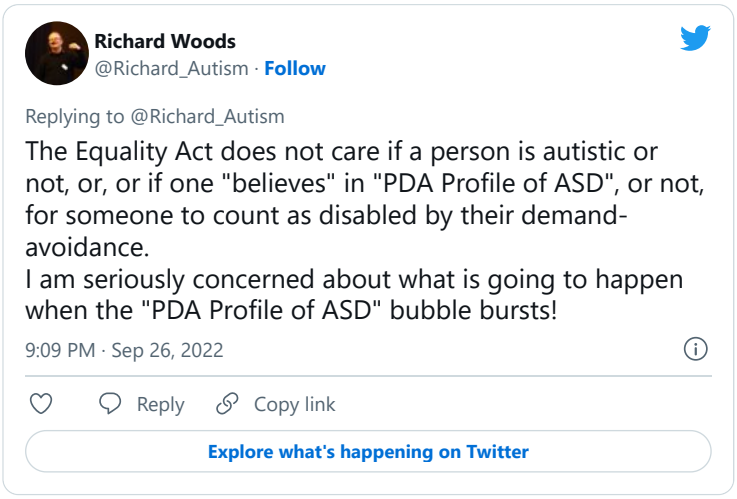
"Equally contributors have noted that, with increased awareness, there has been some over-identification by other practitioners." PDA Society 2022, p1.

There are examples of non-autistic persons with PDA in PDA literature & non-pervasive PDA diagnoses too. So it is possible to construct &/ or diagnose PDA in a broad inclusive manner (I can provide examples if needed).

So do not let PDA Society & others tell you otherwise.

Richard you are waffling again, why does a broad inclusive approach to PDA matter?

The below tweet is why.



There are many reasons why I take a broad-inclusive approach to PDA, a key factor is for legal reasons. I am not silly enough to discriminate against non-autistic persons with PDA, or those who do not believe "PDA Profile of ASD" by prioritising proponents of "PDA Profile of ASD"

This is a tangent. I did not intend for this thread to be about me critiquing "PDA Profile of ASD" again. I apologise for that.

I think it is important to consider distress &/ or stress levels many autistic persons are commonly experiencing. I suggest Cross-Cutting Symptom Measure by the APA might be useful way to highlight that.

@threadreaderapp please could you unroll?

Thank you in advance.

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