



INFORMATION PAPER:

THE PROPOSED CHANGES TO THE DIAGNOSTIC CRITERIA FOR AUTISM SPECTRUM DISORDERS (DSM-5)

What is the DSM-5?

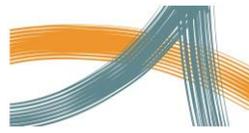
The *Diagnostic and Statistical Manual of Mental Disorders* (the DSM) is developed by the American Psychiatric Association, in order to provide the criteria by which clinicians define and diagnose various psychiatric and developmental conditions, including autism spectrum disorders. Currently, diagnoses are guided by the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition, Text Revision* (DSM-IV-TR)^[1]. In May 2013, the *Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition* (DSM-5) is due for release. With each edition of the DSM, diagnostic criteria are refined according to current research findings. At the present time, the DSM-5 criteria for conditions on the autism spectrum are in the final stages of field trials.

As yet, there are no biological tests (e.g., genetic tests, brain scans) that can be used to reliably diagnose conditions on the autism spectrum. Diagnosis is therefore made on the basis of a set of behavioural symptoms. Our understanding of conditions on the autism spectrum have continued to evolve since they were first recognised by Leo Kanner in 1943^[2] and Hans Asperger in 1944^[3].

What are the proposed changes for autism spectrum disorders in DSM-5?

There are a number of proposed changes, most notably:

- The diagnostic labels: *Autistic Disorder*, *Asperger's Disorder*, *PDD-NOS* and *Childhood Disintegrative Disorder* will no longer be used, as these current subcategories will be merged into the broader diagnostic category of *Autism Spectrum Disorders* (ASD). Rett Syndrome will now no longer be included as part of the autism spectrum.
- The domains of impairment will be reduced from three areas of impairment to two. In the DSM-IV, there were three domains: (1) *Qualitative impairment in social interaction* (2) *Qualitative impairments in communication*, and (3) *Restricted, repetitive and stereotyped patterns of behaviour, interests, and activities*. In the



DSM-5, the social and communication domains will be collapsed into one domain (*Social Communication*). *Restricted, repetitive patterns of behaviours, interests and activities* will remain in the DSM 5 and represents the second domain of impairment.

- Where the DSM-IV did not include atypical sensory processing issues, the DSM-5 includes *Hyper- or hypo-reactivity to sensory input or unusual sensory interests* under the domain *Restricted, repetitive patterns of behaviours, interests and activities*.
- In order to meet criteria for an ASD under DSM-5, the individual must satisfy all three of the *Social Communication* criteria and at least two of the four criteria listed under *Restricted and Repetitive Behaviours* (i.e., a minimum of five out of the seven possible criteria). In contrast, a DSM-IV-TR diagnosis of Autistic Disorder required the person to meet a total of 6 criteria across the three domains of impairment including at least two from the social interaction area, one from the communication area and one from restricted interests and repetitive behaviours. A diagnosis of Asperger's Disorder was considered once Autistic Disorder was ruled out, requiring that the person satisfy at least two social interaction criteria and at least one of the Restricted Interests and Repetitive Behaviour criteria. The DSM-IV-TR requirement for PDD-NOS had no minimum symptom requirement, specifying only evidence of severe social impairment accompanied by either communication impairment or restricted and repetitive behaviours. The DSM-5 therefore allows fewer combinations of criteria to be used in order to achieve a diagnosis (see Appendix A for proposed revision, as publicised in 2012).
- DSM-5 requires that a severity rating be applied for each individual diagnosed with ASD. There will be a severity rating for both domains of impairment ranging from '*Level 1: Requiring Support*' to '*Level 3: Requiring Substantial Support*' (see Appendix B for description of severity rating, as publicised in 2012).
- Clinicians will be able to add specifiers in regards to cognitive skills (with or without intellectual disability) and co-morbidities (e.g., ADHD, anxiety disorder, specific language disorder) to allow for a more comprehensive description of an individual's presentation. While the DSM-IV-TR recommended against co-morbid diagnoses such as ADHD, this will be possible in the DSM-5. Together with the severity rating, these specifiers will provide a clearer picture of the strengths and problems of each



individual. For example, it will be clear that an individual with a diagnosis of ASD, Level 3 Severity in both *Social Communication* and *Restricted and Repetitive Behaviours* and co-morbid moderate-to-severe intellectual disability will present very differently and have different support needs to someone with a diagnosis of ASD, Level 1 Severity in both *Social Communication* and *Restricted and Repetitive Behaviours*, without intellectual disability and co-morbid anxiety disorder. The severity ratings may also be able to demonstrate improvement over time in an individual's functioning.

- The DSM-5 makes reference to the impact of a diagnosis on everyday function (*'Symptoms together limit and impair everyday functioning'*). This was not explicitly stated in the DSM-IV-TR criteria for Autistic Disorder, although the criteria for Asperger's Disorder stated that *'the disturbance causes clinical significant impairment is social, occupational, or other important areas of functioning'*.

What is the rationale behind the proposed changes?

The following rationales have been provided by the American Psychiatric Association^[1]:

- **Moving to a single diagnostic category:**

Differentiation of ASD from typical development and other 'non-spectrum' disorders can be done reliably and with validity. However, distinctions among disorders on the autism spectrum have been found to be inconsistent over time, variable across sites and often associated with severity, language level or intelligence rather than features of the disorder. Because autism is defined by a common set of behaviours, it is best represented as a single diagnostic category that is adapted to the individual's clinical presentation by inclusion of clinical specifiers (e.g., severity, verbal abilities and others) and associated features (e.g., known genetic disorders, epilepsy, intellectual disability and others). Research comparing children diagnosed with Asperger's Disorder and children diagnosed with high-functioning Autistic Disorder have failed to find any consistent differences between these two autism 'subtypes' in terms of potential causes, responses to intervention, and outcomes in adulthood.



Moving from three domains to two domains:

Deficits in communication and social behaviours are inseparable and more accurately considered as a single set of symptoms with contextual and environmental specificities. Delays in language are neither unique nor universal in ASD and are more accurately considered as a factor that influences the clinical symptoms of ASD, rather than defining the ASD diagnosis. Requiring both criteria to be completely fulfilled improves specificity of diagnosis without impairing sensitivity.

- **Inclusion of sensory symptoms**

Consistent findings of atypical sensory responses among people with ASD have led to the inclusion of sensory symptoms in the DSM-5^[4].

Controversies in regards to the proposed changes and implications for diagnostic outcomes

The proposed revision for the diagnostic criteria for ASD has created some controversy in recent times, particularly in relation to the possibility that some individuals who currently meet criteria under the DSM-IV-TR may no longer meet criteria under the proposed DSM-5. This is of concern to many families, because in Australia a clinical diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS currently qualifies a family for governmental assistance. These diagnoses are also currently often required for children to be eligible for additional support at school, although eligibility requirements vary between educational systems in different states. A number of studies^[5-10] have found that a significant proportion (estimates of ranging from 23 to 56%) of individuals diagnosed with high functioning ASD under DSM-IV-TR would not meet criteria under the proposed DSM-5. These findings would therefore indicate that DSM-5 may reduce the number of children who can be diagnosed with an ASD in the future. In contrast, a recent large study^[11] found that DSM-5 criteria identified 91% of children with a clinical DSM-IV diagnosis.

Some research suggests that individuals who are currently diagnosed with PDD-NOS are unlikely to qualify for a diagnosis under the DSM-5, as 97% of them have impairments in social reciprocity and communication, but do not have significant repetitive and stereotyped behaviours^[12]. These individuals are likely meet criteria for a new diagnosis in DSM-5 of



'*Social Communication Disorder*', which is conceptualised as a communication disorder characterised by impairments in pragmatics. However, there are currently no policies regarding the eligibility of children diagnosed with *Social Communication Disorder* for funding and support.

The proposed elimination of the diagnostic category of Asperger's Disorder is also a source of concern for many individuals in the community who are currently diagnosed with Asperger's Syndrome, as they feel that they are losing their identity. For some, this diagnosis is a source of pride.

While the full implications of the changing diagnostic criteria remain unclear, the need for a comprehensive assessment in order to describe all components of the proposed DSM-5 classification is patently clear. Diagnostic assessments should involve multiple sources of information including clinical observation, and information from parents, teachers and other professionals involved with the child.

As the exact wording of the DSM-5 diagnostic criteria for ASD will not be revealed until it is officially released in May, 2013, the full repercussions of this change in diagnostic criteria are as yet unknown.



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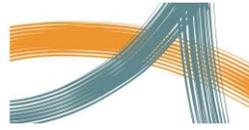


APPENDIX A: PROPOSED DSM-V REVISION

Autism Spectrum Disorder

Must meet criteria A, B, C, and D:

- A. Persistent deficits in social communication and social interaction across contexts, not accounted for by general developmental delays, and manifest by all 3 of the following:
 1. Deficits in social-emotional reciprocity; ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interaction,
 2. Deficits in nonverbal communicative behaviours used for social interaction; ranging from poorly integrated- verbal and nonverbal communication, through abnormalities in eye contact and body-language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures.
 3. Deficits in developing and maintaining relationships, appropriate to developmental level (beyond those with caregivers); ranging from difficulties adjusting behaviour to suit different social contexts through difficulties in sharing imaginative play and in making friends to an apparent absence of interest in people
- B. Restricted, repetitive patterns of behaviour, interests, or activities as manifested by at least two of the following:
 1. Stereotyped or repetitive speech, motor movements, or use of objects; (such as simple motor stereotypies, echolalia, repetitive use of objects, or idiosyncratic phrases).
 2. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behaviour, or excessive resistance to change; (such as motoric rituals, insistence on same route or food, repetitive questioning or extreme distress at small changes).
 3. Highly restricted, fixated interests that are abnormal in intensity or focus; (such as strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
 4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment; (such as apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects).
- C. Symptoms must be present in early childhood (but may not become fully manifest until social demands exceed limited capacities).
- D. Symptoms together limit and impair everyday functioning.



APPENDIX B: SEVERITY RATING

Level 3 'Requiring very substantial support'

- Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others.
- Preoccupations, fixated rituals and/or repetitive behaviours markedly interfere with functioning in all spheres. Marked distress when rituals or routines are interrupted; very difficult to redirect from fixated interest or returns to it quickly.

Level 2 'Requiring substantial support'

- Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others.
- Restricted and repetitive behaviours and/or preoccupations 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 restricted and repetitive behaviours are interrupted; difficult to redirect from fixated interest.

Level 1 'Requiring support'

- 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.
- Rituals and repetitive behaviours cause significant interference with functioning in one or more contexts. Resists attempts by others to interrupt restricted and repetitive behaviours or to be redirected from fixated interest.