
# DSM-5 Autism Spectrum Disorder

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## Why a new classification?

Over the past two decades the criteria for making a diagnosis of a child with a condition such as autism have been agreed to internationally in both the International Classification of diseases 10th edition (ICD 10) of the WHO and the Diagnostic and Statistical Manual 4th edition (DSM-IV) of the American Psychiatric Association (APA). They both specified a group of similar but separate conditions called Pervasive Developmental Disorders comprising in DSM-IV: Autistic Disorder, Asperger's Disorder, Rett's Syndrome, Childhood Disintegrative Disorder, and PDD-Not Otherwise Specified (NOS) or Atypical autism. The cause(s) of only Rett's Syndrome, a genetic disorder, is known. For some 12 years the APA has been conducting an extensive review of the DSM with the aim in part to align diagnoses with research evidence and neurobiological causes, to provide a measure of severity, to include a lifespan developmental perspective, to eliminate if possible NOS categories, to have continuity, if possible with existing criteria, and to add specifiers which describe associated elements of an individual's presentation to guide management. The multidisciplinary review that produced the DSM-5 received thousands of submissions, took into account gender and cultural considerations and has invited controversy and debate.

In 2013, the DSM 5 deleted PDDs and created a new Neurodevelopmental Disorders, Autism Spectrum Disorder (ASD) classification. This is welcome as it defines the term ASD which has been in use for a number of years without any international agreement on its definition. The new disorder requires: (A) Persistent (and pervasive) deficits in social communication and social interaction manifest by deficits in 1.Social-emotional reciprocity, 2.non-verbal communication, and 3. Developing, maintaining, and understanding relationships; and (B) Restricted, repetitive patterns of behaviour, interests, or activities in at least two of 1.Repetitive motor movements, use of objects, or speech, 2.Insistence on sameness, routines or rituals in verbal or non-verbal behaviour, 3. Restricted, repetitive patterns of behaviour or intensely focused interests and preoccupations, 4. (New criterion) Hyper/hypo-reactivity to sensation. This new addition of sensory sensitivity will need to be tested for reliability and validity; and (C) the symptoms must be present from early childhood although may become more apparent with increasing

social demand; and (D) everyday functioning must be impaired; and (E) the presentation is not better explained by Intellectual Disability alone.

**Measuring severity**

The DSM-5 only has one axis but attempts to compensate for the loss of the four other axes of the DSM-IV which create a diagnostic formulation relevant to planning treatment, by requiring the specification of severity for each of category A and B and suggesting the use of other "specifiers". There are three levels of severity: requiring "very substantial support", or "substantial support", or "support". Although there are brief descriptions of each level, the reliability and validity of these levels require testing. DSM-5 also emphasises that these levels should not be used to assess eligibility for services.

**What are the consequences of the DSM-5 ASD category for individuals, families and service delivery?**

Clinicians have already started to use the DSM-5. The ICD-10 also continues to be used, for example in Victorian Child and Adolescent Mental Health Services (CAMHS). Therefore a newly diagnosed child might have both an ICD-10 and a DSM-5 diagnosis of, for example, Asperger's Disorder and an ASD. According to the DSM-5 those who already have a DSM-IV diagnosis should be relabeled with an ASD but services that have a requirement for regular review may require a reassessment according to DSM-5. Individuals who have developed their identity and adjusted to having Asperger's Disorder or High Functioning Autism may be confused and troubled by these changes and we do not know yet how this will work out for them and their families.

Some research indicates that probably about 10-15% of children who would be diagnosed with DSM-IV Autistic disorder or more probably Asperger's Disorder or PDD-NOS will not meet DSM-5 criteria for an ASD. Worley et al (2012) reported that children and adolescents on the autism spectrum decreased by 32.3% of DSM-5 criteria. McPartland et al. 2012 stated:

"Proposed *DSM-5* criteria could substantially alter the composition of the autism spectrum. Revised criteria improve specificity but exclude a substantial portion of cognitively able individuals and those with ASDs other than autistic disorder. A more stringent diagnostic rubric holds significant public health ramifications regarding service eligibility and compatibility of historical and future research" (p 368).

It is likely that criteria for the new diagnosis of Social Communication Disorder (SCD) will include some children who previously did not have a DSM-IV diagnosis but had significant problems in their social communication. SCD requires research and follow-up study to determine its reliability, validity and clinical utility. There will also be some children, particularly girls, who have some social understanding and empathy but have difficulties with rigid and repetitive behaviour and may or may not have some language problems who would have been diagnosed with Asperger's Disorder, Atypical Autism (ICD-10) or PDD-NOS (DSM-IV). They will probably not meet criteria for a DSM-5 diagnosis even though their difficulties are significant.

**References:**

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