The new Autism Spectrum Disorder (ASD) Diagnostic Criteria as defined by the DSM-V

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There have been lots of discussions and debates over the change in the diagnostic criteria for ASD since May 2013. The new criteria has made some changes in the way clinicians will refer to ASD. The biggest change along with the new criteria is that the well-known labels of Asperger Syndrome (AS) and Pervasive Developmental Disorders- Not Otherwise Specified (PDD-NOS) are no longer present. It is however, suggested that individuals who have or would have received a diagnosis of AS or PDD-NOS, will now be recognized under a broader category of Autism Spectrum Disorders.

Following the new criteria, many families felt that they were concerned over their funding. Researchers suggested that we may have less individuals diagnosed with an ASD, as individuals who did not have many Restricted and Repetitive Behaviors (RRBs) would now have a new diagnosis of Social Communication Disorders, instead of ASD.

This article is written for all of us to understand this debate and what it means to us as parents, professionals and diagnosed individuals. This article will take us through various steps- firstly we will look at the new diagnostic criteria as it is defined in the DSM-V, the exact wording and what it means, we will then look at what we know about Social Communication Disorder, further we will compare this with the DSM-IV-TR criteria, and finally discuss what these changes suggest and some references to understand the common debates.

The new criteria as defined in the DSM-V:


Diagnostic Criteria

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:
1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history:

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).

4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Specify if:

With or without accompanying intellectual impairment
With or without accompanying language impairment
Associated with a known medical or genetic condition or environmental factor
(Coding note: Use additional code to identify the associated medical or genetic condition.)
Associated with another neurodevelopmental, mental, or behavioral disorder
(Coding note: Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)
With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119-120, for definition) (Coding note: Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table).

Severity levels for autism spectrum disorder as defined by the new criteria:

<table>
<thead>
<tr>
<th>Severity level</th>
<th>Social communication</th>
<th>Restricted, repetitive behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3</td>
<td>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. For example, a person with few...</td>
<td>Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.</td>
</tr>
<tr>
<td>&quot;Requiring very...&quot;</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

(Coding note: Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)
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

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 responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.

Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Level 1

Without supports in place, deficits in social communication cause noticeable impairments. 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-and-fro conversation with others fails, and whose

Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.
attempts to make friends are odd and typically unsuccessful.

Social (Pragmatic) Communication Disorder 315.39 (F80.89)

Diagnostic Criteria

A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following:

1. Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.

2. Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on the playground, talking differently to a child than to an adult, and avoiding use of overly formal language.

3. Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction.

4. Difficulties understanding what is not explicitly stated (e.g., making inferences) and nonliteral or ambiguous meanings of language (e.g., idioms, humor, metaphors, multiple meanings that depend on the context for interpretation).

B. The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.

C. The onset of the symptoms is in the early developmental period (but deficits may not become fully manifest until social communication demands exceed limited capacities).

D. The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains of word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability (intellectual developmental disorder), global developmental delay, or another mental disorder.

What and why were the changes made in comparison with DSM-IV?
Firstly, the DSM-IV defined ASD as a Pervasive Developmental Disorder with impairments in three domains, mainly, Social Interaction, Communication and presence of Restricted and Repetitive Behaviours and Interests (RRBI). DSM-V has collapsed them into two domains with Social Interaction and Communication as one and RRBI is the second one. It was found that there were clinical inconsistencies in using the DSM-IV criteria, as this was used to diagnose Autistic Disorder, ASD, AS, PDD-NOS and also to some extent the same criteria were applied for Childhood Disintegrative Disorder. With the overlap in features as well as diagnosis, it was found that there were clinical inconsistencies in different set-ups to diagnose these labels separately. Hence, this change in the new criteria was created only to narrow down the diagnosis under one umbrella of Autism Spectrum Disorders and maintain that consistency in clinical settings. The APA suggests that this has enabled a consistent use of the diagnostic criteria. Also, the introduction of severity levels in DSM-V were thought to help clinicians identify the level of the individual’s functioning appropriately, avoiding more labels like High Functioning Autism, Classical Autism etc.

In addition to the single diagnosis the DSM-V now has included sensory impairments in the RRBI- these, though common in ASD, were not mentioned in the DSM-IV. It is believed that this will make the new criteria more sensitive in identifying the complex ASD cases and even identifying more females- who are believed to have more sensory issues than males.

The DSM-V also specifies that symptoms have to be present from early age, this has made the criteria more applicable for younger cohorts, who otherwise would have been diagnosed at a later age. This has also meant that clinicians are now confident in using the diagnostic criteria on younger children (Baron-Cohen, 2013). The studies looking at the early autism phenotype (Barbaro & Dissnayake, 2013; Rogers, 2009; Zwaigenbaum et al., 2009) have shown that ASD can be diagnosed as early as in the first year of life, and this new diagnostic criteria will enable the formal early diagnosis. This is specifically more useful for the high-risk sibling group and also to access early intervention.

Fears created by the new criteria? Should parents/diagnosed individuals be worried?

Following the introduction of this new criteria, people with an AS and PDD-NOS diagnosis, feared they might lose their diagnostic status. Some researchers also claimed that the new criteria were not sensitive to diagnose the more high functioning individuals (McPartland, Reichow & Volkmar, 2012) and parents in many support groups feared that they may lose their diagnosis and hence the funding. It is suggested that the already diagnosed individuals can retain their diagnosis and continue to be recognised as they were e.g. Aspies will still be able to retain their Aspie label. Diagnostically, however, they will now fall under the umbrella
of an Autism Spectrum Disorder. So not much has changed for this group, except that they

The individuals who would have (from 2013 onwards) met criteria for an AS, will now be under the broader ASD diagnosis. Others, who would not have as many RRBIs will now receive a new diagnosis of Social Communication Disorder and not ASD. It is also suggested that most children who were diagnosed with PDD-NOS under the DSM-IV will remain eligible for an ASD diagnosis under the new criteria (Heurta, Bishop, Duncan & Lord, 2012).

The new criteria was feared to reduce the ASD prevalence rate, however, the recent estimates suggest the opposite with 1 in every 68 children being affected with ASD in 2014 as of 1 in 100 in 2007 (CDC, 2014). Whether this is because of the new criteria being more sensitive in diagnosing the less severe ASD individuals, more females and children at a younger age, is still not clearly understood.

There is still more research to be done to examine the new criteria and understand it fully in the coming years. For parents, it does not change their ASD child/ young person, they will still continue to love and raise them despite the changes in labels. For professionals, the work around providing a better quality of life for these individuals still remains the same, the changes in the diagnostic criteria only clarifies the severity of the ASD and the associated impairments to provide a better service and an overall better professional outcome.

Thank you

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References:

http://raisingchildren.net.au/articles/dsm-5_changes_to_autism_diagnosis.html

http://www.autismspeaks.org/what-autism/diagnosis/dsm-5-diagnostic-criteria


