

Autism Spectrum Disorders: Implications from the changes in DSM-V

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The Diagnostic and Statistical Manual of Mental Disorders Volume 5 DSM-5 was released in May 2013, and with it came some significant changes to the conditions formerly classed as pervasive developmental disorders. Most notably, the diagnosis of Autism Spectrum Disorder (ASD) was formally recognised in the DSM for the first time (finally catching up to clinical practice in the field, which has long recognised and used this terminology descriptively). The 'new' ASD is an umbrella diagnosis that subsumes the former classifications of Asperger's disorder/syndrome and Autistic disorder/childhood Autism, as well as the very clunky "Pervasive Developmental Disorder Not Otherwise Specified" (PDDNOS). Childhood Disintegrative Disorder is retained under the Autism spectrum umbrella, while Retts Syndrome is no longer considered a part of this cluster of disorders. So far, so straight forward – the general consensus was that such changes made good sense, and basically just brought the manual in line with clinical practice.

However, in addition to changing the terminology (ie essentially replacing PDD with ASD), the DSM-5 also introduced some criterion changes that subtly but significantly (arguably) alter the construct of the disorder – by changing the combinations and thresholds of clinical features required to make a diagnosis.

One of these changes was the collapsing of the 'triad of impairments' to a dyad; that is, the previous notion of distinct social deficits, separate to communication deficits, has been replaced by the collective "persistent deficits in social communication and social interaction". Again, the murmurings amongst clinicians on this count seem pretty favourable– if you've ever tried to form a social relationship with someone without communicating with them (verbally or non-verbally) in some way, or if you can imagine any scenario where you might purposefully plan to 'communicate' something to nobody – then you should make your case! – because otherwise it seems evident that 'social interaction' and 'communication' are pretty inextricably intertwined. As an aside, in the DSM-V, any degree of *language* impairment has become a separately coded 'specifier' (where previously it constituted one of several possible examples of a core communication impairment) – which is a further nod to the differentiation of language as a *means of*, rather than as *being*, communication.

Another significant change to the criteria is the relaxing of

the age-of-onset criteria (which previously for Autistic Disorder was 3 years), and the option for the behavioural criteria to be met on history (rather than necessarily currently manifest)

Probably most controversial of the changes are the alterations to the 'pick-and-mix' equations that existed in DSM-IV; where individuals were required to have "at least two" from category A (social) + "at least 1" from category B (communication) + "at least 1" from category C (restricted and repetitive interests/behaviours) for a total of "at least 6" altogether to diagnose Autism (and at least 2 from 'A' and 1 from 'B' for Aspergers). This resulted in a myriad of possible combinations of symptoms. Rather, the DSM-V requires ALL of the social-communication deficits to be present, for that criterion to be met. In addition, individuals must present with AT LEAST 2 features from the restricted and repetitive interests and behaviours section to meet that

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criterion. And this is where things have started to get contentious, because in refining the definition to mandate restricted and repetitive interests be present, and to further require that there be evidence of at least 2 qualitatively separate components to how this presents (e.g. an insistence on sameness AND presence of stereotypic motor movements would meet criteria, but an insistence on sameness and ritualised patterns of behaviour would not), there emerge a significant number of individuals who would meet DSM-IV criteria for PDDNOS (and an even a smaller but existent number who would meet criteria for Asperger's or Autistic Disorder), but who do not classify as presenting on the Autism spectrum when considered in terms of the DSM-5 criteria. To capture this group, the DSM-5 also saw creation of a new condition, Social (Pragmatic) Communication Disorder (SCD), which is classified as a language disorder, rather than part of the Autism spectrum.

Those in favour (the purists?) would argue that these changes make sense; that they don't truly alter the underlying

ing construct of the Autism spectrum, they just define it better (ie those who would no longer meet criteria were always on the cusp, and perhaps were given a technical diagnosis when in practice they probably never 'really' presented with the triad/dyad of impairments that constitute Autism). For example, individuals diagnosed with PDDNOS who have never had any restricted or repetitive interests or behaviours.

Those at the coalface of supporting children and their families (and/or those who are just more practically minded) may also recognise, though, that the functional value of a diagnosis is mostly about access to and guidance around what constitutes the best intervention and care. Most families I can think of would be less concerned whether it's called Autism Spectrum or Aspergers, and more interested in how to help their loved ones achieve the best possible outcomes. And when a diagnosis of ASD opens doors to funding and intervention services, but a diagnosis of Social Communication Disorder offers pretty much nothing (the current state of play); there can be no question of 'subtlety' in the re-drawing of the diagnostic boundary that has taken place – the impacts are potentially chasmic. Though it is important to emphasize that this is neither a stipulation nor an intention of the DSM-5; it is a product of how governments and other service providers have opted to interpret and respond to the new diagnostic criteria. The other group that may potentially fall-through the cracks with the revised criteria are those very young children whose full range of symptoms have not yet emerged. In the past, these children might have received an initial diagnosis of PDDNOS later revised to Autism or Aspergers; but in the DSM-5 there is not this flexibility – so for example, a pre-schooler who does not (yet) present with two symptoms from the "restricted/repetitive interests/behaviours" will not meet criteria for

ASD (even though with time further restricted interests etc may emerge, and they may receive the ASD diagnosis at a later date). This has implications for service access, particularly for early intervention, where on the one hand the recommendation is to intervene as early as possible, but on the other there is a risk that age of diagnosis may be delayed.

The other major issue with the introduction of the singular ASD diagnosis was the potential loss of differentiation as compared to having separate Autistic Disorder, Asperger's, and PDDNOS categories. For many, these served as markers of severity. To address this issue, within the diagnosis of ASD the DSM-5 has introduced separate 'general' and 'severity' specifiers, that are intended to be included as part of any formal diagnosis.

The general specifiers are intended to capture any comorbidities, and so require indication of presence and degree of any intellectual disability, presence and degree of any language impairment, association with any known medical conditions, association with any other neurodevelopmental, mental or behavioural disorder, and presence of catatonia. The severity specifiers are intended to communicate the level of support required by the individual *specific to* that ASD criterion. Level 1 equates to 'requiring support', Level 2 'requiring substantial support', and level 3 'requiring very substantial support'. The clinician is required to rate SEPARATELY the degree of severity of social communication impairment, and the degree of severity of restricted and repetitive interests and behaviours.

The use of severity specifiers, while conceptually laudable, seems fraught with challenges. First is the paucity of guidelines and the resulting degree of subjectivity and potential



inter-rater discrepancy in terms of what is meant by the support levels. Arguably even more fundamental is the expectation that clinicians will have read the DSM-5 in close enough detail to know that “Severity of social communication difficulties and restricted, repetitive behaviours should be separately rated.”. In the vast majority of DSM-5 diagnostic reports that I have come across, the individual has only been given one, collective severity rating (eg “ASD, severity Level 3”). Finally, the (potential) misuse of the severity specifiers by funding bodies, and educational and intervention services, is concerning. For example, the NDIS, in their operational guidelines around access to that scheme, specify a minimum Level 2 (Requiring substantial support) to be eligible. That is, despite a diagnosis of ASD with one or both areas classed as “Requires support” (Level 1), the NDIS is effectively deeming that these individuals do NOT require support (or not government funded support, anyway). And this is distinct from the fact that the DSM-5 is explicitly clear that the severity level specifiers “should not be used to determine eligibility for and provision of services”

The DSM-5 is very careful to emphasise that the severity specifiers are NOT intended to be static, rather, can “vary by context and fluctuate over time”. That is, depending on an individual’s personal circumstances, health, environment, and so on, the level of support they will require around either their social communication needs or the management of their restricted or repetitive interests or behaviours – may change. This is again, conceptually, a really important, valuable recognition of the experience of many individuals with an ASD and their families, and goes some way to acknowledging the socially- and environmentally- determined aspects of disability. For example, a young person who has a lot of difficulty coping with transitions and change may have relatively low support needs in this area during a stable period of primary school enrolment between Year 4-6 – but their support level may increase significantly around the point of transition into High School.

Looking to the future, it will be interesting to see what developments emerge in areas related to the revised diagnoses and criteria in the DSM-5.

First of all, evidence is needed around the reliability and validity of SCD as a clinical diagnoses, and the criteria used to define it – particularly, how it is different from ASD, and whether those differences are meaningful (e.g. in regards to things like prognosis and response to treatment), or if the distinction is arbitrary. The reliability and stability of the criteria over time will also be important to track; particularly,

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whether there is an impact on the age of diagnosis and access to early intervention services for pre-schoolers who are ‘subthreshold’ when younger, but later go on to manifest symptoms for an ASD diagnosis.

Table: Summary of key changes to Autism spectrum diagnostic criteria in DSM-5

- ‘Autism Spectrum Disorder’ subsumes/replaces the previous diagnoses of Autistic disorder, Asperger’s disorder, Childhood disintegrative disorder, and PDDNOS
- ‘Social-’ and ‘communication-’ impairments combined into one ‘social communication’ category within which ALL features must be present to diagnose ASD
- Restricted and repetitive behaviours MUST be present (where previously not required for PDDNOS)
- General specifiers introduced to capture any degree of intellectual disability, language impairment, and other comorbidities
- Severity specifiers now included/required; SEPARATE ratings for social-communication, and restricted repetitive interests/behaviours
- Behavioural criteria can be met on history (do not have to be currently manifest)
- Sensory issues now included as an (optional) behavioural symptom rather than just an associated feature
- Functional impairment must be present
- Comorbidities (such as ADHD) can be formally recorded (where previously these were excluded)
- Individuals with a ‘well-established’ DSM-IV diagnosis of Autistic Disorder, Asperger’s Disorder or PDDNOS retain the diagnosis of ASD (even if they do not fully meet the new DSM-5 criteria)

References:

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