

Diagnostic Criteria, History and Future of Autism and Asperger Syndrome



The diagnostic criteria for autism, Asperger syndrome and related conditions are changing in May 2013.

History of Autism and Asperger Syndrome

Autism and Asperger syndrome were 'discovered' at the same time in different parts of the world. Autism is derived from the Greek word *autos*, which means self. In the USA, Austrian born Leo Kanner described 'classic autism' in 1943. He reported about 11 children who shared similarities in their behaviour, such as 'insistence of sameness' and 'autistic aloneness'. Autism was thought of as the childhood form of schizophrenia until the 1970s. Autism then became established as a disorder that was separate from intellectual disability and schizophrenia, and was added to the DSM-III in 1980. Unaware of Kanner's work in the USA, in Austria in 1944, Hans Asperger first described Asperger syndrome. He called his clients 'little professors', noting in them social, behavioural, sensory and language characteristics.

Pervasive Developmental Disorders

Pervasive Developmental Disorders (PDDs) are characterised by impairment in social skills, communication skills, or by the presence of stereotyped interests and behaviour. In the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the category of PDD includes diagnoses of autism, Asperger syndrome, Rett's Disorder, Child Disintegrative Disorder, and Pervasive Developmental

Disorder Not Otherwise Specified (PDD-NOS).

Rett's Disorder

In Rett's Disorder, normal functioning and development is typically seen through the first five months of life. Between the ages of five and 48 months, the rate of head growth decreases. Between five and 30 months of age, a loss of purposeful hand skills is seen and stereotypical hand movements (hand wringing or washing) develop. In the first years after onset, interest in the social environment will decrease, but may develop later on. Other symptoms of Rett's Disorder include uncoordinated body and walking movements, a reduction of physical movements, and impaired expressive and receptive language.

Child Disintegrative Disorder

Child Disintegrative Disorder is characterised by age appropriate development for the first two years of life.

Between the ages of two and 10, there is a significant loss of skills that have been previously acquired. These include language (expressive and receptive), social skills, adaptive skills, motor skills, play, and bowel or bladder control. There are abnormalities in functioning like those seen in autism; impairments in communication and social interaction, and restricted and repetitive behaviour patterns.



Comparison of Autism, Asperger Syndrome and PDD-NOS

Autism	Asperger syndrome	PDD-NOS
Impairments in Social Interaction		
<ul style="list-style-type: none"> • Lack of empathy • Lack of emotional reciprocity • Difficulty developing friendships • Inability to pick up on social cues/body language/tone of voice • Avoid eye contact/ stare at others • Social isolation 	<ul style="list-style-type: none"> • Lack of empathy • Lack of emotional reciprocity • Difficulty developing friendships • Inability to pick up on social cues/body language/tone of voice • Avoid eye contact/ stare at others • Social isolation 	<ul style="list-style-type: none"> • Severe and pervasive impairment in social interaction, such as those for autism and Asperger syndrome, but do not meet criteria for a specific PDD
Restrictive, Repetitive Behaviour		
<ul style="list-style-type: none"> • Dislike change in routine • Delayed motor development • Repetitive motor mannerisms • Intense interests • Dislike change in routine • Preoccupation with parts of objects 	<ul style="list-style-type: none"> • Dislike change in routine • Delayed motor development • Repetitive motor mannerisms • Intense interests • Dislike change in routine • Preoccupation with parts of objects 	<ul style="list-style-type: none"> • Presence of stereotyped behaviour, interests and activities, such as those for autism and Asperger syndrome, but do not meet criteria for a specific PDD
Impairments in Communication		
<ul style="list-style-type: none"> • Delay in or lack of spoken language • Impaired ability to initiate or sustain conversation with others • Stereotyped or repetitive use of language 	<ul style="list-style-type: none"> • No clinically significant delay in language • Advanced or formal style of speaking • Talk about favourite subject • Monologue rather than two-way exchange 	<ul style="list-style-type: none"> • Severe and pervasive impairment in verbal or nonverbal communication skills such as those for autism and Asperger syndrome, but do not meet criteria for a specific PDD



Difference Between High Functioning Autism (HFA) and Asperger Syndrome

HFA and Asperger syndrome are both on the autism spectrum. The main difference is that those diagnosed with HFA will typically have had a delay in language, while those diagnosed with Asperger syndrome have no delay in language. This difference is typically gone by the age of three years. Another difference is that those diagnosed with HFA sometimes have more trouble with adaptive skills.

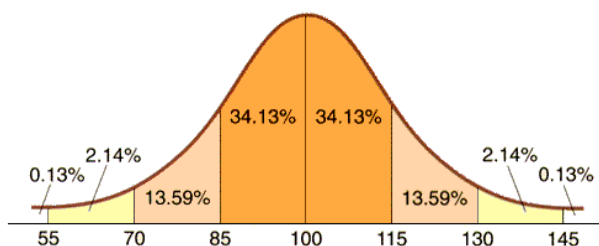
Adaptive Skills

Adaptive skills are those that are needed to independently perform everyday activities. Adaptive skills include communication, self care, home living, social and interpersonal skills, using money and community resources, self-direction, functional academic skills, work, leisure, health, and safety.

IQ - Intelligence Quotient

The IQs of a large enough population (e.g., population of Hamilton) can be described by a normal curve. The percentage under each part of the curve represents the percentage of the population who have an IQ in that range. The average IQ is 100, and most people have an IQ between 85 and 115 (34.13% + 34.13% = 68.26%). The cutoff for an intellectual disability is an IQ of 70. Only

2.27% (2.12% + 0.13% = 2.27%) of the population have an IQ under 70. A diagnosis of HFA requires a minimum IQ of 70, however, this means that they can still be significantly impaired.



Proposed Diagnostic Criteria for the DSM-V

In May 2013, the DSM-V will be published. There are many changes that will be made to the PDD category. The category name will be changed to Autism Spectrum Disorder (ASD). The separate diagnoses of autism, AS, CDD and PDD-NOS will no longer exist (although people diagnosed before this change will retain their diagnoses), and individuals will be diagnosed with varying severity of ASD (table below). In the DSM-IV, there were three domains of impairment used to diagnose PDDs, social, communication, and fixated interests and routinized behaviour. The DSM-V will combine the social and communication domains, so there will be only two domains of impairment used in diagnosis. Rett's Disorder will not be in the DSM-V at all, as it is to be labelled a 'medical disorder'.



Severity Level for ASD	Social Communication	Restricted interests & repetitive behaviors
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 behaviors 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.	RRBs 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 RRB’s 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 behaviors (RRB’s) cause significant interference with functioning in one or more contexts. Resists attempts by others to interrupt RRB’s or to be redirected from fixated interest.

Why is the Criteria Changing?

In the past, clinicians diagnosing PDDs have been reliably able to distinguish these disorders from other ‘nonspectrum’ disorders and typically developing children. However, distinguishing between the different PDDs has been found to be unreliable. There are common behaviours seen in the different PDD diagnoses, but

every individual with autism or AS has a different presentation of these behaviours. The single diagnostic category will be able to be adapted to each individual’s presentation of ASD (e.g., verbal ability, severity etc). The single category is also a better reflection of what is currently known about these disorders.



The combining of the communication and social domains is intended because these behaviours are inseparable and it will help to clarify diagnostic requirements. In the DSM-IV, some of the symptoms from these domains were the same, meaning that some diagnoses may have been biased by the symptoms being counted twice.

These decisions were made based on evidence from research and from consulting experts. The decisions were backed up by other organisations, such as Universities and other organisations involved in autism research, who reviewed this data.

References

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