DSM-5 and Autism Spectrum Disorders: The Changes You Haven't Heard About Yet

To the Editor: Much attention has been drawn to the changes within autism spectrum disorder (ASD) criteria in *DSM-5*. However, in considering the ASD revisions, the changes to diagnoses throughout *DSM-5* also warrant discussion, because they give clinicians new tools for diagnosing the co-occurring conditions often seen in ASD. These revisions may fundamentally change how we conceptualize ASD, because we will be better able to identify co-occurring conditions for research, clinical care, and even insurance coverage. When a patient's presentation is viewed only through the lens of ASD, we run the risk of diagnostic overshadowing or the misattribution of physical or emotional symptoms to the developmental disorder.[1] Such failure to recognize co-occurring symptoms as separate conditions can restrict the types of interventions made available to patients. Furthermore, when co-occurring conditions are not well accounted for in research studies, our ability to detect signal from noise is hampered. The changes in *DSM-5* are an important step in reducing this risk in ASD.

Table 1 lists the disorders in *DSM-IV-TR* and *DSM-5* that specifically name ASD within the criteria, either for differential diagnosis or for guidance about co-occurring diagnoses. Of course, disorders not listed in the table can, and do, co-occur with ASD, especially in the areas of anxiety, mood, learning, sleep, elimination, and food intake.

Much more research is needed to determine how ASD may affect the presentation of co-occurring disorders, especially those with behavioral overlap. In some cases, the 2 conditions can be easily recognized, such as in the individual with ASD who articulates social anxiety and fear of negative appraisal (ASD and social anxiety) or the individual with ASD who describes intrusive thoughts about germs and compulsive hand-washing (ASD and obsessive-compulsive disorder [OCD]). However, in other cases, ASD may color the presentation of the co-occurring disorder, such as the individual with ASD who cannot articulate social anxiety, but who is visibly distressed in social situations with unfamiliar children (ASD and possible social anxiety). Or the individual with ASD who repetitively sorts or lines up toys "just so" in pursuit of a circumscribed interest rather than to reduce unwanted intrusive thoughts (ASD rather than OCD). *DSM-5* acknowledges that some diagnoses should not be made if the impairments "are better explained by"[2(pp156,203)] ASD, but these distinctions can be difficult to make, especially for clinicians less familiar with ASD.

DSM-5 wording for 3 disorders (attention-deficit/hyperactivity disorder, language disorders, developmental coordination disorder) was changed to facilitate codiagnosis. These and many other impairments (eg, sleep, feeding, anxiety, pica, self-injury) are frequent targets for

Table 1. Specific References to Autism Spectrum Disorder (ASD) Within *DSM* Diagnostic Criteria

DSM-IV-TR Diagnoses	*DSM-5* Diagnoses
Autistic disorder Asperger disorder Childhood disintegrative disorder PDD not otherwise specified	ASD, with specifiers Level of support needed for social communication domain and for restricted, repetitive behaviors domain (severity levels 1–3) Specify presence of: Intellectual impairment Language impairment Known medical, genetic, environmental factors Known neurodevelopmental, mental, or behavioral disorders Catatonia
Rett disorder	ASD associated with Rett syndrome: Rett disorder is no longer in *DSM*, ASD is not to be assumed when there is a co-occurring genetic disorder
ADHD: could not occur exclusively during PDD	ADHD: can co-occur with ASD
Catatonic disorder due to a general medical condition: not diagnosed if disturbance is better accounted for by another mental disorder	Catatonia associated with another mental disorder: include as part of the catatonia specifier
Developmental coordination disorder: rule out PDD before diagnosing	Developmental coordination disorder: can co-occur with ASD, but must be beyond intellectual disability or global developmental delay
NA	Disruptive mood regulation disorder: only if it cannot be better explained by ASD
Generalized anxiety disorder: could not occur exclusively during the course of an ASD	Generalized anxiety disorder: can now co-occur with ASD
NA	Hoarding disorder: only if not better explained by repetitive behaviors in ASD
Mental retardation: could co-occur with a PDD	Intellectual disability or global developmental delay: can co-occur with ASD
Intermittent explosive disorder: PDD not mentioned	Intermittent explosive disorder: must be in excess of ASD and warrant independent clinical attention
Expressive language disorder and mixed expressive/receptive language disorder: could not occur exclusively during a PDD	Language disorder: can co-occur with ASD, but must be beyond intellectual disability or global developmental delay
Obsessive-compulsive disorder: ASD not mentioned in criteria	Obsessive-compulsive disorder: only if not better explained by repetitive behaviors in ASD
Pica or rumination: must warrant clinical attention	Pica or rumination: must warrant independent clinical attention
Reactive attachment disorder: must warrant clinical attention	Reactive attachment disorder: only if criteria are not met for an ASD
Schizoid personality disorder: could not occur exclusively during an ASD	Schizoid personality disorder: cannot occur exclusively during an ASD
Schizophrenia: could not occur exclusively during ASD	Schizophrenia: if there is a history of ASD, diagnose only if prominent delusions or hallucinations, and other criteria, are also present for at least 1 month
NA	Social (pragmatic) communication disorder: consider if ASD not met
Stereotypic movement disorder: not if it is "part of a PDD"	Stereotypic movement disorder: if self-injury is focus of treatment
Social anxiety disorder: must not be better accounted for by PDD	Social anxiety disorder: only if cannot be better explained by ASD

Abbreviations: ADHD = attention-deficit/hyperactivity disorder, NA = not applicable, PDD = pervasive developmental disorder.

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both pharmacologic and behavioral treatment. *DSM-5* presents a new opportunity for documentation to more thoroughly reflect the targeting of these specific symptoms within an individualized treatment plan.

There are now very few disorders in *DSM-5* that *cannot* be codiagnosed with ASD. Only 2 require ruling ASD out: reactive attachment disorder and the new social (pragmatic) communication disorder. Three other diagnoses (selective mutism, schizoid personality disorder, and schizotypal personality disorder) should be made only if symptoms "do not occur exclusively during the course of"[2(pp195,653,656)] ASD. Since ASD is not characterized by episodes in which symptoms are present, absent, and then present again, the "course" of ASD is generally lifelong. Therefore, any condition would, by default, occur during the "course" of ASD. For these conditions, then, it may be better to diagnose when the symptoms "are not better explained by"[2(pp156,203)] ASD and for *DSM* to provide more guidance on how to distinguish them. For example, all 3 involve a change in functioning (speaking to mute, ASD alone to ASD with a personality disorder).

By identifying co-occurring conditions accurately and completely, we can ensure that we are treating the whole individual with ASD and better study this heterogeneous group.

References

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