Dear Sir,

According to the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5), autism spectrum disorders (ASD) are neurodevelopmental disorders whose core clinical features are persisting deficits in social communication and interaction as well as restricted, repetitive behaviors, interests, and activities.[1] Today, there are no biomarkers for ASD, whose diagnosis is still strictly clinical.[2]

In 2013 DSM-5 introduced several innovations in the ASD nosography, including some appreciable changes such as the grouping of the symptoms related to social interaction and communication into one category (being recognized the necessary social nature of communication); symptoms concerning sensory issues have been given more weight (see hyper- or hypo-reactivity to sensory input); and the possibility that behavioral criteria are met based on history.[1] But alongside these favorable aspects, there are also a series of troubles. DSM-5 deleted the subdivision into 5 diagnostic subcategories (see DSM 4th Edition Text Revision [DSM-IV-TR]):[3] autistic disorder, Asperger disorder, Rett disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified), encompassing in a single diagnostic category a large number of conditions that appear very heterogeneous due to (1) the severity and complexity of the characteristic ASD symptoms; (2) the conditions that may occur in comorbidity (primarily intellectual disability); (3) and the underlying etiologies. All this in our opinion did not provide sufficient clarification neither in terms of clinical practice nor of research. Meanwhile, there are a lot of clinical features that justify the nosographic identity and autonomy of ASD; at the same time, the phenotypic differences among the ASD cases can be extremely significant. In fact, this broad diagnostic category may include very solitary and yet ingenious individuals who can also play a role of great responsibility in the society, as well as cases affected by severe encephalopathy with serious comorbid medical conditions, in which the presence of atypical behaviors leads to an ASD diagnosis. In view of this situation, in our opinion, the separation implemented in the DSM-5 into 3 subgroups according to severity (subjects requiring support, substantial support, and very substantial support correspond to level 1, 2, and 3, respectively)[4] appears simplistic and without any contribution to the qualitative characterization of ASD. As we previously pointed out, to make a reliable prognosis and plan an individualized treatment for these patients, it is important to consider not only the intensity but also the quality of symptoms.[4] An example of this is the differences in the cognitive profile that can be found between those patients who once according to DSM-IV-TR would receive a diagnosis of autistic disorder (“high-functioning”) and those who would receive a diagnosis of Asperger disorder, but who all now fall into an ASD (usually severity level 1) according to DSM-5.[1] On the other hand, while according to the DSM-5 intellectual disability appears as one of the most important associated conditions in patients with ASD, the DSM-5 subdivision into four severity groups (mild, moderate, severe, and profound) of intellectual disability is based on descriptive criteria concerning adaptive functioning in the domains of conceptualization, socialization, and practical skills and no longer on the intelligence quotient (as it was the case according to the DSM-IV-TR).[1,3] However, it is known that the adaptive abilities of individuals with ASD are impaired by definition, so that in cases with ASD and comorbid intellectual disability (association far from rare) we cannot understand to what extent the social maladjustment can be attributed to autism itself or to the cognitive deficit. Therefore, the prognostic value of the intellectual level in cases with ASD is somewhat questionable and difficult to establish.

These are some of the issues related to the DSM-5 and ASD that are still open and require an in-depth discussion by specialists who deal with these disorders.

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There are no conflicts of interest.

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