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# DSM-5 Differential Diagnoses: Autism Spectrum Disorder (ASD)

| Neurodevelopmental Conditions | |
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| **Rett Syndrome** | Disruption of social interaction may be observed during the regressive phase of Rett syndrome (typically between 1-4 years of age); thus, a substantial proportion of affected young girls may have a presentation that meets diagnostic criteria for ASD. However, after this period, most individuals with Rett syndrome improve their social communication skills, and autistic features are no longer a major area of concern. Consequently, ASD should be considered only when all diagnostic criteria are met. |
| **Selective Mutism** | In selective mutism, early development is not typically disturbed. The affected child usually exhibits appropriate communication skills in certain contexts and settings. Even in settings where the child is mute, social reciprocity is not impaired, nor are restricted or repetitive patterns of behaviour present.<br><br>Individuals with ASD, schizophrenia, or another psychotic disorder, or severe intellectual disability may have problems in social communication and be unable to speak appropriately in social situations. In contrast, selective mutism should be diagnosed when a child has an established capacity to speak in some social situations (e.g. typically at home). |
| **Language Disorders and Social (Pragmatic) Communication Disorder** | In some forms of language disorder, there may be problems of communication and some secondary social difficulties. However, specific language disorder is not usually associated with abnormal nonverbal communication, not with the presence of restricted, repetitive patterns of behaviour, interests, or activities. When an individual shows improvement in social communication and social interactions but does not show restricted and repetitive behaviour or interests, criteria for social (pragmatic) communication disorder, instead of ASD, may be met. The diagnosis of ASD supersedes that of social (pragmatic) communication disorder whenever the criteria for ASD are met, and care should be taken to enquire carefully regarding past or current restricted/repetitive behaviour.<br><br>Individuals with ASD may only display the restricted/repetitive patterns of behaviour, interests, and activities during the early developmental period, so a comprehensive history should be obtained. Current absence of symptoms would not preclude a diagnosis of ASD, if the restricted interests and repetitive behaviours were present in the past. A diagnosis of social (pragmatic) communication disorder should be considered only if the developmental history fails to reveal any evidence of restricted/repetitive patterns of behaviour, interests, or activities. |
| **Attention-Deficit/Hyperactivity Disorder (ADHD)** | Abnormalities of attention (overly focused or easily distracted) are common in individuals with ASD, as is hyperactivity. A diagnosis of ADHD should be considered when attentional difficulties or hyperactivity exceeds that typically seen in individuals of comparable age. |

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| **Intellectual Disability (ID) (Intellectual Development Disorder) without ASD** | ID without ASD may be difficult to differential from ASD in very young children. Individuals with ID who have not developed language or symbolic skills also present a challenge for differential diagnosis, since repetitive behaviour often occurs in such individuals as well. A diagnosis of ASD in an individual with ID is appropriate when social communication and interaction are significantly impaired relative to the developmental level of the individual's nonverbal skills (e.g. fine motor skills, nonverbal problem solving). In contrast, intellectual disability is the appropriate diagnosis when there is no apparent discrepancy between the level of social-communicative skills and other intellectual skills.<br><br>ID is common among individual with ASD. Assessment of intellectual ability may be complicated by social-communication and behaviour deficits inherent to ASD, which may interfere with understanding and complying with test procedures. Appropriate assessment of intellectual function in ASD is essential, with reassessment across the developmental period, because IQ scores in ASD may be unstable, particularly in early childhood. |
| **Stereotypic Movement Disorder** | Stereotypic movements may be a presenting symptom of ASD and should be considered when repetitive movements and behaviours are being evaluated. Deficits of social communication and reciprocity manifesting in ASD are generally absent in stereotypic movement disorder, and thus social interaction, social communication, and rigid repetitive behaviours and interests are distinguishing features. When ASD is present, stereotypic movement disorder is diagnosed only when there is self-injury or when the stereotypic behaviours are sufficiently severe to become the focus of treatment. |
| **Developmental Coordination Disorder** | Individuals with ASD may be uninterested in participating in tasks requiring complex coordination skills, such as ball sports, which affect test performance and function but not reflect core motor competence. Co-occurrence of developmental coordination disorder and ASD is common. If criteria for both disorders are met, both diagnoses can be given. |
| **Other conditions** | |
| **Schizophrenia** | Schizophrenia with childhood onset usually develops after a period of normal, or near normal, development. A prodromal state has been described in which social impairment and atypical interests and belief occur, which could be confused with the social deficits seen in ASD. Hallucinations and delusions, which are defining features of schizophrenia, are not features of ASD. However, clinicians must take into account the potential for individuals with ASD to be concrete in their interpretation of questions regarding the key features of Schizophrenia (e.g. "Do you hear voices when no one is there?" "Yes [on the radio]")<br><br>ASD or communication disorders may also have symptoms resembling a psychotic episode but are distinguished by their respective deficits in social interaction with repetitive and restricted behaviour and other cognitive and communication deficits. An individual with ASD or communication disorder must have symptoms that meet full criteria for schizophrenia, with prominent hallucinations or delusions for at least 1 month, in order to be diagnosed with schizophrenia as a comorbid condition. |

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| **Disruptive Mood Dysregulation Disorder** | Children with ASD frequently present with temper outbursts when, for example, their routines are disturbed. In that instance, the temper outbursts would be considered secondary to the ASD, and the child should not receive the diagnosis of disruptive mood dysregulation disorder. |
| **Social Anxiety Disorder** | Social anxiety and social communication deficits are hallmarks of ASD. Individuals with social anxiety disorder typically have adequate age-appropriate social relationships and social communication capacity, although they may appear to have impairment in these areas when first interacting with unfamiliar peers or adults. |
| **Hoarding Disorder** | Hoarding disorder is not diagnosed if the accumulation of objects is judged to be a direct consequence of a neurodevelopmental disorder, such as ASD or ID. |
| **Trichotillomania (Hair-Pulling Disorder)** | In neurodevelopmental disorders, hair pulling may meet the definition of stereotypies (e.g. in stereotypic movement disorder). Tics (in tic disorders) rarely lead to hair pulling. |
| **Reactive Attachment Disorder** | Aberrant social behaviours manifest in young children with reactive attachment disorder, but they also are key features of ASD. Specifically, young children with either condition can manifest dampened expression of positive emotions, cognitive and language delays, and impairments in social reciprocity. As a result, reactive attachment disorder must be differentiated from ASD. These two conditions can be distinguished based on differential histories of neglect and on the presence of restricted interests or ritualised behaviours, specific deficit in social communication, and selective attachment behaviours. Children with reactive attachment disorder have experienced a history of severe social neglect, although it is not always possible to obtain detailed histories about the precise nature of their experiences, especially in initial evaluations. Children with ASD will only rarely have a history of social neglect. The restricted interests and repetitive behaviours characteristic of ASD are not a feature of reactive attachment disorder. These clinical features manifest as excessive adherence to rituals and routines; restricted, fixated interests; and unusual sensory reactions. However, it is important to note that children with either condition can exhibit stereotypic behaviours such as rocking or flapping. Children with either disorder also may exhibit a range of intellectual functioning, but only children with ASD exhibit selective impairments in social communicative behaviours, such as intentional communication (i.e., impairment in communication that is deliberate, goal-directed, and aimed at influencing the behaviour of the recipient). Children with reactive attachment disorder show social communicative functioning comparable to their overall level of intellectual functioning. Finally, children with ASD regularly show attachment behaviour typical for their developmental level. In contrast children with reactive attachment disorder do so only rarely or inconsistently, if at all. |

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| **Avoidant/Restrictive Food Intake Disorder** | Individuals with ASD often present with rigid eating behaviours and heightened sensory sensitivities. However, these features do not always result in the level of impairment that would be required for a diagnosis of avoidant/restrictive food intake disorder. Avoidant/restrictive food intake disorder should be diagnosed concurrently only if all criteria are met for both disorders and when the eating disturbance requires specific treatment. |
| **Intermittent Explosive Disorder** | Children with ASD may exhibit impulsive aggressive outbursts. The level of impulsive aggression in individuals with a history of such a condition has been reported as lower than that in comparable individuals whose symptoms also meet intermittent explosive disorder Criteria A through E. Accordingly, if Criteria A through E are also met, and the impulsive aggressive outbursts warrant independent clinical attention, a diagnosis of intermittent explosive disorder may be given. |
| **Mild Neurocognitive Disorder** | A careful clarification of the individual's baseline status will help distinguish neurocognitive disorders from a specific learning disorder or other neurodevelopmental disorders. |
| **Schizoid PD** | There may be a great difficulty differentiating individuals with schizoid personality disorder from those with milder forms of ASD, which may be differentiated by more severely impaired social interaction and stereotyped behaviours and interests. |
| **Schizotypal PD** | There may be great difficulty differentiating children with schizotypal personality disorder from the heterogeneous group of solitary, *odd* children whose behaviour is characterised by marked social isolation, eccentricity, or peculiarities of language and whose diagnoses would probably include milder forms of ASD or language communication disorders. Communication disorders may be differentiated by the primacy and severity of disorder in language and by the characteristic features of impaired language found in a specialised language assessment. Milder forms of ASD are differentiated by the even greater lack of social awareness and emotional reciprocity and stereotyped behaviours and interests. |

*Disclaimer: Unless otherwise specified, all language and terminology has been extracted directly from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (APA, 2013).*

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