Project ACCESS: Supporting Missouri Autism Educators

FACT SHEET NUMBER 13

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AUTISM OR PERVASIVE DEVELOPMENTAL DISORDER: WHAT'S THE DIFFERENCE?

It is the responsibility of the school multidisciplinary team to diagnose autism for the purpose of determining eligibility for special education and related services. The issue is sometimes complicated when the district concludes that the child has autism but the child has been seen by a physician or psychologist who has given a diagnosis of Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS) or Asperger's Disorder. Educators and parents may wonder if these disorders are related and perhaps which diagnosis should be given precedence.

Autism, Pervasive Developmental Disorder-Not Otherwise Specified, and Asperger's Disorder are all subtypes of a larger category of disorders referred to in the Diagnostic and Statistical Manual of the American Psychiatric Association, 4th Edition (DSM-IV) as Pervasive Developmental Disorder (PDD). Pervasive Developmental Disorders include Rett's Disorder and Childhood Disintegrative Disorder as well. The latter two disorders are quite uncommon, so our discussion will be limited to autism, PDD-NOS and Asperger's. Oversimply stated, Asperger's Disorder roughly coincides with what some people call High Functioning Autism. Generally, the person with Asperger's Disorder has general intelligence within wide normal limits and language which, although often odd, is sufficient for ordinary day to day communication. There are cognitive problems such as difficulties with perspective taking and rigidity in thought patterns. Socially awkward, these students are often the brunt of other children's teasing and may have few, if any, friends.

Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS), on the other hand, is a diagnosis which is most often given when many of the characteristics of autism are present (according to the DSM-IV) but not enough to technically diagnose autism. Autism, Asperger's, Rett's, and Disintegrative Disorder have been ruled out but the diagnosticians still believe the child has a Pervasive Developmental Disorder. Thus, the child is given the "Not otherwise specified" label.

In Missouri we do not make a differential diagnosis among the three disorders for educational purposes. The State Plan for Compliance with IDEA requires only that students be diagnosed as having one of the twelve disabling conditions which are spelled out on the Federal Register. Autism is the only Pervasive Developmental Disorder mentioned in either The Federal Register or the State Plan.

While some districts and states allow students with other diagnoses such as PDD-NOS or Asperger's to be served under the Other Health Impaired category, this is frustrating and confusing to most families as well as educators. For example, when a child comes to the school district with a medical diagnosis of Asperger's Disorder or PDD-NOS, the school personnel must somehow convert that diagnosis into one which can be used in the educational system. Usually the diagnosis is autism. ACCESS can provide you with a scheme for meshing the medical and educational criteria, if necessary.

Once eligibility for services is determined, labels are considerably less important than identification of characteristics which lead to appropriate educational programming. There is no question that children who share the Pervasive Developmental Disorder umbrella tend to share certain characteristics. A few of these are stimulus over selectivity, perseveration, and difficulty with generalization. Because of this, children with PDD/Autism usually have difficulty learning through generalization of experiences. Although there are certainly significant learning style differences among children with the Pervasive Developmental Disorder label, we must not assume that all children within a particular subgroup will necessarily share the same learning styles or other characteristics. There are vast differences between a child with severe autism and mental retardation and one with Asperger's (high functioning autism). However, the differences in learning styles are often just as great within a subtype. We must look at individuals, not labels.

It is less important educationally that we differentiate between the subtypes for purposes of labeling than it is to note that a particular child learns best in a particular environment as opposed to another or responds better to one technique than to another. The limited resources out there in the schools need to be focused on assessment for programming, not to split diagnostic hairs. It is much more important that a functional education program be developed for the academically able student than that he be called autistic, Asperger's, PDD-NOS or anything else. To be in compliance, however, schools must place every child diagnosed into one of the twelve diagnostic categories in the State Plan. What is most important for the most behaviorally involved students is analysis of behavior to determine its communicative functions. Non-verbal/low verbal students need assessment for augmentative or alternative communication systems more than they need differential diagnosis.

Most professionals agree that the borders between the subtypes of PDD are fuzzy at best. These lines MAY sometimes need to be more clearly drawn for purposes other than educational treatment. Those concerned with medical research and treatment may find it necessary to divide the Pervasive Developmental Disorder "pie" into extremely small, clearly defined pieces so that the efficacy of various treatments can be determined.

Almost any physician will admit, however, that they base their treatment choices on specific characteristics displayed, not on the diagnostic label. In any case, it is not the determination of the small medical diagnostic category into which a child falls which determines educational programming. Educational programming is developed from good educational assessment, not from a diagnostic label.

Differential diagnosis, then, is most importantly made between the autism spectrum disorders and learning disabilities or mental retardation or behavior disorders, not just within the spectrum. Beyond diagnosis, educators will need to develop skills in assessment for programming, including applied behavior analysis, development of functional programs, functional communication training, and planning for social skills development. It is in these areas that the educator will be of the most service to the children, families, and school systems they serve.

***The Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association 5th edition was published in early 2013. The new edition contained big changes for autism.

The DSM-5 eliminated all of the Pervasive Developmental Disorders category and subcategories, to be replaced by one category titled "*Autism Spectrum Disorder.*" The revision committee found that research verifies the existence of one overall disorder, with the severity of symptoms varying among individuals. Severity Levels for ASD now fall into three levels, as follows: Level 1: Requiring Support, Level 2: Requiring Substantial Support and Level 3: Requiring Very Substantial Support.

Teachers are reminded to refer to the Missouri Department of Elementary and Secondary Education (MO-DESE) website for the Missouri State Plan definition and eligibility criteria for autism. This is the final authority for educators serving children who experience autism.