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ПРЕГЛЕД ЛИТЕРАТУРЕ / REVIEW ARTICLE

Autism and Autistic Spectrum Disorders in the Context of New DSM-V Classification, and Clinical and Epidemiological Data

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SUMMARY
Autism is one of disorders from the autism spectrum, besides Asperger syndrome, atypical autism and pervasive developmental disorder not otherwise specified. They are classified as mental disorders as being manifested by a wide range of cognitive, emotional and neurobehavioural abnormalities. Key categorical characteristics of the disorder are clear impairments of the development of the child's socialisation, understanding and production of verbal and non-verbal communication and restricted and repetitive patterns of behaviour. Demarcation boundaries are not clear, neither within the very group of the disorders from the autistic spectrum, nor with respect to the autistic behavioural features in the general population. For this reason, the term spectrum points out the significance of the dimensional assessment of autistic disorders, which will most likely be the basis of the new diagnostic classification of the disorders belonging to the current group of pervasive developmental disorders in the new DSM-V classification. The understanding, as well as the prevalence of the autistic spectrum disorders has changed drastically in the last four decades. From the previous 4 per 10,000 people, today's prevalence estimates range from 0.6 to around 1%, and the increase of prevalence cannot be explained solely by better recognition on the part of experts and parents or by wider diagnostic criteria. The general conclusion is that the autistic spectrum disorders are no longer rare conditions and that the approach aimed at acknowledging the warning that this is an urgent public health problem is completely justified.
Keywords: autism; autistic spectrum disorders; DSM-V classification; epidemiological data

INTRODUCTION

Autism is one of the pervasive developmental disorders, as well as one of the autistic spectrum disorders. The understanding of the autistic spectrum disorders has undergone significant changes in the last decades. Kanner's [1] strict criteria have been replaced by Rutter's [2] criteria and later the classifications of the American Psychiatric Association (Diagnostic and Statistical Manual of Mental Disorders – DSM classification) [3, 4] provided a completely different way of understanding and defining this disorder. All this contributed to dividing autism into several related disorders, which have common key symptoms but different specific symptoms, as well as defining their differences with respect to the age at onset and the progression of the disorder.

According to the current DSM-IV classification, the group of pervasive developmental disorders includes autism, Rett's syndrome, disintegrative developmental disorder (Heller's syndrome), Asperger syndrome and pervasive developmental disorder not otherwise specified (PDD-NOS) which includes atypical autism [4]. The proposed new DSM-V classification, according to the reports by the Neurodevelopmental Disorders Work Group [5], will most probably include one diagnostic category, autistic spectrum disorders which will include autism, Asperger syndrome and PDD-NOS. Rett's syndrome will be listed as a separate category or added to genetic disorders, while Heller's syndrome will most probably not be listed as a separate disorder as the latest findings have confirmed that the existence of developmental regression in autism is a continuous variable.

The changes of classification and the introduction of the term autistic spectrum disorders emphasize the importance of dimensional assessments of autistic disorders. The implications of future changes are the diminishing of diagnostic confusion by forming three different levels of the disorder, depending on the intensity of pathological expression (similar to the classification of mental retardation which will also change its name to intellectual disability [5].

During the last decades, with the classification changes and better understanding of the autistic spectrum, the data about the prevalence of the autistic disorders and the increase of the number of individuals with this disorder have changed significantly, which prompted a dilemma whether it was the revisions of the diagnostic criteria which contributed to the 'current epidemics' of autistic disorders.

AETIOLOGICAL BASES

The bases for including autism in the developmental mental disorders are the behavioural

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Table 1. Genetic disorders with autistic syndrome

Mitochondriopathy
Phenylketonuria
Fragile X syndrome
Tuberous sclerosis
Williams syndrome
Mucopolysaccharidosis (Type I)
Celiakia
Smith-Lemli-Optiz syndrome
Angelman syndrome
Smith-Magenis syndrome
Landau-Kleffner syndrome
Klinefelter syndrome
Turner syndrome
Lesch-Nyhan syndrome
Cornelia de Lange syndrome
Mobius syndrome
CHARGE syndrome
XYY syndrome
15q11-13 duplication
22q13 deletion

manifestations which characterize this disorder and their onset dynamics. Even though the exact aetiology of the disorder is unknown, it is, quite rightly, recognised as a complex neurobiological disorder, which includes structural anomalies of the brain, abnormalities of the neural links, integration and compliance of brain functions and impairments of brain energy metabolism, and which is to a large extent genetically conditioned [6-9]. This claim can be substantiated by both research and the fact that autism, as a condition, is present in various other disorders, such as fragile X syndrome, tuberous sclerosis, mitochondriopathy (a wider overview is given in Table 1) [6, 7].

The symptoms of autism are related to neural functioning disorder in the area of the temporal cortex, mainly the left fusiform gyrus, amygdala and the ventromedial prefrontal cortex [10]. The above mentioned abnormalities manifested by a wide spectrum of cognitive, emotional and neurobehavioural disorders with clear impairments to the socialisation of such children, their ability to understand, verbal production and nonverbal communication, as well as restricted and repetitive patterns of behaviour. In other words, autism and the autistic spectrum disorders can be regarded as conditions characterized by impairments to the functioning of those areas of the brain in charge of socialisation, communication and the use of language, movements and sensory sensitivity [11, 12]. Intellectual functioning at the level of mental retardation is present in 25-70% of children with autism, and ranges from mild to severe [13].

CLINICAL SIGNS

The basic deficit in social interactions is the lack of initiative in social relations due to the underdeveloped or altered use of language, absence of joint attention and nonverbal communication in general which would allow them to show interest in other people [14]. The hardest thing for the parents is precisely the fact that their child appears not to care what the parents think, want and feel. Also, there is a defect in social orientation which implies a lack of reactivity in the presence of others, not responding to name (despite the fact that hearing is intact) or focusing on certain objects for a long time without the initiative for eye contact with people [15]. Even if they are focussed on a human face, the attention is placed on certain parts of the face (usually the mouth), and not the face as a whole. Autistic children appear not to differentiate between people and things. There is also a lack of focus on other people's emotions, most probably as a result of the lack of ability to form predictions (theory) about other people's feelings, thoughts, wishes and intentions (abnormal theory of mind) [16]. Autistic persons understand what others see, but they do not understand what others think, what their intentions, wishes and beliefs are.

The second category of key disorders implies abnormalities in communication which can have wide manifestations ranging from a complete lack of language development (which is not accompanied by an effort to compensate for it with alternative forms of communication such as gesticulation, mime, babble), to the specified disorder in the ability to initiate or sustain conversations with others (non-pragmatism of speech) and stereotyped and repetitive use of language or forming idiosyncratic language, echolalia and paraphasia [16]. Children with Asperger syndrome or high-functioning autism (it is a term for a pervasive disorder which is diagnostically classified as pervasive developmental disorder not otherwise specified, F84.9 PDD-NOS, but the name itself does not justify what it describes because autism in itself is a condition which does not imply functionality) show a tendency towards communication which, however, is not reciprocal (they address others, but rarely engage in dialogues) [17]. The markers of altered communication can be the inability to understand sarcasm, idioms, slang as well as to interpret the figurative meaning of fairy tales, which worsens the problems in social interactions, especially in adolescence, when this type of communication is quite common [14, 16].

It is highly probable that the new DSM-V classification will not have the existing three groups of diagnostic criteria, as the first two will be fused into a common category – social communication deficits [5].

The current third key category (while in the future, it will most probably be the second) includes significantly restricted (fixed) interests, repetitive activities and stereotyped patterns of behaviour, which are manifested by abnormal play and preoccupation with one or more objects or activities (depending on the intensity and focus of attention), stereotyped and repetitive motor mannerisms (e.g. flapping or twisting of the arms, hands or fingers, banging of the head or complex movements of the whole body). It is usual for children with autism not to know how to play, not to understand the functional parts of toys, or to excessively line up their toys. What is conspicuous is the fact that they do not imitate the play of others, which is a common feature for children with normal development

before turning the age of two. Basically, there are difficulties in the skill of executive modulation of behaviour (planning, executing and lack of modelling), which is expressed by a rigid simple repetitive approach to solving problems and guiding behaviour, most probably as a consequence of the abnormal functioning of the frontal areas of the brain and the mirror neurons [18, 19]. This aspect of behaviour of children with autism is usually the most conspicuous one, both because of what it looks like, and the time the child spends on non-functional activities and interests [15, 16]. It is important to know that the change of settings does not change the child's behaviour, which differentiates autistic children from children with other developmental disorders.

Children with autism often have other developmental disorders as an integral part of the clinical image of autism or as a comorbid condition which does not have an impact on the diagnosis of autism itself. There are often different forms of attention disorders, impulsiveness, hyperactivity and repetitive behaviour, as separate symptoms or as a part of attention deficit hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), mood disorders or tic disorders [20]. Occasional and unpredictable tantrums and other emotional reactions accompanied by different levels of self-injury are often connected to the change of the established routine and rules, as well as different aspects of sensory disintegration, sensory hypo- or hypersensitivity to proprioceptive and pain stimuli [21, 22]. It is believed that the abnormality of sensory processing has a great impact on the commonly restrictive and texture-selective intake of food, sleep disorder, reduced or increased pain sensitivity accompanied by abnormal sensitivity to sound, touch or other sensory stimulation, which in itself has an important effect on the specific nature of play and behaviour of children with autism.

For the time being, a specific phenotype for the children with one of the autistic spectrum disorders has not been established, although, some recurring specific morphological anomalies have been observed, as well as more common occurrence of internal organ diseases, above all of the gastrointestinal tract [22-25]. On the other hand, the autistic syndrome occurs significantly more frequently with particular diseases and syndromes, which have been mentioned in the introductory part of this paper.

DIAGNOSIS

The threshold for making a diagnosis, at any age, is conditioned by the level of everyday functioning and clinical assessment. On the other hand, the backbone of the diagnosis is the categorical assessment of autistic disorders because, within the same disorder, there is a wide range of individual abilities and intensity of a certain deficit, ranging from mild, characterised by high functionality, to severe.

The first diagnostic parameter in the clinical diagnosis of classic autism is that the abnormal social behaviour of the child appears before the age of three. Even though a slow or altered development of language most often delays the identification of the symptoms, parents are usually the first to notice the symptoms of autism in their children as early as at the age of 18 months [26, 27]. For this reason, a screening algorithm for early detection has been proposed, so as to reveal the deficits in social development, communication and imaginative play during the first two years of the child's life. According to the guidelines for screening and diagnosis, clinical identification of children with autism implies two levels of clinical examination: 1) routine development monitoring; 2) specific screening for autism, which have been described in a special article by the American Neurology Academy [27].

The first level of examination should be applied in all children and it should imply the identification of specific risks for autism and atypical psychomotor development. The second level implies much more specific tests performed in children with previously diagnosed autism or children in whom it is necessary to make differential diagnostics from other developmental disorders, so as to determine the optimal therapeutic strategies based on the child's weaknesses and strengths.

Today, there are numerous researches which offer relevant evidence that, even at the age of 18 months or earlier, it is possible and necessary to make the diagnosis and begin early therapeutic interventions, because in autistic children, even of this age, it is clear that there are impairments of attention focus and attention orientation, development of language, imitative play and make belief [28, 29]. The symptoms have been shown to be stable throughout early childhood and preschool period [28]. The need for the early diagnosis of autistic symptoms, according to some authors [30], can possibly be shifted to the age of 8 months, when it is possible to distinguish children with autism from children with other developmental disorders. These claims have been made on the basis of a retrospective analysis of video footage [31].

Unlike autism with early onset, another type of autism, the so-called regressive autism has been described. It includes periods of clearly normal development, followed by a gradual or sudden loss of the acquired social and/or language skills and activities, most often between the ages of 15 and 30 months [32]. Some authors even describe a mixed type of the disorder, which is characterized by early slow-down or disharmony of development followed by the loss of acquired functions [33]. It is estimated that 25-30% of children with autistic spectrum disorders suffer from the regressive type of the disorder, which is, in the relevant literature, often connected to autoimmune processes [34, 35].

The proposed method of early autism diagnosis is being introduced in the USA as a routine developmental screening for all children [27]. In Europe, primarily in Great Britain, the strategy of early detection implies the selective screening for children based on the warning symptoms recognised by experts and parents [36], due to the fact that the standardized screening tests for the entire children population have not been met with support in Great Britain because of their low sensitivity and specific nature. There are still no significant studies on the differences in the efficiency of these approaches, but in the rest of the world, what prevails is the approach based on routine

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screening of all children using standardized tests and the education of experts and parents in the recognition of the warning symptoms [27].

DIAGNOSTIC INSTRUMENTS

The semi-structured research and clinical questionnaire ADOS (Autism Diagnostic Observation Schedule) [37] and ADI-R (Revised Autism Diagnostic Interview) [38] are recommended as the gold standard in the diagnostic observation of an autistic child. ADOS shows non-specific features compared to children with mental retardation, while the lack of ADI-R is the time needed for administration (1-3 hours).

CHAT questionnaire (The Checklist for Autism in Toddlers), which represents the most often used tool for screening children aged up to 18 months, is, for the time being, reliable and has been validated for a number of years [28], while the Autism Screening Questionnaire for children aged 4 has proved its validity on a large sample of children. CHAT questionnaire is less sensitive to the more functional forms of pervasive disorders (Asperger syndrome, atypical autism, high-functioning autism).

The use of standard intelligence tests while performing psychological testing has indicated significantly lower scores for cognitive functioning, bearing in mind that around 2/3 of children with autism have a problem with language development and verbal communication. The most recent recommendations state that children with autism should be tested using Raven's progressive matrices, which give a more reliable picture of a child's cognitive abilities, as the test is based to a larger extent on the assessment of other communication and behavioural aspects (primarily nonverbal) [39].

DIFFERENTIAL DIAGNOSIS OF PERVASIVE DEVELOPMENTAL DISORDERS

Until the new classification and new diagnostic criteria are introduced, the existing classification still recognises categorical differences between the pervasive disorders.

- Classic autism includes the above mentioned deficits in all three behavioural domains: reciprocal social interactions, communication, interests and activities.
- Asperger syndrome includes an almost normal development of language and intelligence, with a characteristic deficit in social interactions, narrow range of interest and ideomotor dyspraxia.
- Pervasive developmental disorder not otherwise specified (PDD-NOS, high-functioning autism) in the DSM-IV classification includes atypical autism which is a separate entity according to the ICD-10 classification [40]. Unlike children with classic autism, these children have better developed language and intelligence, they are less dyspractic but also less sociable than children with Asperger syndrome. Basically, this category refers to children with autistic features [16].
- Atypical autism implies that criteria are not met for a more specific pervasive disorder, where the subject shows signs of significantly altered reciprocal social interactions and verbal and non-verbal communication with the disorder onset at the age which is atypical for autism or when autism develops parallel to severe mental retardation as the primary disorder. Only ICD-10 classification recognises this entity.
- Disintegrative developmental disorder (Heller's syndrome) involves a previous completely normal psychomotor development, while the disorder develops through symptoms of massive regressions at the ages of 2 to 10 (usually between the ages of 3 and 4) resulting in a severe form of autism [41]. By definition, this condition excludes the existence of a degenerative brain disease or early child schizophrenia.
- Rett's syndrome is a genetic disorder affecting girls almost exclusively (several cases of Rett's syndrome in boys with genetic mosaicism have been described) [42, 43]. This syndrome is characterized by psychomotor regression between the ages of 5 and 18 months, deceleration of the rate of head growth including microcephaly, apraxia of the arms with specific stereotyped hand gestures, severe mental retardation with multiple neurological disorders which worsen in the course of the four described phases of disorder progression. Rett's syndrome will most probably disappear from the list of autistic disorders, as it will be moved to the category of genetic syndromes [5].

The most common dilemmas in the differential estimate are related to the disorders from the autistic spectrum themselves (Table 2), that is, autism, Asperger syndrome and PDD-NOS, but also in relation to mental retardation and the language development disorders (Table 3).

EPIDEMIOLOGICAL DATA – DILEMMAS AND WARNING SIGNS

According to past beliefs, there is an equal global prevalence of autism and there are no greater differences in the frequency of occurrence with respect to geographical position, racial and ethnic origin, which is today considered an unjustified generalisation as it is not supported by sufficient epidemiological studies [44]. Also, from today's perspective, we are faced with the fact that there are few studies which take into account the specific nature of environmental impacts which are increasingly emphasized as significant factors in the aetiology of the disorder.

The prevalence of autistic spectrum disorders has changed drastically in the last four decades and from the previous 4 per 10,000 people, today's prevalence estimate is around 1%, while the estimated trend goes even up to 2%, i.e. current speculations are made with the prevalence of 57-94 per 10,000 (0.6-1%), depending on the year of research and the research methods [44, 45, 46]. The previously observed disbalance among the sexes is sustained and ranges from 4-8:1 in favour of men.

Table 2. Differential diagnostic features of autism spectrum disorders (Table adapted from Levy S, Mandell D, Schultz R. Autism. Lancet. 2009; 374(9701):1627-38).

Parameter	Autism	Asperger syndrome	PDD-NOS
Age at recognition (diagnosis)	0–3 years (3–5 years)	>3 years (6–8 years)	Variable
Psychomotor deployment	About 25% (social development or communication)	No	Variable
Sex ratio (male:female)	2:1	4:1	male>female; variable
Socialisation	Poor; >2 DSM-IV criteria	Poor	Variable
Communication	Delayed development, changed, undeveloped	No early developmental delay; delayed qualitative and pragmatic difficulties	Variable
Behaviour	More impaired than in Asperger's syndrome or PDD-NOS (also including stereotypy)	Variable (limited interests)	Variable
Intellectual disability	>60	Mild to normal intelligence	Mild to severe
Cause	Probably of genetic predisposition	Variable	Variable
Seizures	25% over lifespan	Roughly about 10%	Roughly about 10%
Outcome	Poor to fair	Fair to good	Fair to good

PDD-NOS – pervasive developmental disorder not otherwise specified

The prevalence of classic autism as a separate category has also increased rapidly during the same period of observation, so that the present data reach the range of 22-40 per 10,000 in Europe and the United States, with the ratio of 2:1 in favour of men [47].

A Finnish study from 2000 [48] even emphasizes a very rapid trend of prevalence increase as there is a significant difference with respect to the subjects' age. In their sample, the adolescents aged 15 to 18 had the lowest prevalence of 6.1 per 10,000, while the children aged 5 to 7 had the highest prevalence for autism of 20.7 per 10,000.

The reasons for such an 'epidemiological' increase of prevalence are still unknown and have been researched from several different aspects. The epidemiological studies from the period between 1967 to 1982, which used Kenner's diagnostic criteria, registered the prevalence of 4.5-5 per 10,000 [1], while later studies which used Ratter's criteria registered an increase of 5.6-10.8 per 10,000 [2]. A significant leap of prevalence was registered parallel to the introduction of the DSM-IV classification, as a more precise division between the autistic spectrum disorders and other conditions, above all mental retardation, could be made to a larger extent. However, journal articles only managed to point out the difficulties in understanding the trend of prevalence increase with respect to the changes of diagnostic criteria, but could not confirm that the change of criteria was the reason for such a significant increase of prevalence [48]. In other words, it is certain that the increase of prevalence cannot be explained only by better recognition on the part of experts and parents, or by wider diagnostic criteria.

A research carried out on 1200 families with children suffering from autism shows that the average age of a child at the time of autism diagnosis ranges between 3 and 6 years of age [26, 28, 49]. The world-wide experience shows that autism diagnosis is most often given at least two or three years after the recognition of the first symptoms [28]. The most common reasons are trying to avoid child stigmatisation or previous incorrect diagnoses [49]. This way, families fall behind with initial intensive interventions, planning further treatment protocols, education of the child and the parents and their involvement in family counselling, educational and support groups, as well as family and individual psychotherapy. Special significance is given to forming support networks between medical, social and non-government sectors towards protection and realisation of the rights of these children and their families [50].

CONCLUSION

Based on its increasing trend and the increased prevalence of nearly 1%, autism and the autistic spectrum disorders have shown the greatest expansion, leaving behind juvenile diabetes and children malignant diseases. The logical and cautious approach is aimed towards acknowledging the warning signs that this is an urgent public health problem and that autism no longer represents a rare disorder (the prevalence of less than 5 per 10,000 categorizes a disorder as rare), even with the use of the strictest criteria.

There is great heterogeneity of clinical phenotypes of the autistic spectrum disorders, with variations of the dominance of the key symptoms and their severity. The generally accepted attitude is that early detection ensures early intervention during the period when the therapeutic window is wide open and when it is necessary to give psychosocial support to the family [26, 51].

Observations and concerns by parent are of vital importance, as it has been proved that most parents notice that something is wrong with their child as early as at the age of 18 months, while less than 10% of children with autism are medically and diagnostically assessed before the age of two. More than 50% of parents emphasize the fact that the educational system and other parents proved to be a better support system than the medical system [27, 52]. For this reason, previous recommendations that autistic spectrum disorders should not be diagnosed before the age of three have been abandoned while the new guidelines for screening and diagnosis which emphasize the earliest possible detection of the critical symptoms have been offered [53]. Apart from the behavioural and clinical assessment, the increasing significance is given to the detection of genetic, neurodevelopmental, neuroinflammatory, immunological

Table 3. Differential diagnosis of autistic spectrum disorders with respect to mental retardation and language development disorders

Parameter	Autistic spectrum disorders	Primary speech and language disorder specified speech development disorders	Mental retardation
Age of possible detection	Autism even before the age of 18 months; Asperger syndrome after the age of 3	After the age of 18 months	Developmental milestones reached with delay
Psychomotor development	Markedly disharmonious, regression with more than 25% of children with autism	Most often harmonious except for the delayed speech development, without regression	Harmonious or mildly disharmonious
Family history	Developmental disorders	Possible language and speech disorders	Negative or mental retardation
Social orientation	Weak or interrupted from the start: without the initiative to make contact with parents. They avoid eye contact, look at face parts, are able to "focus" if they do not avoid eye contact	Adequate eye contact	Adequate eye contact
Protoimperative and protodeclarative pointing	Do not appear during spontaneous development	At the expected age	+ Can be delayed
Intelligence	With 2/3 below the level for the age, uneven because of the damaged relational processing; Very difficult to solve problems which do not require an explicit „true-false" solution	Large difference between Iqv and IQm	Below the level for the age Even
Motor skills	Gross motor skills usually well organised	Gross and fine motor skills equally mature and organised	Gross and fine motor skills generally less mature, less organised, less harmonious; Oriented
Speech	Delay, total loss without compensatory forms of communication; Impaired initiation or sustained communication, nonpragmatism; Stereotyped, echolalic, paraphasic or idiosyncratic use of speech; Agrammatism, damaged deixis, changed prosody	Abnormal speech development, non-existent or underdeveloped for the age; There are compensatory forms of communication; Initiation and sustained nonverbal communication appropriate for the age; Usually no stereotyped behaviour	Speech acquisition delayed; Adequate initiation and sustained communication; Acquired vocabulary is used; For communication purposes
Emotional life	No apparent mood swings; Emotional reactions rather than emotional relations, complex emotions (disappointment, shame, pride) are rare; Connected to the existence of routines	Rich, lasting emotional bonds	Rich, lasting emotional bonds
Anxiety	Accompanies changes of routines	Occasional, in swings, during impaired gestural communication	+/-
Imitative play, social imitation	-	+/-	+
Sphincter control training impaired	+/-	-	In keeping with mental development
Eating disorders	++	-	-
Productive psychopathology	-/+	-	-
Interest in goings-on and activities	--/+	+	+
Tendency towards permanency of situations, people and activities	++ (change of routine accompanied by tantrum and protest)	-	-/+ (relatively good at change of routine)
Fascinations	++	-	-
Ritual actions	Frequent	-	Rare
Stereotypy	++	-	+

and biochemical abnormalities. The standard multidisciplinary diagnostic approach includes the use of ICD or DSM diagnostic criteria, medical history of the disorder, the use of standardized questionnaires and psychological tests and the diagnosis of comorbid conditions [54]. The prevention of delay in autism diagnosis and better professional recognition of the autistic spectrum disorders in regional health centres impose themselves as important issues in further planning of general prevention in these groups of developmental disorders by the public health sector.

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Аутизам и спектар аутистичног поремећаја у контексту нове *DSM-V* класификације и клиничких и епидемиолошких података

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КРАТАК САДРЖАЈ

Аутизам је један од поремећаја из аутистичног спектра, поред Аспергеровог синдрома, атипичног аутизма и первазивног поремећаја који није другде класификован. Ови поремећаји су сврстани међу менталне поремећаје, јер се манифестују кроз широк спектар когнитивних, емоционалних и неуробихејвиоралних ненормалности. Кључне категоријалне одлике поремећаја су: јасно оштећење развоја социјализације детета, разумевања и продуковања вербалне и невербалне комуникације, те ограничени и понављани обрасци понашања. Демаркационе границе нису јасне ни унутар саме групе поремећаја из спектра аутистичног поремећаја, нити у односу на аутистичне црте понашања у општој популацији. Због тога термин „спектар" указује на значај димензионог сагледавања аутистичних поремећаја, што ће највероватније бити основа и у новом дијагностичком класификовању поремећаја из садашње групе первазивних поремећаја развоја у новој класификацији *DSM-V* (*Diagnostic and Statistical Manual of Mental Disorders*, пето издање) Америчког удружења психијатара (*American Psychiatric Association – APA*). Разумевање поремећаја из аутистичног спектра, али и преваленција поремећаја, коренито су се мењали у последње четири деценије. Тако се предвиђања преваленције од четири оболела на 10.000 особа данас крећу од 0,6% до око 1%. Ово повећање преваленције не може се објаснити искључиво бољим препознавањем поремећаја од стране стручњака и родитеља, нити ширим дијагностичким критеријумима. Општи је закључак да поремећаји из аутистичног спектра више нису ретка стања и да је потпуно оправдан приступ усмерен ка прихватању упозорења да је реч о хитном проблему јавног здравства.

Кључне речи: аутизам; аутистични спектар поремећаја; *DSM-V* класификација; епидемиолошки подаци

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