Pervasive Developmental Disorders are characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities. The qualitative impairments that define these conditions are distinctly deviant relative to the individual's developmental level or **mental age.** This section contains Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified. These disorders are usually evident in the first years of life and are often associated with some degree of Mental Retardation, which, if present, should be coded on Axis II. The Pervasive Developmental Disorders are sometimes observed with a diverse group of other general medical conditions (e.g., chromosomal abnormalities, congenital infections, structural abnormalities of the central nervous system). If such conditions are present, they should be noted on Axis III. Although terms like "psychosis" and "childhood schizophrenia" were once used to refer to individuals with these conditions, there is considerable evidence to suggest that the Pervasive Developmental Disorders are distinct from Schizophrenia (however, an individual with Pervasive Developmental Disorder may occasionally later develop Schizophrenia).

299.00 Autistic Disorder

Diagnostic Features

The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual. Autistic Disorder is sometimes referred to as **early infantile autism, childhood autism, or Kanner's autism.**

The impairment in reciprocal social interaction is gross and sustained. There may be marked impairment in the use of multiple nonverbal behaviors (e.g., eye-to-eye gaze, facial expression, body postures and gestures) to regulate social interaction and communication (Criterion Ala). There may be failure to develop peer relationships appropriate to developmental level (Criterion Alb) that may take different forms at different ages." Younger individuals may have little or no interest in establishing friendships. Older individuals may have an interest in friendship but lack understanding of the conventions of social interaction. There may be a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., not showing, bringing, or pointing out objects they find interesting) (Criterion A1c). Lack of social or emotional reciprocity may be present (e.g., not actively participating in simple social play or games, preferring solitary activities, or involving others in activities only as tools or "mechanical" aids) (Criterion A1d). Often an individual's awareness of others is markedly impaired. Individuals with this disorder may be oblivious to other children (including siblings), may have no concept of the needs of others, or may not notice another person's distress.

The impairment in communication is also marked and sustained and affects both verbal and nonverbal skills. There may be delay in, or total lack of, the development of spoken language..(Criterion A2a). In individuals who do speak, there may be marked impairment in the ability to initiate or sustain a conversation with others (Criterion A2b), or a stereotyped and repetitive use of language or idiosyncratic language (Criterion A2c). There may also be a lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level (Criterion A2d). When speech does develop, the pitch, intonation, rate, rhythm, or stress may be abnormal (e.g., tone of voice may be monotonous or contain question like rises at ends of statements). Grammatical structures are often immature and include stereotyped and repetitive use of language (e.g., repetition of words or phrases regardless of meaning; repeating jingles or commercials) or metaphorical language (i.e., language that can only be understood clearly by those familiar with the individual's communication style). A disturbance in the comprehension of language may be evidenced by an inability to understand simple questions, directions, or jokes. Imaginative play is often absent or markedly impaired. These individuals also tend not to engage in the simple imitation games or routines of infancy or early childhood or do so only out of context or in a mechanical way.

Individuals with Autistic Disorder have restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. There may be an encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus (Criterion A3a); an apparently inflexible adherence to specific, nonfunctional routines or rituals (Criterion A3b); stereotyped and repetitive motor mannerisms (Criterion A3c); or a persistent preoccupation with parts of objects (Criterion A3d). Individuals with Autistic Disorder display a markedly restricted range of interests and are often preoccupied with one narrow interest (e.g., with amassing facts about meteorology or baseball statistics). They may line up an exact number of play things in the same manner over and over again or repetitively mimic the actions of a television actor. They may insist on sameness and show resistance to or distress over trivial changes (e.g., a younger child may have a catastrophic reaction to a minor change in the environment such as a new set of curtains or a change in place at the dinner table). There is often an interest in nonfunctional routines or rituals or an unreasonable insistence on following routines (e.g., taking exactly the same route to school every day). Stereotyped body movements include the hands (clapping, finger flicking) or whole body (rocking, dipping, and swaying). Abnormalities of posture (e.g., walking on tiptoe, odd hand movements and body postures) may be present. These individuals show a persistent preoccupation with parts of objects (buttons, parts of the body). There may also be a fascination with movement (e.g., the spinning wheels of toys, the opening and closing of doors, an electric fan or other rapidly revolving object). The person may be highly attached to some inanimate object (e.g., a piece of string or a rubber band).

The disturbance must be manifest by delays or abnormal functioning in at least one of the following areas prior to age 3 years: social interaction, language as used in social" communication, or symbolic or imaginative play (Criterion B). There is typically no period of unequivocally normal development, although 1 or 2 years of relatively normal development has been reported in some instances. In a minority of cases, parents report regression in language development, generally manifest as the cessation of speech after a child has acquired from 5 to 10 words. By definition, if there is a period of normal development, it cannot extend past age 3 years. The disturbance must not be better accounted for by Rett's Disorder or Childhood Disintegrative Disorder (Criterion C).

Associated Features and Disorders

Associated descriptive features and mental disorders. In most cases, there is an associated diagnosis of Mental Retardation, commonly in the moderate range (IQ 35-50). Approximately 75% of children with Autistic Disorder function at a retarded level. There may be abnormalities in the development of cognitive skills. The profile of cognitive skills is usually uneven, regardless of the general level of intelligence (e.g., a 4 1/2 year-old girl with Autistic Disorder may be able to read, i.e., hyperlexia). In many higher-functioning children with Autistic Disorder, the level of receptive language (i.e., language comprehension) is below that of expressive language (e.g., vocabulary). Individuals with Autistic Disorder may have a range of behavioral symptoms, including hyperactivity, short attention span, impulsivity, aggressiveness, self-injurious behaviors, and, particularly in young children, temper tantrums. There may be odd responses to sensory stimuli (e.g., a high threshold for pain, oversensitivity to sounds or being touched, exaggerated reactions to light or odors, fascination with certain stimuli). There may be abnormalities in eating (e.g., limiting diet to a few foods, Pica) or sleeping (e.g., recurrent awakening at night with rocking). Abnormalities of mood or affect (e.g., giggling or weeping for no apparent reason, an apparent absence of emotional reaction) may be present. There may be a lack of fear in response to real dangers, and excessive fearfulness in response to harmless objects. A variety of self-injurious behaviors may be present (e.g.. head banging or finger, hand, or wrist biting). In adolescence or early adult life, individuals with Autistic Disorder who have the intellectual capacity for insight mav become dgpressed in response to the realization of their serious impairment.

Associated laboratory findings. When Autistic Disorder is associated with a general medical condition, laboratory findings consistent with the general medical condition will be observed. There have been reports of group differences in measures of serotonergic activity, but these are not diagnostic for Autistic Disorder. Imaging studies may be abnormal in some cases, but no specific pattern has been clearly identified. EEG abnormalities are common even in the absence of seizure disorders.

Associated physical examination findings and general medical conditions

Various nonspecific neurological symptoms or signs may be noted (e.g., primitive reflexes, delayed development of hand dominance) in Autistic Disorder. The condition is sometimes observed in association with a neurological or other general medical condition (e.g., encephalitis, phenylketonuria, tuberous sclerosis, fragile X syndrome, anoxia during birth, maternal rubella). Seizures may develop (particularly in adolescence) in as many as 25% of cases. When other general medical conditions are present, they should be noted on Axis III.

Prevalence

Epidemiological studies suggest rates of Autistic Disorder of 2-5 cases per 10,000 individuals.

Course

By definition, the onset of Autistic Disorder is prior to age 3 years. In some instances, parents will report that they have been worried about the child since birth or shortly afterward because of the child's lack of interest in social interaction. Manifestations of the disorder in infancy are more subtle and difficult to define than those seen after age 2 years. In a minority of cases, the child may be reported to have developed normally for the first year (or even 2 years) of life. Autistic Disorder follows a continuous course. In school-age children and adolescents, developmental gains in some areas are common (e.g., increased interest in social functioning as the child reaches school age). Some individuals deteriorate behaviorally during adolescence, whereas others improve. Language skills (e.g., presence of communicative speech) and overall intellectual level are the strongest factors related to ultimate prognosis. Available follow-up studies suggest that only a small percentage of individuals with the disorder go on as adults to live and work independently. In about one-third of cases, some degree of partial independence is possible. The highest functioning adults with Autistic Disorder typically continue to exhibit problems in social interaction and communication along with markedly restricted interests and activities.

Familial Pattern

There is an increased risk of Autistic Disorder among siblings of individuals with the disorder.

Differential Diagnosis

Periods of developmental regression may be observed in normal development, but these are neither as severe nor as prolonged as in Autistic Disorder. Autistic Disorder must be differentiated from **other Pervasive Developmental Disorders.Rett'sDisorder** differs from Autistic Disorder in its characteristic sex ratio and pattern of deficits. Rett's Disorder has been diagnosed only in females, whereas Autistic Disorder occurs much more frequently in males. In Rett's Disorder, there is a characteristic pattern of head growth deceleration, loss of previously acquired purposeful hands kills, and the appearance of poorly coordinated gait or trunk movements. Particularly during the preschool years, individuals with Rett's Disorder may exhibit difficulties in social interaction similar to those observed in Autistic Disorder, but these tend to be transient. This differs from **Childhood Disintegrative Disorder,** which has a distinctive pattern of developmental regression following at least 2 years of normal development. In Autistic Disorder, developmental abnormalities are usually noted within the first year of life. When information on early development is unavailable or when it is not possible to document the required period of normal development, the diagnosis of Autistic Disorder should be made. **Asperger's Disorder** can be distinguished from Autistic Disorder by the lack of delay in language development. Asperger's Disorder is not diagnosed if criteria are met for Autistic Disorder.

Schizophrenia with childhood onset usually develops after years of normal, or near normal, development. An additional diagnosis of Schizophrenia can be made if an individual with Autistic Disorder develops the characteristic features of Schizophrenia (see p. 274) with active-phase symptoms of prominent delusions or hallucinations that last for at least 1 month. In **Selective Mutism,** the child usually exhibits appropriate communication skills in certain contexts and does not have the severe impairment in social interaction and the restricted patterns of behavior associated with Autistic Disorder. In **Expressive Language Disorder** and **Mixed Receptive-Expressive Language Disorder,** there is a language impairment, but it is not associated with the presence of a qualitative impairment in social interaction and restricted, repetitive, and stereotyped patterns of behavior. It is sometimes difficult to determine whether an additional diagnosis of Autistic Disorder is warranted in an individual with Mental Retardation, especially if the **Mental Retardation** is Severe or Profound. An additional diagnosis of Autistic Disorder is reserved for those situations in which there are qualitative deficits in social and communicative skills and the specific behaviors characteristic of Autistic Disorder are present. Motor stereotypies are characteristic of Autistic Disorder; an additional diagnosis of **Stereotypic Movement Disorder** is not given when these are better accounted for as part of the presentation of Autistic Disorder.

Diagnostic criteria for 299.00 Autistic Disorder

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

(1) qualitative impairment in social interaction, as manifested by at least two of the following:

- marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- failure to develop peer relationships appropriate to developmental level
- a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
- lack of social or emotional reciprocity

(2) qualitative impairments in communication as manifested by at least one of the following:

- delay in, or total lack of, the development of spoken language not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
- in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
- stereotyped and repetitive use of language or idiosyncratic language
- lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

- encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- apparently inflexible adherence to specific, nonfunctional routines or rituals
- stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the followingareas,with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

C. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.

Diagnostic Features

The essential feature of Rett's Disorder is the development of multiple specific deficits following a period of normal functioning after birth. Individuals have an apparently normal prenatal and perinatal period (Criterion AI) with normal psychomotor development through the first 5 months of life (Criterion A2). Head circumference at birth is also within normal limits (Criterion A3). Between ages 5 and 48 months, head growth decelerates (Criterion BI). There is a loss of previously acquired purposeful hand skills between ages 5 and 30 months, with the subsequent development of, characteristic stereotyped hand movements resembling hand-wringing or hand washing (Criterion B2). Interest in the social environment diminishes in the first few years after the onset of the disorder (Criterion B3), although social interaction may often develop later in the course. Problems develop in the coordination of gait or trunk movements (Criterion B4). There is also severe impairment in expressive and receptive language development, with severe psychomotor retardation (Criterion B5).

Associated Features and Disorders

Rett's Disorder is typically associated with Severe or Profound Mental Retardation, which, if present, should be coded on Axis II. There are no specific laboratory findings associated with the disorder. There may be an increased frequency of EEC abnormalities and seizure disorder in individuals with Rett's Disorder. Nonspecific abnormalities on brain imaging have been reported.

Prevalence

Data are limited to mostly case series, and it appears that Rett's Disorder is much less common than Autistic Disorder. This disorder has been reported only in females.

Course

The pattern of developmental regression is highly distinctive. Rett's Disorder has its onset prior to age 4 years, usually in the first or second year of life. The duration of the disorder is lifelong, and the loss of skills is generally persistent and progressive. In most instances, recovery is quite limited, although some very modest developmental gains may be made and interest in social interaction may be observed as individuals enter later childhood or adolescence. The communicative and behavioral difficulties usually remain relatively constant throughout life.

Differential Diagnosis

Periods of developmental regression may be observed in normal development, but these are neither as severe or as prolonged as in Rett's Disorder. For the differential between Rett's Disorder and **Autistic Disorder,** see p. 69. Rett's Disorder differs from Childhood **Disintegrative Disorder** and **Asperger's Disorder** in its characteristic sex ratio, onset, and pattern of deficits. Rett's Disorder has been diagnosed only in females, whereas Childhood Disintegrative Disorder and Asperger's Disorder appear to be more common in males. The onset of symptoms in Rett's Disorder can begin as early as age 5 months, whereas in Childhood Disintegrative Disorder the period of normal development is typically more prolonged (i.e., at least until age 2 years). In Rett's Disorder, there is a characteristic pattern of head growth deceleration, loss of previously acquired purposeful hand skills, and the appearance of poorly coordinated gait or trunk movements. In contrast to Asperger's Disorder, Rett's Disorder is characterized by a severe impairment in expressive and receptive language development.

Diagnostic criteria for 299.80 Rett's Disorder

A. All of the following:

- apparently normal prenatal and perinatal development
- apparently normal psychomotor development through the first 5 months after birth
- normal head circumference at birth

B. Onset of all of the following after the period of normal development:

- deceleration of head growth between ages 5 and 48 months
- loss of previously acquired purposeful hand skills between ages 5 and 30 months with the subsequent development of stereotyped hand movements (e.g., hand-wringing or hand washing)
- loss of social engagement early in the course (although often social interaction develops later)
- appearance of poorly coordinated gait or trunk movements
- severely impaired expressive and receptive language development with severe psychomotor retardation

Diagnostic Features

The essential feature of Childhood Disintegrative Disorder is a marked regression in multiple areas of functioning following a period of at least 2 years of apparently normal development (Criterion A). Apparently normal development is reflected in age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior. After the first 2 years of life (but before age 10 years), the child has a clinically significant loss of previously acquired skills in at least two of the following areas: expressive or receptive language, social skills or adaptive behavior, bowel or bladder control, play, or motor skills (Criterion B). Individuals with this disorder exhibit the social and communicative deficits and behavioral features generally observed in Autistic Disorder (see p. 66). There is qualitative impairment in social interaction (Criterion Cl) and in communication (Criterion C2), and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities (Criterion C3). The disturbance is not better accounted for by another specific Pervasive Developmental Disorder or by Schizophrenia (Criterion D). This condition has also been termed Heller's syndrome, dementia infantilis, or disintegrative psychosis

Associated Features and Disorders

Childhood Disintegrative Disorder is usually associated with Severe Mental Retardation, which, if present, should be coded on Axis II. Various nonspecific neurological symptoms or signs may be noted. There seems to be an increased frequency of EEG abnormalities and seizure disorder. Although it appears likely that the condition is the result of some insult to the developing central nervous system, no precise mechanism has been identified. The condition is occasionally observed in association with a general medical condition (e.g., metachromatic leukodystrophy, Schilder's disease) that might account for the developmental regression. In most instances, however, extensive investigation does not reveal such a condition. If a neurological or other general medical condition is associated with the disorder, it should be recorded on Axis III. The laboratory findings will reflect any associated general medical conditions

Prevalence

Epidemiological data are limited, but Childhood Disintegrative Disorder appears to be very rare and much less common than Autistic Disorder. Although initial studies suggested an equal sex ratio, the most recent data suggest that the condition is more common among males.

Course

By definition, Childhood Disintegrative Disorder can only be diagnosed if the symptoms are preceded by at least 2 years of normal development and the onset is prior to age 10 years. When the period of normal development has been quite prolonged (5 or more years), it is particularly important to conduct a thorough physical and neurological examination to assess for the presence of a general medical condition.In most cases, the onset is between ages 3 and 4 years and may be insidious or abrupt, Premonitory signs can include increased activity levels, irritability, and anxiety followed by a loss of 'speech and other skills. Usually the loss of skills reaches a plateau, after which some limited improvement may occur, although improvement is rarely marked. In other instances, especially when the disorder is associated with a progressive neurological condition, the loss of skills is progressive. This disorder follows a continuous course, and in the majority of cases, the duration is lifelong. The social, communicative, and behavioral difficulties remain relatively constant throughout life.

Differential Diagnosis

Periods of regression may be observed in normal development, but these are neither as severe nor as prolonged as in Childhood Disintegrative Disorder. Childhood Disintegrative Disorder must be differentiated from **other Pervasive Developmental Disorders.** For the differential diagnosis with **Autistic Disorder,** see p. 69. For the differential diagnosis with **Rett's Disorder,** see p. 72. In contrast to **Asperger's Disorder,** Childhood Disintegrative Disorder is characterized by a clinically significant loss in previously acquired skills and a greater likelihood of Mental Retardation. In Asperger's Disorder, there is no delay in language development and no marked loss of developmental skills. Childhood Disintegrative Disorder must be differentiated from a dementia with onset during infancy or childhood. **Dementia** occurs as a consequence of the direct physiological effects of a general medical condition (e.g., head trauma), whereas Childhood Disintegrative Disorder typically occurs in the absence of an associated general medical condition.

Diagnostic criteria for 299.10 Childhood Disintegrative Disorder

A. Apparently normal development for at least the first 2 years after birth as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior.

B. Clinically significant loss of previously acquired skills (before age 10 years) in at least two of the following areas:

- expressive or receptive language
- social skills or adaptive behavior
- bowel or bladder control
- play
- motor skills

C. Abnormalities of functioning in at least two of the following areas:

- qualitative impairment in social interaction (e.g., impairment in nonverbal behaviors, failure to develop peer relationships, lack of social or emotional reciprocity)
- qualitative impairments in communication (e.g., delay or lack of spoken language, inability to initiate or sustain a conversation, stereotyped and repetitive use of language, lack of varied make-believe play)
- restricted, repetitive, and stereotyped patterns of behavior, interests, and activities, including motor stereotypies and mannerisms

D. The disturbance is not better accounted for by another specific Pervasive Developmental Disorder or by Schizophrenia.

Diagnostic Features

The essential features of Asperger's Disorder are severe and sustained impairment in social interaction (Criterion A) and the development of restricted, repetitive patterns of behavior, interests, and activities (Criterion B) (see p. 66 in Autistic Disorder for a discussion of Criteria A and B). The disturbance must cause clinically significant impairment in social, occupational, or other important areas of functioning (Criterion C). In contrast to Autistic Disorder, there are no clinically significant delays in language (e.g., single words are used by age 2 years, communicative phrases are used by age 3 years) (Criterion D). In addition, there are no clinically significant delays in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood. (Criterion E). The diagnosis is not given if the criteria are met for any other specific Pervasive Developmental Disorder or for Schizophrenia (Criterion F).

Associated Features and Disorders

Asperger's Disorder is sometimes observed in association with general medical conditions that should be coded on Axis III. Various nonspecific neurological symptoms or signs may be noted. Motor milestones may be delayed, and motor clumsiness is often observed.

Prevalence

Information on the prevalence of Asperger's Disorder is limited, but it appears to be more common in males.

Course

Asperger's Disorder appears to have a somewhat later onset than Autistic Disorder, or at least to be recognized somewhat later. Motor delays or motor clumsiness may be noted in the preschool period. Difficulties in social interaction may become more apparent in the context of school. It is during this time that particular idiosyncratic or circumscribed interests (e.g., a fascination with train schedules) may appear or be recognized as such. As adults. individuals with the condition may have problems with empathy and modulation of social interaction. This disorder apparently follows a continuous course and, in the vast majority of cases, the duration is lifelong.

Familial Pattern

Although the available data are limited, there appears to be an increased frequency of Asperger's Disorder among family members of individuals who have the disorder.

Differential Diagnosis

Asperger's Disorder is not diagnosed if criteria are met for another **Pervasive Developmental Disorder** or for **Schizophrenia.** For the differential diagnosis with **Autistic Disorder,** see p. 69. For the differential diagnosis with **Rett's Disorder,** see p. 72. For the differential diagnosis with **Childhood Disintegrative Disorder,** see p. 74. Asperger's Disorder must also be distinguished from **Obsessive-Compulsive Disorder and Schizoid Personality Disorder.** Asperger's Disorder and Obsessive-Compulsive Disorder share repetitive and stereotyped patterns of behavior. In contrast to Obsessive-Compulsive Disorder, Asperger's Disorder is characterized by a qualitative impairment in social interaction and a more restricted pattern of interests and activities. In contrast to Schizoid Personality Disorder, Asperger's Disorder is characterized by stereotyped behaviors and interests and by more severely impaired social interaction.

Diagnostic criteria for 299.80 Asperger's Disorder

A. Qualitative impairment in social interaction, as manifested by at least two of the following:

- marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
- failure to develop peer relationships appropriate to developmental level
- a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
- lack of social or emotional reciprocity

B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one, of the following:

- encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
- apparently inflexible adherence to specific, nonfunctional routines or rituals
- stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- persistent preoccupation with parts of objects

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

D. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).

E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.

F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

299.80 Pervasive Developmental Disorder Not Otherwise Specified (Including Atypical Autism)

This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction or verbal and nonverbal communication skills, or when stereotyped behavior, interests, and activities are present, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder. For example, this category includes "atypical autism" presentations that do not meet the criteria for Autistic Disorder because of late age at onset, atypical symptomatology, or subthreshold symptomatology, or a|l of these.