“Frank” Autism

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Do we recognise autism by virtue of having previously seen and remembered it, or rather by consciously and deliberately applying criteria one after the other? And if we do recognise it as we would a face, without a second thought, do we recognise it according to the specific criteria outlined for example in the DSM-5 (a clinician’s bible for diagnosing mental disorders)? These are the questions that Ashley de Marchena, a young researcher, attempted to address. For this purpose, 151 clinicians, each with 1 to 40 years of diagnostic experience, were asked to fill questionnaires investigating the time they needed to detect autism in a person, and the factors they reported using to make this judgement.

The results are startling. Firstly, a large majority of clinicians (97%) report an experience of “frank” autism (also referred to as “hallway autism”, to imply that it was recognisable since the person entered the waiting room; our group uses the term *prototypical* autism). Autism is therefore recognised by the clinician prior to confirmation through comprehensive diagnostic assessment in an average of 40% of people who go on to receive a diagnosis of autism. Furthermore, this recognition of autism occurs independently from the person’s level of functioning or language abilities. For example, it may occur as frequently in a non-verbal individual and a person who talks extensively. What this tells us is that the “frank” or prototypical autism identified by experts is not associated with intellectual disability (contrary to popular belief that “real” autistic people are those with an intellectual disability). Clinicians require, on average, less than 10 minutes to form this impression. Lastly, this capacity to recognise autism so rapidly is determined not by profession (psychologist or physician), but by the number of autistic people the clinician has previously evaluated.

One of the findings of this study is that “frank” autism is recognised in part based on criteria which differ from those outlined in diagnostic manuals such as the DSM-5. An apparent lack of social reciprocity in eye gaze or facial expressions, both of which are part of DSM-5 diagnostic criteria, indeed play a large role in the recognition of “frank” autism, but clinicians also rely on atypical gait, intonation and posture, which are not mentioned in DSM-5. Furthermore, DSM-5 criteria largely emphasise socio-communicative signs in diagnosing autism, whilst this study reported that repetitive behaviours were what first came to mind in terms of traits facilitating a recognition of “frank” autism. Ultimately, this recognition does not occur *differentially*, as is the case when one makes a differential diagnosis by distinguishing one condition from another, which might also explain the same symptoms. Clinicians therefore recognise autism as one might recognise a face: when I recognise someone, there is no need for elaborate reasoning to eliminate other possible identities, except in cases where a face might be blurry or partially hidden.

These results explain findings from another study, which demonstrated that consciously applying diagnostic criteria improved reliability of diagnosis in inexperienced clinicians, but *compromised* it in experts! What this suggests is that exposure to numerous cases of autism is essential for building good diagnostic skills, and that scientists would potentially have a lot to gain from studying “frank” autism traits, who appear more typical of the condition than those presently being studied around the world. This could help to determine with more certainty whether people in the grey area of autism (i.e. not belonging to the “frank” autism group) are indeed autistic, or if the resemblance is merely superficial.

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