

English edition

Dutch
Interview for
Diagnostic assessment
Autism spectrum disorder in adults **(NIDA)**

Manual and **Interview**

Richard Vuijk

English translation

Richard Vuijk

Niall Jassim

Katy Klugkist

Dutch Interview for Diagnostic assessment Autism spectrum disorder in adults (NIDA) - Manual and Interview

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Foreword

This work is the English translation of the third, revised edition of the *Nederlands Interview voor Diagnostiek Autismespectrumstoornis bij volwassenen (NIDA) - Handleiding en Interview* [Dutch Interview for Diagnostic Assessment Autism spectrum disorder in adults (NIDA) – Manual and Interview] (Vuijk 2023). The original Dutch edition of the NIDA was first published in 2014 (Vuijk 2014). The second, unaltered Dutch edition appeared in 2016 (Vuijk 2016). After publication of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association 2013), I developed the NIDA for diagnostic assessment of autism spectrum disorder (ASD) in adults in mental health services. In the Netherlands, the NIDA has acquired a permanent position in diagnostic assessment of ASD in adults in various mental health institutions and with many mental health professionals.

The current edition of the NIDA has been revised and updated, including a manual based on scientific research in diagnostic assessment of ASD in adults. In the current edition, the complete text of the diagnostic criteria for ASD according to DSM-5-TR, text revision of DSM-5 (American Psychiatric Association 2022) is included. In a user-friendly approach, we have broken down several interview questions into sub-questions with associated examples. As can be found in this manual, a recent study examining the psychometric properties of the NIDA has demonstrated the NIDA to be a reliable and valid instrument for assessing DSM-5(-TR) (diagnostic criteria of) ASD in adults (Vuijk et al. 2022).

Aligned with the DSM-5-TR and in accordance with common practices in Dutch mental healthcare, the NIDA employs person-first language (i.e., a person with ASD) rather than identity-first language (i.e., an autistic person). It should be noted that we acknowledge the different perspectives as well as the growing general preference for identity-first language (Botha et al. 2023; Bury et al. 2023; Taboas et al. 2023; Vivanti 2021).

Given the apparent need for the NIDA in international clinical practice, we have responded by making the instrument available in English alongside the release of the third revised Dutch edition. Translation into other languages has been planned. The NIDA appears to be regularly used in scientific research.

Development and publication of the first Dutch editions of the NIDA have been facilitated by Sarr Autisme Rotterdam, part of Parnassia Psychiatric Institute. Sarr Autisme Rotterdam and Parnassia Academy have provided financial support to produce this current edition.

For future development of the NIDA, I would greatly appreciate feedback from people in clinical practice and scientific research.

Rotterdam,
July 28, 2024

Richard Vuijk, MSc, PhD

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Manual

1. Diagnostic assessment of autism spectrum disorder in adults

1.1 Introduction

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR; American Psychiatric Association 2022), autism spectrum disorder (ASD) is a neurodevelopmental disorder characterized by persistent deficits in social communication and social interaction (e.g., abnormal social approach and failure of normal back-and-forth conversation) and restricted, repetitive patterns of behavior, interests, or activities (e.g., insistence on sameness, fixated interests, and hyper- or hyporeactivity to sensory input). The worldwide prevalence of ASD in the general population is estimated to be 1% to 2% (Brugha et al. 2016; Hirota & King 2023; Lord et al. 2020; Roman-Urrestarazu et al. 2021; Zeidan et al. 2022). ASD prevalence estimates in inpatient psychiatric settings range from 2% to 10% (Tromans et al. 2018). Prevalence of ASD in an adult outpatient psychiatry population is estimated to be at least 19% (Nyrenius et al. 2022); a recalculation resulted in a prevalence of 9% (Bejerot & Nylander 2022). About one-third of people with ASD have a concurrent diagnosis of intellectual developmental disorder (Baio et al. 2018; Lord et al. 2020; Rydzewska et al. 2018; Shenouda et al. 2023; Zeidan et al. 2022). The etiopathogenesis of ASD is unclear, but gene variants and gene-environment interactions have been identified as two of the main causes of the ASD pathophysiology (Waterhouse et al. 2016; Lord et al. 2020). For many years, there has been a debate surrounding the male-to-female ratio in ASD and the variations in ASD presentation between men and women (McCrossin 2022; Napolitano et al. 2022; Rujeedawa & Zaman 2022; Walsh et al. 2023). A systematic review, meta-analysis, and pooled data-analysis showed no differences between men and women in social communication and social interaction (Tillmann et al. 2018; Van Wijngaarden-Cremers et al. 2014). Results of a random forest study examining diagnostic data from the *Autism Diagnostic Observation Schedule-Generic/Second edition* (ADOS-G/-2; Lord et al. 2000, 2012) do not suggest the need for new or altered diagnostic algorithms for women with ASD: the existing diagnostic instruments seem to sufficiently capture the core ASD features (i.e., a score at least at or above the cut-off point) (Stroth et al. 2022).

According to (inter)national guidelines for ASD in adults (Kan et al. 2013; NICE 2021), diagnostic assessment of ASD in adults consists of case identification of ASD, inventory of current functioning and challenging behavior, behavioral observation, assessment of early developmental history, and inventory of healthcare needs. Diagnostic assessment of ASD can be divided into two or three phases and associated steps (Vuijk 2018; see Table 1). In Phase 1, individuals themselves or their close relations begin to notice difficulties related to social communication and interaction, and initial indications of ASD arise. In Phase 2, case identification or the initial assessment of ASD involves two steps. In Step 1, the initial indication of ASD is substantiated or refuted. In Step 2, the involved mental health professional(s) reflect(s) on information obtained from Step 1 to determine whether or not Phase 3, a comprehensive assessment of suspected ASD, is warranted. The case identification outcome may also lead to diagnostic assessment of disorders and conditions other than ASD. Phase 3 also consists of two steps. During Step 3, diagnostic classification and person-centered assessment take place using structured methods like interviews, questionnaires, and observation. Finally in Step 4, the involved mental health professional(s) reflect(s) on the information obtained from Step 3, leading to a (person-centered) diagnosis, including a DSM-5-TR diagnosis (whether or not ASD or otherwise) and a personalized treatment plan.

Table 1 Phases and steps in diagnostic assessment of ASD in adults¹**Phase 1** Initial indication of ASD**Phase 2** Case identification

- Step 1: Substantiating first indication of ASD
- Step 2: Reflection on case identification (yes/no indication for Phase 3)

Phase 3 Diagnostic classification and person-centered assessment

- Step 3: Testing the ASD hypothesis
- Step 4: Reflection on diagnostic classification and person-centered assessment

ASD = autism spectrum disorder

¹ Table from *Method - Psychodiagnostic assessment autism spectrum disorder in adults* (Vuijk 2018, p. 6)

Limited evidence exists for a gold standard diagnostic instrument assessing ASD in adults: many instruments lack evidence of validity and reliability (Baghdadli et al. 2017; Conner et al. 2019; Metcalfe et al. 2020; Wigham et al. 2019). For assessing the DSM-5-TR diagnostic criteria for ASD, the present *Dutch Interview for Diagnostic Assessment Autism spectrum disorders in adults* (NIDA) can be administered during diagnostic classification and person-centered assessment (Phase 3) (see Chapter 3).

Assessment of differential diagnoses and comorbid disorders or conditions should be part of the diagnostic assessment of ASD (see Alexander & Farrelly 2022; Allely et al. 2023; Carthy & Murphy 2021; Cumin et al. 2022; Defresne & Mottron 2022; Frigaux et al. 2019; Fusar-Poli et al. 2022; Gillett et al. 2023; Lai 2022; Lai et al. 2019; May et al. 2021; Thurm et al. 2019). Comorbidity rates of mental disorders, including anxiety disorders, depressive disorders, attention-deficit/hyperactivity disorder (ADHD), and personality pathology/disorders in people with ASD range from 14% to 80% (Buck et al. 2014; Croen et al. 2015; Hollocks et al. 2019; Kentrou et al. 2021; Lever & Geurts 2016; Linden et al. 2023; Lugo-Marín et al. 2019; Rinaldi et al. 2021; Uljarević et al. 2020; Vuijk et al. 2018).

In adulthood, ASD is associated with both improvements and possibilities as well as difficulties in daily functioning that impact quality of life and mental health (Baron-Cohen & Lombardo 2017; Howlin 2021; Lawson et al. 2020; Mason et al. 2019, 2021; Umagami et al. 2022).

1.2 DSM-5-TR diagnostic criteria for autism spectrum disorder

Autism Spectrum Disorder

(American Psychiatric Association 2022, pp. 56-58)

F84.0 Diagnostic Criteria

- A Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following, currently or by history (examples are illustrative, not exhaustive; see text):
 - 1 Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
 - 2 Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
 - 3 Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
- B Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
 - 1 Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 - 2 Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take the same route or eat same food every day).
 - 3 Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
 - 4 Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).
- C Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- D Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

- E These disturbances are not better explained by intellectual developmental disorder (intellectual disability) or global developmental delay. Intellectual developmental disorder and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual developmental disorder, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify current severity based on social communication impairments and restricted, repetitive patterns of behavior (see Table 2):

Requiring very substantial support

Requiring substantial support

Requiring support

Specify if:

With or without accompanying intellectual impairment

With or without accompanying language impairment

Specify if:

Associated with a known genetic or other medical condition or environmental factor (**Coding note:** Use additional code to identify the associated genetic or other medical condition.)

Associated with a neurodevelopmental, mental, or behavioral problem

Specify if:

With catatonia (refer to the criteria for catatonia associated with another mental disorder, p. 135, for definition) (**Coding note:** Use additional code F06.1 catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

Table 2 Severity levels for autism spectrum disorder (examples of level of support needs)

Severity level 3
'Requiring very substantial support'

Social communication

Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.

Restricted, repetitive behaviors

Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.

Severity level 2
'Requiring substantial support'

Social communication

Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and who has markedly odd nonverbal communication.

Restricted, repetitive behaviors

Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Severity level 1
'Requiring support'

Social communication

Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.

Restricted, repetitive behaviors

Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

2. Description of the NIDA

2.1 Intended purpose

The NIDA is a semi-structured interview for assessing the persistent deficits in social communication and social interaction, and restricted, repetitive patterns of behavior, interests, or activities, characterizing ASD according to DSM-5-TR (American Psychiatric Association 2022). The NIDA consists of eight interview questions, derived from the DSM-5-TR diagnostic criteria for ASD covering current or past functioning and the early developmental period (i.e., early childhood and early school years). Questions 1, 2, and 3 are related to the features of criterion A ('persistent deficits in social communication and social interaction'). Questions 4, 5, 6, and 7 are related to the features of criterion B ('restricted, repetitive patterns of behavior, interests, or activities'). Questions 1, 3, 4, 5, and 7 comprise sub-questions derived from parts of the associated features of criteria A and B. Criterion C ('Symptoms must be present in the early developmental period but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life') is assessed based on the answers to the questions covering the early developmental period. Question 8 is related to criterion D ('Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning'). By providing three answer options per question, the mental health professional evaluates the degree to which a feature or criterion is applicable to the client: 'Yes' indicates the feature or criterion is present, 'No' signifies it is not present, and '?' denotes that information is missing, questionable, or unreliable.

The NIDA has been developed to assess the DSM-5-TR diagnostic criteria for ASD in adults. The NIDA is one of the few diagnostic instruments for ASD in adults which follows the DSM-5-TR algorithm for scoring (see Evers et al. 2021).

2.2 Target population

The NIDA is a useful instrument for diagnosing DSM-5-TR ASD in adults. The questions include clear examples of DSM-5-TR diagnostic criteria for ASD covering current or past functioning and the early developmental period to facilitate considering the diagnostic criteria. The examples are based on the DSM-5-TR diagnostic criteria for ASD and ASD literature.

The questions target the current, past, and early childhood behavior of adults aged 18 years and older, both with and without an intellectual disability. The NIDA is administered to the client and/or someone who is well-acquainted with the client and has regular contact, such as a partner, family member, mentor, or coach (e.g., as part of the heteroanamnesis).

The NIDA generally takes between 30 to 60 minutes to administer. In addition, reporting the information also takes between 30 to 60 minutes.

The NIDA is administered by mental health professionals such as (clinical/neuro) psychologists, psychiatrists, and nurse practitioners who are proficient at diagnostic assessment and possess expertise and experience in assessing ASD in adults (Hume 2022; Jellett & Flower 2023).

3. Administering and scoring

3.1 Material

The NIDA consists of a manual, interview and scoring forms. The NIDA is available as a PDF file and in a paperback edition. For usability, permission is granted to reproduce the scoring forms (pp. 62-65) and include them in a diagnostic report.

3.2 Administration instructions

The NIDA can be administered to people with self-insight, willingness, and ability to engage in conversation and to answer interview questions. Several studies (Hesselmark et al. 2015; Keith et al. 2019; Rodgers et al. 2020; Sasson et al. 2018; Schriber et al. 2014) showed that people with ASD have self-insight and are able to adequately and reliably assess their functioning. It should be considered that there are people with ASD who demonstrate a relative lack of self-understanding and are unable to express their thoughts, feelings, and experiences (Jackson et al. 2012). *The Dutch guideline on diagnosis and treatment of adults on the autism spectrum* (Kan et al. 2013) highlights that certain individuals with ASD may not perceive their symptoms as distressing and lacking awareness of their mental health condition. Nevertheless, these symptoms might be more apparent to those in their social environment. In such cases, it is advisable not to directly administer the NIDA to the individual but to someone in frequent contact with them and who knows them well. This person could be a partner, family member, mentor, or coach.

With or without the client being present, the NIDA could be administered to a partner, mentor, or coach when conducting a heteroanamnesis, and to a family member when examining developmental history or conducting a heteroanamnesis. Information provided by a partner, family member, mentor, or coach is additional to the client's information. Conflicting answers will be discussed with the client if possible. Considering the client's level of self-insight, the mental health professional evaluates the preferred information using their clinical judgement.

The mental health professional verbally presents each interview question along with an associated example, asking the interviewee to identify if they recognize the example in current or past functioning, and/or the early developmental period (i.e., early childhood and early school years). Subsequently, the interviewee is prompted to provide their own example. The mental health professional may then offer one or more examples. This step is particularly crucial when the interviewee fails to recognize the example, cannot identify one, or provides an example unrelated to the question. Each acknowledged or provided example relevant to the question is duly noted and marked as present. Additionally, any ASD features observed by the mental health professional during the NIDA administration to the client can be documented as present if they align with the question.

It is essential to clarify that the client is not obligated to identify with all examples. For every question, a comprehensive assessment must be made to determine the presence or absence of the DSM-5-TR criteria A, B, C, and D, along with any associated features for ASD.

3.3 Instructions for client and other informants

The following instruction is given to the client at the start of administering the NIDA:

Using this interview, the features of autism spectrum disorder will be assessed in your current functioning (if necessary: or in your past functioning¹) (if necessary and possible: and in early childhood²). Questions are based on the DSM-5-TR diagnostic criteria for autism spectrum disorder. I will ask you a question and give an example. I will also ask you to give an example yourself. During the interview, I will give you one or a few examples per question that describe how adults (if applicable: and children) show characteristics of autism spectrum disorder. In this way, I will get an overview of your current functioning (if applicable: or your past functioning¹/and your early childhood²) in order to assess if autism spectrum disorder is present. If you do not understand the question, please let me know and I will clarify the question by giving another example.

If applicable:

Your partner, likely familiar with you during your adulthood will be requested to share insights into your functioning throughout the duration of your relationship.

Your family has known you since early childhood, and I will ask if they can share about your early childhood functioning (if applicable: and your current functioning or past functioning¹).

Your mentor or coach⁴ who has likely known you since adulthood will be approached to offer insights into your functioning throughout the duration of your relationship.

The following instruction is given to the client's partner at the start of administering the NIDA:

Using this interview, the features of autism spectrum disorder will be assessed in your partner's current functioning (if necessary and possible: or past functioning¹). Questions are based on the DSM-5-TR diagnostic criteria for autism spectrum disorder. I will ask you a question and give an example. I will also ask you to give an example yourself. During the interview, I will give you one or a few examples per question that describe characteristics of autism spectrum disorder in adults. In this way, I will get an overview of your partner's current functioning (if applicable: or past functioning¹) in order to assess if autism spectrum disorder is present. If you do not understand the question, please let me know and I will clarify the question by giving another example.

The following instruction is given to the client's family member at the start of administering the NIDA:

Using this interview, the features of autism spectrum disorder will be assessed in your son's/daughter's/brother's/sister's³ early childhood functioning² (if necessary and possible: and in current functioning or in past functioning¹). Questions are based on the DSM-5-TR diagnostic criteria for autism spectrum disorder. I will ask you a question and give an example. I will also ask you to give an example yourself. During the interview, I will give you one or a few examples per question that describe how children (if applicable: and adults) show characteristics of autism spectrum disorder. In this way, I will get an overview of your son's/daughter's/brother's/sister's³ early childhood functioning² (if applicable: and his/her current functioning or past functioning¹) in order to assess if autism spectrum disorder is present. If you do not understand the question, please let me know and I will clarify the question by giving another example.

The following instruction is given to the client's mentor or coach⁴ at the start of administering the NIDA:

Using this interview, the features of autism spectrum disorder will be assessed in your client's current functioning (if necessary and possible: or in past functioning¹). Questions are based on the DSM-5-TR diagnostic criteria for autism spectrum disorder. I will ask you a question and give an example. I will also ask you to give an example yourself. During the interview, I will give you one or a few examples per question that describe how adults show characteristics of autism spectrum disorder. In this way, I will get an overview of your client's current functioning (if applicable: or past functioning¹) in order to assess if autism spectrum disorder is present. If you do not understand the question, please let me know and I will clarify the question by giving another example.

- 1 DSM-5-TR criteria A and B for ASD require that the impairments are currently present or have been present in the past. It is to be expected that people register at a mental health institution with current (mental health) conditions: when indicated, the NIDA is initially administered to assess whether the ASD features are present in current functioning. Difficulties/impairments may be masked by interventions, compensation, or support, or may not be prominent in current functioning (Bradley et al. 2021; Cook et al. 2021; Cook et al. 2022; Hull et al. 2017; Livingston et al. 2020; McQuaid et al. 2022; Milner et al. 2023; Perry et al. 2022; Walsh et al. 2023). Individuals who have developed compensation strategies for some social challenges still struggle in novel or unstructured situations and suffer from the effort and anxiety of consciously calculating what is socially intuitive for most individuals (American Psychiatric Association 2022, p. 61). In addition, special interests may sometimes provide avenues for education or employment. Manifestations of the social and communication impairments and restricted, repetitive behaviors that define ASD are clearly present in the early developmental period (DSM-5-TR criterion C for ASD), and overall, remain sufficient to cause current impairment in social, occupational, or other important areas of functioning (DSM-5-TR criterion D for ASD).
- 2 Early childhood encompasses the early developmental period and the first school years. ASD can be diagnosed later in life, when the individual is under more social demand and challenges, or when the ASD features are masked by interventions, compensation, or supports. It should be clear that DSM-5-TR criteria A and B for ASD are present in the early developmental period (i.e., DSM-5-TR criterion C for ASD).
- 3 Specify relationship to family member.
- 4 When a mentor or coach is involved with the client, the NIDA can be administered to them if necessary and beneficial.

3.4 Scoring instructions

To score the NIDA, the forms for summary of DSM-5-TR diagnostic criteria and associated features for autism spectrum disorder, scoring and diagnostic considerations of DSM-5-TR autism spectrum disorder, and current severity levels for DSM-5-TR autism spectrum disorder (pp. 62-67) can be used. For usability in a diagnostic report for the client, referrer, and/or (future) mental health professional, it is optional to include the forms on pages 62-65 in an appendix of the diagnostic report.

Instructions for scoring the questions

During or after administering the NIDA, it should be assessed per question if the features and criterion are present or not in current or past functioning and in the early developmental period (i.e., early childhood and early school years). For questions 1 and 3, to score the feature as present (with 'Yes'), all of the sub-questions must be answered affirmatively. For questions 4, 5, and 7, to score the feature as present (with 'Yes'), at least one sub-question must be answered affirmatively. For question 8, to score the criterion as present (with 'Yes'), at least the question must be answered affirmatively for current functioning.

If features (in current or past functioning and/or in the early developmental period) are masked by interventions, compensation, or support, and during diagnostic assessment and evaluation, it becomes clear that apparent adequate social functioning actually takes a lot of effort, we mark those questions with 'Yes' (feature is present for current or past functioning and/or the early developmental period). For example, when one has learned to suppress repetitive behavior in public, and special interests may be a source of pleasure and motivation, and provide avenues for education and employment, DSM-5-TR criterion B and associated features for ASD (questions 4 to 7) may be no longer present or less obvious. Still, DSM-5-TR ASD may be diagnosed, when

during diagnostic assessment restricted, repetitive patterns of behavior, interests, or activities were clearly present during childhood or at some time in the past.

When information about the early developmental period is missing, questionable, or unreliable, a question mark (?) is used for that period. Still, DSM-5-TR ASD may be diagnosed, when during diagnostic assessment and evaluation ASD features are clearly present. In such cases, there should be no evidence that social communication and social interaction were adequate in the early developmental period.

For question 8, we evaluate whether the features cause clinically significant impairment or suffering in social, occupational, or other important areas of current functioning. When there is little to no burden or limitation in current functioning due to interventions, compensations, or support, we still mark the question with 'Yes' if the person has to put in a substantial effort for optimal functioning.

Instructions for completing the form for summary of DSM-5-TR diagnostic criteria and associated features for autism spectrum disorder

On the *form for summary of DSM-5-TR diagnostic criteria and associated features for autism spectrum disorder* (p. 62), the DSM-5-TR criteria A, B, and D, and associated features for ASD, scored as present (with 'Yes') on the eight questions for current or past functioning and the early developmental period, are specified. Then, the features of DSM-5-TR criteria A and B for ASD are summed up per criterion.

Instructions for completing the form for scoring and diagnostic considerations of DSM-5-TR autism spectrum disorder

The following outlines the ten steps required on the *form for scoring and diagnostic considerations of DSM-5-TR autism spectrum disorder* (p. 63):

1. Record the client's name and date of birth. Record who administered the NIDA, assessment date, and interviewee(s).
2. For DSM-5-TR criteria A and B for ASD, indicate whether three out of three features are present for criterion A, and at least two out of four features for criterion B, either currently or in the past. To perform Step 3, also indicate this for the early developmental period. To do so, the scores on questions 1 to 7 can be taken from the *form for summary of DSM-5-TR diagnostic criteria and associated features for autism spectrum disorder* (p. 62).
3. For DSM-5-TR criterion C for ASD, specify if the features are present in the early developmental period (i.e., early childhood and early school years). ASD can be diagnosed later in life, when the client is under more social demands and challenges, or when the ASD features are masked by interventions, compensation, or supports. It should be clear that DSM-5-TR criteria A and B for ASD are present in the early developmental period. See Step 2.
4. For DSM-5-TR criterion D for ASD, specify if the features cause clinically significant impairment in social, occupational, or other important areas of current functioning. To do so, the answer to question 8 can be taken from the *form for summary of DSM-5-TR diagnostic criteria and associated features of autism spectrum disorder* (p. 62).
5. For DSM-5-TR criterion E for ASD, specify if the features are not better explained by intellectual developmental disorder (intellectual disability) or global developmental delay.
6. Specify if:
 - With or without accompanying intellectual impairment
 - With or without accompanying language impairment
 - Associated with a known genetic or other medical condition or environmental factor
 - Associated with a neurodevelopmental, mental, or behavioral problem
 - With catatonia and use additional code F06.1 catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.

7. Indicate if the information obtained using the NIDA has been considered contextually with other diagnostic instruments, and specify which ones have been used.
8. Indicate if the features are not better explained by one or more other disorder(s) and/or environmental factor(s). If applicable, specify the differential diagnosis/diagnoses of ASD and/or condition(s) comorbid to ASD.
9. The diagnosis remains a clinical one, taking all available information into account, and is not solely dictated by the score on a particular questionnaire or observation measure (American Psychiatric Association 2022, p. 62). When the aforementioned steps are completed, and all bold 'Yes' have been circled on the *form for scoring and diagnostic considerations of DSM-5-TR autism spectrum disorder* (p. 63), a qualified mental health professional considers if the expected positive effect of DSM-5-TR ASD diagnosis outweighs any negative effect(s) (Defresne & Mottron 2022; Harmens et al. 2022; Huang et al. 2022) and makes the decision whether or not to diagnose ASD. Research exploring the experiences of diagnostic assessment of ASD in adulthood showed most adults expressing positive emotions such as relief, understanding, and confidence on receiving an ASD diagnosis. However, the path to receiving the diagnosis is often experienced as complicated, and the post-diagnostic services and supports are often experienced as inadequate (De Broize et al. 2022; see also Brede et al. 2022; Darazsdi & Bialka 2023; Huang et al. 2020; Ishler et al. 2023; Jellett & Flower 2023; Legg et al. 2023; Mazurek et al. 2023; Wigham et al. 2023; Wilson et al. 2023).
10. Specify the current severity levels for DSM-5-TR ASD based on impairments in social communication and restricted, repetitive behaviors. To specify them, the scores on the *form for current severity levels for DSM-5-TR autism spectrum disorder* (p. 66) can be used.

Instructions for completing the form for current severity levels for DSM-5-TR autism spectrum disorder

The current severity levels for DSM-5-TR ASD (based on impairments in social communication and restricted, repetitive behaviors) are specified on the *form for current severity levels for DSM-5-TR autism spectrum disorder* (p. 66). To score the need for support for the domains 'social communication' and 'restricted, repetitive behaviors' with 'Yes', the associated behavioral features of the domains must be answered with 'Yes' for one of the three current severity levels.

In studies evaluating the severity level ratings in children with ASD, associations were found between higher severity ratings in both domains and lower intellectual functioning (Mazurek et al. 2019), and between higher severity ratings in the domain of 'restricted, repetitive behaviors' and lower adaptive functioning (Hong & Matson 2021). A literature review exploring the DSM-5 ASD severity levels suggests that intellectual functioning can be confounded with overall ASD severity (Qari 2022).

4. Psychometric properties

4.1 Introduction

The psychometric properties of the NIDA have been studied. The focus of the study included the eight interview questions of the current functioning part and ‘yes or no DSM-5 diagnosis ASD’. For more information on this study, see Vuijk et al. (2022). Demographic characteristics and results are briefly presented here.

4.2 Demographic characteristics

The study involved a cohort of 90 male participants, categorized into three groups: (1) those with ASD with or without personality disorder (PD), (2) those with PD without (a suspicion of) ASD, and (3) those without ASD and PD. Group 1 participants were recruited from Sarr Autisme Rotterdam in the Netherlands, Group 2 participants were recruited from Parnassia Psychiatric Institute in the Netherlands, and Group 3 participants were recruited from the general Dutch population through advertisements and flyers. Detailed demographic characteristics of all participants are provided in Table 3 (Vuijk et al. 2022, p. 3529).

Table 3 Demographic characteristics of participants (*N* = 90)

		ASD	PD	COM
<i>N</i>		30	30	30
Age, years	Mean	43.23	44.13	44.37
	SD	11.00	12.64	14.85
	Range	18-62	19-63	18-65
Marital status	Unmarried	23 (77%)	19 (63%)	18 (60%)
	Married	7 (23%)	4 (13%)	9 (30%)
	Divorced	0	6 (20%)	0
	Other	0	1 (3%)	3 (10%)
Education	University	7 (23%)	3 (10%)	10 (33%)
	Higher vocational education	8 (27%)	10 (33%)	13 (43%)
	Secondary school	8 (27%)	8 (27%)	6 (20%)
	Lower vocational education	5 (17%)	6 (20%)	0
	Elementary school	1 (3%)	2 (7%)	0
	Unknown/other	1 (3%)	1 (3%)	1 (3%)
ASD diagnosis†		30	0	0
	Autistic disorder	6 (20%)		
	Asperger's disorder	10 (33%)		
	ASD	14 (47%)		

Table 3 (Continued)

Table 3 (Continued)		ASD	PD	COM
PD diagnosis‡		n=18	n=30§	n=23¶
	Avoidant PD	1 (3%)	3 (10%)	7 (23%)
	Dependent PD	0	1 (3%)	1 (3%)
	Obsessive-compulsive PD	5 (18%)	0	4 (13%)
	Paranoid PD	0	0	0
	Schizotypal PD	0	0	0
	Schizoid PD	3 (10%)	0	0
	Histrionic PD	0	0	0
	Narcissistic PD	0	3 (10%)	2 (7%)
	Borderline PD	0	7 (23%)	5 (17%)
	Antisocial PD	1 (3%)	1 (3%)	3 (10%)
	Other specified PD (≥5 traits)	12 (40%)	19 (63%)	15 (50%)
Psychological symptoms and disorders ‡	Alcohol, drugs & medication problems	2 (7%)		4 (13%)
	Psychotic symptoms	1 (3%)		0 (0%)
	Depressive disorder	5 (17%)		11 (37%)
	Panic disorder	2 (7%)		2 (7%)
	PTSD	3 (10%)		4 (13%)
	Specific phobia	1 (3%)		1 (3%)
	Social anxiety disorder	1 (3%)		6 (20%)
	Generalized anxiety disorder	1 (3%)		3 (10%)
	Obsessive-compulsive disorder	2 (7%)		2 (7%)
	Somatic symptom disorder and related disorders	0 (0%)		2 (7%)
	Eating disorders	0 (0%)		1 (3%)
	Adjustment disorder	2 (7%)		1 (3%)
	Relational problems	1 (3%)		2 (7%)
	Bereavement disorder	1 (3%)		1 (3%)
	Problems with aggression	1 (3%)		2 (7%)
	Other complaints	3 (10%)		2 (7%)

ASD = autism spectrum disorder; COM = general population comparison group without ASD and PD; PD = personality disorder; PTSD = posttraumatic stress disorder; SD = standard deviation. † ASD diagnosis clinically assessed without using *Dutch Interview for Diagnostic assessment Autism spectrum disorder in adults (NIDA)*. ‡ The number of participants with PD diagnosis is lower than the total number of specific PDs. Explanation for the difference is that some participants have been diagnosed with more than one specific PD. § PDs assessed in the past with the *Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First et al. 1997; Dutch translation: Weertman et al. 2000)*, *SCID-5-P Gestructureerd klinisch interview voor DSM-5 persoonlijkheidsstoornissen* [Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD)] (American Psychiatric Association 2017), or psychological-psychiatric assessment. ¶ PDs assessed with SCID-5-PD in current NIDA study. ‡ Psychological symptoms and disorders were assessed with a semi-structured interview for mental disorders in this study.

4.3 Reliability

Inter-rater reliability

To determine the inter-rater reliability of the NIDA, the outcomes of its eight questions for current functioning and for its diagnosis 'yes or no DSM-5 ASD diagnosis' were used, independently assessed by the person conducting the assessment and an observer. Cohen's kappa values (Cohen 1960) and Krippendorff's alpha values (Hayes & Krippendorff 2007) were calculated for each of the eight questions as well as for the diagnosis. The results showed a very good inter-rater reliability with kappa values above .70 (ranging from .79 to .95, CI 0.67-1.01) and alpha values above .80 (ranging from .80 to 1.00, CI 0.65-1.00).

Note: the raters were trained in administering and scoring the NIDA.

4.4 Validity

Convergent validity

Convergent validity between the ASD diagnosis assessed with the NIDA and ADOS-2 (Lord et al. 2012; Dutch translation: De Bildt et al. 2013) and between the ASD diagnosis assessed with the NIDA and the clinically assessed ASD diagnosis in the past were calculated with Cohen's kappa (Cohen 1960). The results showed kappa values above .80 (ranging from .80 to .95) with sensitivity scores ranging from .76 to .96 and specificity scores from .93 to 1.00: ASD participants were correctly identified as having a DSM-5 ASD diagnosis (in accordance with the ADOS-2 classification of ASD and the clinically assessed ASD diagnosis in the past), and the other participants were correctly identified as having no DSM-5 ASD diagnosis.

Note: participants were strictly selected. ASD participants were selected on their overt ASD presentation (De Marchena & Miller 2017) without too much camouflaging and compensating for ASD features (Cook et al. 2021; Frigaux et al. 2021; Motttron 2021). The other participants were selected on having no ASD diagnosis and no suspicion of ASD.

Concurrent criterion-related validity

Concurrent criterion-related validity of the eight questions of the NIDA for current functioning was established by using one-way MANOVA followed up by Bonferroni corrected pairwise comparisons between groups.

The MANOVA on the outcomes of the eight questions revealed a statistically significant effect of group: $F(18, 158) = 47.73, p < .001$, Wilk's $\Lambda = 0.024, \eta_p^2 = .85$. ASD participants reached an average total score of 6.70 (SD 1.15, SE .18), PD participants without (a suspicion of) ASD an average total score of 0.57 (SD 1.19, SE .18), and participants without ASD and PD an average total score of 0 (SD 0, SE .18), suggesting the NIDA to be a good discriminator between ASD participants, PD participants, and participants without ASD and PD.

Note: raters were trained in assessing ASD and PDs in adults, and in administering and scoring the NIDA and the *Structured Clinical Interview for DSM-IV Axis II Personality Disorders* (SCID-II; First et al. 1997; Dutch translation: Weertman et al. 2000), the former version of the *Structured Clinical Interview for DSM-5 Personality Disorders* (SCID-5-PD) (American Psychiatric Association 2017).

4.5 NIDA in research

The NIDA is regularly used in scientific research. On February 21, 2023, a search was conducted in *Google Scholar* (Martín-Martín et al. 2021), using the keywords 'NIDA', 'autism(e)' and 'Vuijk'. We conducted a search for studies where the NIDA was administered to participants either before or during the study. The reference list and methods section of the publications were reviewed using the keywords 'NIDA' and 'Vuijk'. A total of 16 studies, published between 2020 and 2022, were identified in which the NIDA was administered to the study population. Table 4 shows the 16 studies in alphabetical order.

Table 4 Studies, published between 2020 and 2022, in which the NIDA was administered to the study population

Appel, J.E., Vrijzen, J.N., Marchetti, I., Becker, E.S., Collard, R.M., Van Eijndhoven, P., Schene, A.H., & Tendolkar, I. (2021). The role of perseverative cognition for both mental and somatic disorders in a naturalistic psychiatric patient sample. *Psychosomatic Medicine*, 83(9), 1058-1066. <https://doi.org/10.1097/PSY.0000000000001003>

Bergman, M.A., Vissers, C.Th.W.M., Collard, R.M., Van Eijndhoven, P., Schene, A.H., Vrijzen, J.N. (2021). The effect of alexithymia on attentional bias toward emotional stimuli in depression: An eye-tracking study. *Frontiers in Psychiatry*, 11. <https://doi.org/10.3389/fpsyt.2020.569946>

Bergman, M.A., Vrijzen, J.N., Rinck, M., Van Oostrom, I., Kan, C.C., Collard, R.M., Van Eijndhoven, P.F., Visser, C.Th.W.M., & Schene, A.H. (2021). Is a negative attentional bias in individuals with autism spectrum disorder explained by comorbid depression? An eye-tracking study. *Journal of Autism and Developmental Disorders*, 51(11), 4213-4226. <https://doi.org/10.1007/s10803-021-04880-6>

Bezemer, M.L., Blijd-Hoogewys, E.M.A. & Meek-Heekelaar, M. (2021). The predictive value of the AQ and the SRS-A in the diagnosis of ASD in adults in clinical practice. *Journal of Autism and Developmental Disorders*, 51(7), 2402-2415. <https://doi.org/10.1007/s10803-020-04699-7>

Brolsma, S.C.A., Vrijzen, J.N., Vassena, E., Rostami Kandroodi, M., Bergman, M.A., Van Eijndhoven, P.F., Collard, R.M., Den Ouden, H.E.M., Schene, A.H., & Cools, R. (2022). Challenging the negative learning bias hypothesis of depression: Reversal learning in a naturalistic psychiatric sample. *Psychological Medicine*, 52(2), 303-313. <https://doi.org/10.1017/S0033291720001956>

Duyser, F.A., Vrijzen, J.N., Van Oort, J., Collard, R.M., Schene, A.H., Tendolkar, I., & Van Eijndhoven, P.F. (2022). Amygdala sensitivity for negative information as a neural marker for negative memory bias across psychiatric diagnoses. *Psychiatry Research: Neuroimaging*, 323, 111481. <https://doi.org/10.1016/j.pscychresns.2022.111481>

Geurts, H.M., Agelink van Rentergem, J.A., Radhoe, T., Torenvliet, C., Van der Putten, W.J., & Groenman, A.P. (2021). Ageing and heterogeneity regarding autism spectrum conditions: A protocol paper of an accelerated longitudinal study. *BMJ Open*, 11(3), e040943. <https://doi.org/10.1136/bmjopen-2020-040943>

Guineau, M.G., Ikani, N., Rinck, M., Collard, R.M., Van Eijndhoven, P., Tendolkar, I., Schene, A.H., Becker, E.S., & Vrijzen, J.N. (2022). Anhedonia as a transdiagnostic symptom across psychological disorders: A network approach. *Psychological Medicine*, 1-12. <https://doi.org/10.1017/S0033291722000575>

Melchior, K., Franken, I.H.A., Vuijk, R., Peerbooms, V., & Van der Heiden, C. (2021). The assessment of thought fusion beliefs and beliefs about rituals in clinical and non-clinical populations: Psychometric properties of the Thought Fusion Instrument (TFI) and Beliefs About Rituals Inventory (BARI). *Psychological Test Adaptation and Development*, 2(1), 50-61. <https://doi.org/10.1027/2698-1866/a000011>

Muit, J.J., Bothof, N., & Kan, C.C. (2020). Pharmacotherapy of ADHD in adults with autism spectrum disorder: Effectiveness and side effects. *Journal of Attention Disorders*, 24(2), 215-225. <https://doi.org/10.1177/1087054719866255>

Mulders, P., Eijndhoven, P., Van Oort, J., Oldehinkel, M., Duyser, F., Kist, J., Collard, R., Vrijsen, J., Haak, K., Beckmann, C., Tendolkar, I., & Marquand, A. (2022). Striatal connectopic maps link to functional domains across psychiatric disorders. *Translational Psychiatry*, 12(1). <https://doi.org/10.1038/s41398-022-02273-6>

Shi, Y., Sprooten, E., Mulders, P., Vrijsen, J., Bralten, J., Demontis, D., Børglum, A., Walters, G., Stefansson, K., Van Eijndhoven, P., Tendolkar, I., Franke, B., & Mota, N. (2022). Multi-polygenic scores in psychiatry: From disorder-specific to transdiagnostic perspectives. *Medrxiv*. <https://doi.org/10.1101/2022.05.30.22275563>

Van Eijndhoven, P., Collard, R., Vrijsen, J., Geurts, D.E.M., Vasquez, A.A., Schellekens, A., Van den Munckhof, E., Brolsma, S., Duyser, F., Bergman, A., Van Oort, J., Tendolkar, I., & Schene, A. (2022). Measuring Integrated Novel Dimensions in Neurodevelopmental and Stress-Related Mental Disorders (MIND-SET): Protocol for a cross-sectional comorbidity study from a research domain criteria perspective. *JMIRx Med*, 3(1), e31269. <https://doi.org/10.2196/31269>

Van Oort, J., Kohn, N., Vrijsen, J.N., Collard, R., Duyser, F.A., Brolsma, S.C.A., Fernández, G., Schene, A.H., Tendolkar, I., & Van Eijndhoven, P.F. (2020). Absence of default mode downregulation in response to a mild psychological stressor marks stress-vulnerability across diverse psychiatric disorders. *NeuroImage: Clinical*, 25, 102176. <https://doi.org/10.1016/j.nicl.2020.102176>

Van Oort, J., Tendolkar, I., Collard, R., Geurts, D.E.M., Vrijsen, J.N., Duyser, F.A., Kohn, N., Fernández, G., Schene, A.H., & Van Eijndhoven, P.F.P. (2022). Neural correlates of repetitive negative thinking: Dimensional evidence across the psychopathological continuum. *Frontiers in Psychiatry*, 13, 915316. <https://doi.org/10.3389/fpsy.2022.915316>

Vuijk, R., Deen, M., Arntz, A., & Geurts, H.M. (2022). First psychometric properties of the Dutch Interview for Diagnostic assessment of Autism spectrum disorder in adult males without intellectual disability. *Journal of Autism and Developmental Disorders*, 52, 3523-3535. <https://doi.org/10.1007/s10803-021-05225-z>

NIDA = Dutch Interview for Diagnostic assessment of Autism spectrum disorder in adults

5. Training

In the Netherlands, the author provides training in the NIDA for mental health professionals. The training provides an introduction to and guidance in the use of the NIDA with the opportunity to practice administering and scoring.

The NIDA training is designed for mental health professionals, including (clinical/neuro) psychologists, psychiatrists, and nurse practitioners with expertise in ASD and diagnostic assessment. This training is intended for those who aim to utilize the NIDA in diagnosing ASD in adults within clinical practice or research settings.

A NIDA training ideally contains the following elements:

- Studying the manual to become familiar with the NIDA and its value in diagnostic assessment of ASD in adults.
- Studying the DSM-5-TR diagnostic criteria for ASD.
- Practicing administering the interview questions and associated examples of the NIDA properly.
- Practicing administering the NIDA with a colleague who plays the role of the client.
- Practicing scoring of the NIDA with a colleague.

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About the author

Richard Vuijk, MSc, PhD, is a clinical psychologist actively engaged in researching, training, and clinical practice focused on ASD in adults. He is affiliated with Sarr Autisme Rotterdam, part of Parnassia Psychiatric Institute in the Netherlands. Additionally, he owns AutismeSpectrumNederland and serves as a lecturer at Parnassia Academy as well as various institutions for postgraduate mental health education (RINO) in the Netherlands. His research projects address diagnostic assessment, personality (pathology), and psychotherapy in adults with ASD. In 2022, he received a doctoral degree (PhD) for his dissertation *Adults with autism spectrum disorder: Diagnostic assessment, personality (pathology), and psychotherapy* at the University of Amsterdam.

In 2014 (second edition 2016; third, revised edition 2023), he developed and published the *Nederlands Interview ten behoeve van Diagnostiek Autismespectrumstoornis bij volwassenen* (NIDA) [Dutch Interview for Diagnostic assessment Autism spectrum disorder in adults (NIDA)], and in 2018, he developed and published the *Werkwijzer - Psychodiagnostiek autismespectrumstoornis volwassenen* [Method - Psychodiagnostic assessment autism spectrum disorder in adults], both available free of charge for diagnostic assessment of ASD in adults in the Netherlands.

In 2016, he received an honorable mention for his Schema Therapy study in adults with ASD and PD at the National Autism Congress in the Netherlands, and in 2018, he was awarded the *Jeffrey Young Investigator Award* of the *International Society of Schema Therapy* in recognition of high research standards for this study.



Responsibilities

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Declaration of interest

The author of this work has no conflicting or commercial interests to declare.

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Dutch
Interview for
Diagnostic assessment
Autism spectrum disorder in adults **(NIDA)**

Richard Vuijk

English translation

Richard Vuijk

Niall Jassim

Katy Klugkist

Administration instructions (see p. 17)

Read out each interview question along with the associated example, asking the interviewee to identify if they recognize the example in current or past functioning, and/or in the early developmental period (i.e., early childhood and early school years).

Then prompt the interviewee to provide their own example.

Then offer one or more examples yourself. This step is particularly crucial when the interviewee fails to recognize the example, cannot identify one, or provides an example unrelated to the question.

Each acknowledged or provided example relevant to the question is duly noted and marked as present.

Features of autism spectrum disorder (ASD) observed by the mental health professional during the NIDA administration to the client can be documented as present if they align with the question.

The client is not obligated to identify with all examples. For every question, a comprehensive assessment must be made to determine the presence or absence of the DSM-5-TR ASD criteria A, B, C, and D, along with any associated features.

When administering the NIDA to informants other than the client, the questions need to be reformulated. For example: 'Are you ...' becomes 'Is (name client) ...' etc.

In the examples given with questions 2 and 3, 'atypical' can be interpreted as different from what is considered normal or average.

Early childhood refers to the early developmental period and the first school years.

Personal and practical information

Name of client : _____

Date of birth : ____ - ____ - ____

Age : ____ years

Gender : male/female/other

Date of assessment : ____ - ____ - ____

Name of mental health professional : _____

Function of mental health professional : ☐ psychologist
☐ healthcare psychologist
☐ clinical psychologist
☐ clinical neuropsychologist
☐ psychiatrist
☐ nurse practitioner mental healthcare

Administered to : ☐ client
☐ partner
☐ family member
If yes, specify: _____
☐ mentor/coach

Additional information : _____

Question 1**DSM-5-TR criterion A - feature 1 for autism spectrum disorder****Sub-question 1A**

Are you impaired in forming connections with others, for example needing to deliberately think through social interactions that seem naturally intuitive to most people?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been an impairment in your past?)

Examples

- ☐ Consciously having to calculate what is socially intuitive for most people
- ☐ Consciously having to calculate when and how to engage in a conversation
- ☐ Consciously having to calculate what one should or should not say (socially awkward)
- ☐ Limited or not initiating social interactions
- ☐ Limited ability or inability to initiate, respond to, or maintain social interactions (misunderstanding them)
- ☐ Limited ability or inability to engage in back and forth conversation (e.g., monologue, interrupting others)
- ☐ Behavior/interaction comes across as learned/scripted
- ☐ Despite using strategies to compensate in social challenges, there are still difficulties in novel situations or situations with limited support
- ☐ Additional: _____

Sub-question 1B

Are you impaired in sharing thoughts and feelings, for example often responding only from your own perspective and experience?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been an impairment in your past?)

Examples

- ☐ Responding only from own perspective and experience
- ☐ Lack of social reciprocity in language and speech: requesting or labelling, and not sharing feelings or holding a conversation
- ☐ Not adapting to others and not taking their emotions into account (e.g., difficulty attuning to the other; can be perceived as blunt, hard, cold by others)
- ☐ Limited or no sharing of and understanding emotions (e.g., happiness, fear, anger, sadness)
- ☐ Limited or no sharing of interests
- ☐ Limited social reciprocity in conversations and good at theorizing (conversations have to be 'meaningful')
- ☐ Additional: _____

Feature A1 present in current or past functioning:

Yes

?

No

Note: To score the feature as present, both sub-questions must be answered affirmatively.

Sub-question 1A

In early childhood, were you impaired in forming connections with others, for example not responding to or not knowing how to respond to social interaction?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ Difficulties responding to or not understanding social interactions, often seeming like you did not hear them at all or misunderstanding them
- ☐ Not responding to own name
- ☐ Limited or not initiating social interactions
- ☐ Abnormal social approach (clearly deviating from what is commonly accepted and age appropriate)
- ☐ Responding only to a very direct social approach
- ☐ Approaching others only to meet your own needs
- ☐ Limited ability or inability to engage in back and forth conversation (e.g., monologue, interrupting others)
- ☐ Behavior/interaction comes across as learned/scripted
- ☐ Appears to be emotionally younger than peers
- ☐ Despite using strategies to compensate in social challenges, there are still difficulties in novel situations or situations with limited support
- ☐ Additional: _____

Sub-question 1B

In early childhood, were you impaired in sharing thoughts and feelings, for example often responding only from your own perspective and experience?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ Responding only from own perspective or experience
- ☐ Lack of social reciprocity in language and speech: requesting or labelling, and not sharing feelings or holding a conversation
- ☐ Not adapting to others and not taking their emotions into account (e.g., laughing when another child is showing sadness; can be perceived as blunt, hard, cold by others)
- ☐ Limited or no sharing of and understanding emotions (e.g., happiness, fear, anger, sadness)
- ☐ Limited or no sharing of interests
- ☐ Limited or no imitation of others' behavior
- ☐ Limited social reciprocity in conversations and good at theorizing (conversations have to be 'meaningful')
- ☐ Additional: _____

Feature A1 present in early childhood:

Yes ? No

Note: To score the feature as present, both sub-questions must be answered affirmatively.

Question 2

DSM-5-TR criterion A - feature 2 for autism spectrum disorder

Current or past functioning

Are you impaired in your nonverbal communication, for example not making eye contact?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been an impairment in your past?)

Examples

- ☐ Not making eye contact
- ☐ Staring at others
- ☐ Looking through others
- ☐ Lack of or limited hand gestures
- ☐ Difficulty in spontaneously using expressive gestures
- ☐ Lack of, limited, and/or atypical use of facial expressions
- ☐ Lack of, limited, and/or atypical use of body language (e.g., odd, wooden, or exaggerated body language)
- ☐ Lack of or limited 'reading' and responding to eye contact, gestures, facial expressions, and/or body language of others
- ☐ Rational instead of intuitive understanding of facial expressions
- ☐ Atypical intonation in speech, not suited to the content of the conversation (e.g., slow, fast, loud, soft, insistent, unclear, not adjusted)
- ☐ Impaired joint attention (failure to follow someone's eye gaze)
- ☐ Not finding or misjudging the right social distance (standing too close to another person)
- ☐ Impairments may be relatively subtle but noticeable in poor integration of eye contact, gestures, facial expressions, body posture and rhythm, emphasis and intonation for social communication
- ☐ Additional: _____

Feature A2 present in current or past functioning:

Yes

?

No

In early childhood, were you impaired in your nonverbal communication, for example not making eye contact?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ Not making eye contact
- ☐ Staring at others
- ☐ Looking through others
- ☐ Lack of or limited hand gestures
- ☐ Difficulty in spontaneously using expressive gestures
- ☐ Lack of, limited, and/or atypical use of facial expressions (e.g., at 12 months, no reciprocal smile)
- ☐ Lack of, limited, and/or atypical use of body language (e.g., odd, wooden, or exaggerated body language)
- ☐ Lack of or limited 'reading' and responding to eye contact, gestures, facial expressions, and/or body language of others
- ☐ Rational instead of intuitive understanding of facial expressions
- ☐ Atypical intonation in speech, not suited to the content of the conversation (e.g., slow, fast, loud, soft, insistent, unclear, not adjusted)
- ☐ Impaired joint attention (e.g., lack of pointing, showing, or bringing objects to share interests with others; failure to follow someone's pointing or eye gaze)
- ☐ Not finding or misjudging the right social distance (standing too close to another person)
- ☐ Impairments may be relatively subtle but noticeable in poor integration of eye contact, gestures, facial expressions, body posture and rhythm, emphasis and intonation for social communication
- ☐ Additional: _____

Feature A2 present in early childhood:

Yes ? No

Question 3**DSM-5-TR criterion A - feature 3 for autism spectrum disorder****Sub-question 3A**

Are you impaired in building relationships, for example showing no interest in peers?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been an impairment in your past?)

Examples

- ☐ No interest in peers
- ☐ No interest in social relationships (instrumental/formal contact)
- ☐ No, limited, and/or atypical social interest (e.g., rejecting others, passivity, or inappropriate approaches that seem aggressive or disruptive)
- ☐ Difficulties in making friends
- ☐ Preference for interacting with much younger or older people
- ☐ Preference to be or live alone (e.g., relationships are seen as unnecessary, unpleasant, stressful or tiring; seen as a loner)
- ☐ Additional: _____

Sub-question 3B

Are you impaired in maintaining relationships, for example struggling to develop close friendships?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been an impairment in your past?)

Examples

- ☐ No developing of close relationships; superficial relationships
- ☐ Difficulty maintaining friendships (one-sided friendships; friendships based solely on shared special interests)
- ☐ Additional: _____

Sub-question 3C

Are you impaired in understanding relationships, for example not knowing what friendship entails?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been an impairment in your past?)

Examples

- ☐ No realistic idea of/not knowing what friendship entails
- ☐ Lack of or limited understanding what behavior is considered appropriate in one situation/relationship but not another (e.g., home versus work, casual behavior during a job interview)
- ☐ Lack of or limited understanding of the different ways in which language may be used to communicate (e.g., irony, white lies, humor, fantasy, pretending, taking things literally)
- ☐ Additional: _____

Feature A3 present in current or past functioning:

Yes

?

No

Note: To score the feature as present, all sub-questions must be answered affirmatively.

Sub-question 3A

In early childhood, were you impaired in building relationships, for example showing no interest in peers?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ No interest in peers
- ☐ No interest in social relationships (instrumental contact)
- ☐ No, limited, and/or atypical social interest (e.g., rejecting others, passivity, or inappropriate approaches that seem aggressive or disruptive)
- ☐ Difficulties in making friends
- ☐ Preference to be or live alone (e.g., relationships are seen as unnecessary, unpleasant, stressful or tiring; seen as a loner)
- ☐ Additional: _____

Sub-question 3B

In early childhood, were you impaired in maintaining relationships, for example struggling with shared social play?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ No, limited, and/or atypical social or imaginative play (insisting on playing by very fixed rules; no role-play; no shared social play; no pretend play)
- ☐ No deepening of relationships; superficial relationship (at 12 months no 'social interactive' babbling)
- ☐ Difficulty maintaining friendships (one-sided friendships; friendships based solely on shared special interests)
- ☐ Additional: _____

Sub-question 3C

In early childhood, were you impaired in understanding relationships, for example not knowing what friendship entails?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ No realistic idea of/not knowing what friendship entails
- ☐ Lack of or limited understanding what behavior is considered appropriate in one situation/relationship but not another (e.g., home versus school; parents/teachers versus peers)
- ☐ Lack of or limited understanding of the different ways in which language may be used to communicate (e.g., irony, white lies, humor, fantasy, pretending, taking things literally)
- ☐ Additional: _____

Feature A3 present in early childhood:

Yes ? No

Note: To score the feature as present, all sub-questions must be answered affirmatively.

Question 4**DSM-5-TR criterion B - feature 1 for autism spectrum disorder****Sub-question 4A**

Do you have a fixed or repetitive way of moving, for example body rocking?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been a problem in your past?)

Examples

- ☐ Body rocking
- ☐ Flapping arms and hands
- ☐ Finger flicking
- ☐ Body spinning
- ☐ Additional: _____

Sub-question 4B

Do you have a fixed or repetitive way of using objects, for example arranging them?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been a problem in your past?)

Examples

- ☐ Not using objects functionally (e.g., arranging them)
- ☐ Flipping objects
- ☐ Additional: _____

Sub-question 4C

Do you have a fixed or repetitive way of speaking, for example precisely repeating others' words?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been a problem in your past?)

Examples

- ☐ Literally or precisely repeating others' sounds, words or phrases, immediate or delayed
- ☐ Stereotypical, special, or unusual rhythm, emphasis, intonation of the voice when uttering words and sentences (deviates from what is considered normal)
- ☐ Making up new words or phrases
- ☐ Using formal or old-fashioned language
- ☐ Using 'you' to refer to yourself
- ☐ Speaking too loud/soft/slow/fast/a lot/little
- ☐ Additional: _____

Feature B1 present in current or past functioning:

Note: To score the feature as present, at least one of the sub-questions must be answered affirmatively.

Yes ? No

Sub-question 4A

In early childhood, did you have a fixed or repetitive way of moving, for example body rocking?
(When answered 'yes':) Could you give me an example?

Examples

- ☐ Body rocking
- ☐ Flapping arms and hands
- ☐ Finger flicking
- ☐ Body spinning
- ☐ Toe walking
- ☐ Additional: _____

Sub-question 4B

In early childhood, did you have a fixed or repetitive way of using objects, for example arranging them?
(When answered 'yes':) Could you give me an example?

Examples

- ☐ Not using objects functionally (e.g., arranging them)
- ☐ Flipping objects
- ☐ Lining up toys or carrying them around but not playing with them
- ☐ Additional: _____

Sub-question 4C

In early childhood, did you have a fixed or repetitive way of speaking, for example precisely repeating others' words?
(When answered 'yes':) Could you give me an example?

Examples

- ☐ Literally or precisely repeating others' sounds, words or phrases, immediate or delayed
- ☐ Stereotyped, special, or unusual rhythm, emphasis, intonation of the voice when uttering words and sentences (deviates from what is considered normal)
- ☐ Making up new words or phrases
- ☐ Using formal or old-fashioned language
- ☐ Using 'you' to refer to yourself
- ☐ Speaking too loud/soft/slow/fast/a lot/little
- ☐ Additional: _____

Feature B1 present in early childhood:

Yes ? No

Note: To score the feature as present, at least one of the sub-questions must be answered affirmatively.

Question 5**DSM-5-TR criterion B - feature 2 for autism spectrum disorder****Sub-question 5A**

Do you have a strong preference for sameness, for example struggling with changes in routine?

(When answered 'yes:') Could you give me an example?

(If this is not recognized in current functioning: Has this ever been a problem in your past?)

Examples

- ☐ Resistance to change (e.g., needing to eat the same food, to wear the same clothes every day)
- ☐ Extreme tension/distress in response to change (e.g., in time, order, setting, activities, appointments)
- ☐ Experiencing great difficulty in response to change
- ☐ Difficulty with transitions (e.g., moving house, changing jobs, daylight saving time, change of seasons, holidays, public holidays)
- ☐ Rigid thinking patterns (e.g., rule is rule, law is law, a deal is a deal, insisting on adherence to rules)
- ☐ Strictly adhering to social conventions (formal)
- ☐ Additional: _____

Sub-question 5B

Do you adhere to rigid routines or exhibit ritualized patterns in your verbal behavior, for example using formal greetings?

(When answered 'yes:') Could you give me an example?

(If this is not recognized in current functioning: Has this ever been a problem in your past?)

Examples

- ☐ Greeting others overly formal or extensively
- ☐ Speaking with excessive emphasis, very formal or elaborated (long-winded)
- ☐ Repetitive questioning
- ☐ Additional: _____

Sub-question 5C

Do you adhere to rigid routines or exhibit ritualized patterns in your actions, for example needing to perform activities in a specific sequence?

(When answered 'yes:') Could you give me an example?

(If this is not recognized in current functioning: Has this ever been a problem in your past?)

Examples

- ☐ Feeling the need to perform activities in a specific sequence and at a specific time
- ☐ Feeling the need to take the same route every time
- ☐ Pacing back and forth (e.g., pacing a perimeter)
- ☐ Additional: _____

Feature B2 present in current or past functioning:

Yes

?

No

Note: To score the feature as present, at least one of the sub-questions must be answered affirmatively.

Sub-question 5A

In early childhood, did you have a strong preference for sameness, for example struggling with changes in routine?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ Resistance to change (e.g., needing to eat same food every day)
- ☐ Extreme tension/distress in response to change (e.g., in time, order, setting, activities, appointments)
- ☐ Experiencing great difficulty in response to change
- ☐ Difficulty with transitions (e.g., moving house, advancing to the next grade in school, daylight saving time, change of seasons, holidays, public holidays)
- ☐ Rigid thinking patterns (e.g., rule is rule, law is law, a deal is a deal, insisting on adherence to rules)
- ☐ Strictly adhering to social conventions (formal)
- ☐ Additional: _____

Sub-question 5B

In early childhood, did you adhere to rigid routines or exhibit ritualized patterns in your verbal behavior, for example using formal greetings?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ Greeting others overly formal or extensively
- ☐ Speaking with excessive emphasis, very formal or elaborated (long-winded)
- ☐ Repetitive questioning
- ☐ Additional: _____

Sub-question 5C

In early childhood, did you adhere to rigid routines or exhibit ritualized patterns in your actions, for example needing to perform activities in a specific sequence?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ Feeling the need to perform activities in a specific sequence and at a specific time
- ☐ Feeling the need to take the same route every time
- ☐ Pacing back and forth (e.g., pacing a perimeter)
- ☐ Additional: _____

Feature B2 present in early childhood:

Yes ? No

Note: To score the feature as present, at least one of the sub-questions must be answered affirmatively.

Question 6**DSM-5-TR criterion B - feature 3 for autism spectrum disorder**

Do you have highly restricted, fixated interests that are abnormal in intensity or focus, for example intensively collecting information about a subject?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been a problem in your past?)

Examples

- ☐ A very strong preference to be occupied with (un)usual objects or information (e.g., collecting, ordering, studying, fantasizing)
- ☐ Highly restricted interests (for only one topic, activity)
- ☐ Pervasive, persistent interests (in terms of time spent on them, not being able to stop in time, preoccupied by them)
- ☐ Interests which may seem strange to others
- ☐ Being occupied with these interests hinders social interaction and daily functioning
- ☐ Time spent on these interests increases in times of stress and tension
- ☐ Being occupied with these interests reduces tension (has a calming effect)
- ☐ Being occupied with these interests comes across as compulsive
- ☐ Disturbance by others while busy with these interests leads to confusion, irritation, anger, anxiety or tension
- ☐ Additional: _____

Feature B3 present in current or past functioning:

Yes

?

No

In early childhood, did you have highly restricted, fixated interests that are abnormal in intensity or focus, for example intensively collecting information about a subject?
(When answered 'yes':) Could you give me an example?

Examples

- ☐ A very strong preference to be occupied with (un)usual objects or information (e.g., collecting, ordering, studying, fantasizing)
- ☐ Highly restricted interests (for only one topic, activity)
- ☐ Pervasive, persistent interests (in terms of time spent on them, not being able to stop in time, preoccupied by them)
- ☐ Interests which may seem strange to others
- ☐ Being occupied with these interests hinders social interaction and daily functioning
- ☐ Time spent on these interests increases in times of stress and tension
- ☐ Being occupied with these interests reduces tension (has a calming effect)
- ☐ Being occupied with these interests comes across as compulsive
- ☐ Disturbance by others while busy with these interests leads to confusion, irritation, anger, anxiety or tension
- ☐ Additional: _____

Feature B3 present in early childhood:

Yes

?

No

Question 7**DSM-5-TR criterion B - feature 4 for autism spectrum disorder****Sub-question 7A**

Do you show an unusually high or low reaction to sensory inputs, for example to sound, light, or smell?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been a problem in your past?)

Examples

- ☐ Hypersensitive to and/or extreme response to pain, temperature, sound, light, smell, food, textures
- ☐ Indifferent to and/or no sensation or recognition of pain, temperature, sound, light, smell
- ☐ Unable to tolerate being touched by others or tolerating this with great difficulty
- ☐ Additional: _____

Sub-question 7B

Do you have an unusual interest in sensory aspects of the environment, for example in sounds, lights, or smells?

(When answered 'yes':) Could you give me an example?

(If this is not recognized in current functioning: Has this ever been a problem in your past?)

Examples

- ☐ Visual fascination/detail perception (e.g., light, movements)
- ☐ Auditory fascination/detail perception (e.g., sound, musical tones)
- ☐ Excessive smelling or touching of objects or people
- ☐ Additional: _____

Feature B4 present in current or past functioning:

Note: To score the feature as present, at least one of the sub-questions must be answered affirmatively.

Yes ? No

Sub-question 7A

In early childhood, did you show an unusually high or low reaction to sensory inputs, for example to sound, light, or smell?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ Hypersensitive to and/or extreme response to pain, temperature, sound, light, smell, food, textures
- ☐ Indifferent to and/or no sensation or recognition of pain, temperature, sound, light, smell
- ☐ Unable to tolerate being touched by others or tolerating this with great difficulty
- ☐ Additional: _____

Sub-question 7B

In early childhood, did you have an unusual interest in sensory aspects of the environment, for example in sounds, lights, or smells?

(When answered 'yes':) Could you give me an example?

Examples

- ☐ Visual fascination/detail perception (e.g., light, movements)
- ☐ Auditory fascination/detail perception (e.g., sound, musical tones)
- ☐ Excessive smelling or touching of objects or people
- ☐ Additional: _____

Feature B4 present in early childhood:

Yes ? No

Note: To score the feature as present, at least one of the sub-questions must be answered affirmatively.

Question 8
DSM-5-TR criterion D for autism spectrum disorder

Have you experienced distress or impairments regarding any area of functioning due to any of the features that you identified in the previous questions, for example at work?

Examples

- ☐ Establishing independence
- ☐ Partner relationship/family
- ☐ Family that you were born and/or raised in
- ☐ Social contacts, friends, acquaintances (social isolation)
- ☐ Work/daily activities/education
- ☐ Free time, hobby, sports
- ☐ Self-esteem/self-image
- ☐ No or limited impairment due to interventions, compensatory behaviors or support (with great effort of those involved for most optimal functioning)
- ☐ Additional: _____

Criterion D present in current functioning:

Yes ? No

Note: To score the criterion as present, at least the question must be answered affirmatively for current functioning.

Optional

In early childhood, have you experienced distress or impairments regarding any area of functioning due to any of the features that you identified in the previous questions, for example at school?

Examples

- ☐ Family that you were born and/or raised in
- ☐ Family
- ☐ Social contacts, friends, peers
- ☐ Kindergarten/nursery school/primary school (hampered learning)
- ☐ Free time, hobby, sports, play
- ☐ Self-esteem/self-image
- ☐ Eating and sleeping, self-care (e.g., haircuts, dental work)
- ☐ No or limited impairment due to interventions, compensatory behaviors or support (with great effort of those involved for most optimal functioning)
- ☐ Additional: _____

Form for summary of DSM-5-TR diagnostic criteria and associated features for autism spectrum disorder

Specify which DSM-5-TR criteria A, B, and D, and associated features for ASD have been scored as present (with 'Yes') in current or past functioning and in the early developmental period. Then sum up the features of DSM-5-TR criteria A and B for ASD for each respective criterion.

Question	Feature/criterion	Present in current or past functioning	Present in early developmental period
1	A1 Deficits in social-emotional reciprocity		
2	A2 Deficits in nonverbal communicative behaviors used for social interaction		
3	A3 Deficits in developing, maintaining, and understanding relationships		
	Total number of features of DSM-5-TR criterion A for ASD (Persistent deficits in social communication and social interaction)	/ 3	/ 3
4	B1 Stereotypical or repetitive motor movements, use of objects, or speech		
5	B2 Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior		
6	B3 Highly restricted, fixated interests that are abnormal in intensity or focus		
7	B4 Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment		
	Total number of features of DSM-5-TR criterion B for ASD (Restricted, repetitive patterns of behavior, interests, or activities)	/ 4	/ 4
8	D Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning (DSM-5-TR criterion D for ASD)	/ 1	

Form for scoring and diagnostic considerations of DSM-5-TR autism spectrum disorder

1.

Name of client : _____

Date of birth : ____ - ____ - ____

Date of assessment : ____ - ____ - ____

NIDA administered by

Name of mental health professional : _____

Function of mental health professional : _____

NIDA administered to : ☐ client
☐ partner
☐ family member
If yes, specify : _____
☐ mentor/coach

2.

DSM-5-TR criterion A for autism spectrum disorder

Yes No

Persistent deficits in social communication and social interaction across multiple contexts

Currently or by history:

Are three features present? Yes ? No

Early developmental period

Are three features present? Yes ? No

DSM-5-TR criterion B for autism spectrum disorder

Yes No

Restricted, repetitive patterns of behavior, interests, or activities

Currently or by history:

Are two or more features present? Yes ? No

Early developmental period:

Are two or more features present? Yes ? No

3.

DSM-5-TR criterion C for autism spectrum disorder

Yes No

Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked in later life by learned strategies).

4.

DSM-5-TR criterion D for autism spectrum disorder

Yes No

Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

5.

DSM-5-TR criterion E for autism spectrum disorder

Yes No

These disturbances are not better explained by intellectual developmental disorder (intellectual disability) or global developmental delay. Intellectual developmental disorder and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual developmental disorder, social communication should be below that expected for general developmental level.

6.

Specify if:

With or without accompanying intellectual impairment

Yes No

If yes, specify current severity:

- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Profound

With or without accompanying language impairment

Yes No

If yes, specify:

Associated with a known genetic or other medical condition or environmental factor

Yes No

If yes, specify:

Associated with a neurodevelopmental, mental, or behavioral problem

Yes No

If yes, specify:

With catatonia

Yes No

If yes, use additional code F06.1 catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.

7.

Context

Has the information obtained with the NIDA been considered within the context of other sources of information?

Yes No

If yes, specify the diagnostic assessment(s) used:

- ☐ Intake assessment
- ☐ Developmental history
- ☐ Heteroanamnesis
- ☐ Behavioral observation
- ☐ Neuropsychological assessment
- ☐ Personality assessment
- ☐ Intelligence assessment
- ☐ Psychiatric assessment
- ☐ Assessment of somatic conditions
- ☐ Additional

If yes, specify: _____

8.

Differential diagnosis or comorbid diagnosis

The features cannot be more adequately explained by (an-)other disorder(s) and/or environmental factor(s).

Yes No

Specify, if applicable, differential diagnosis/diagnoses of ASD and/or condition(s) comorbid to ASD:

- ☐ Intellectual disability
- ☐ Social (pragmatic) communication disorder
- ☐ Attention-deficit/hyperactivity disorder (ADHD)
- ☐ Schizophrenia spectrum- and/or other psychotic disorder
- ☐ Bipolar disorder
- ☐ Depressive disorder
- ☐ Social anxiety disorder
- ☐ Generalized anxiety disorder
- ☐ Obsessive-compulsive disorder
- ☐ Trauma- and/or stressor-related disorder
- ☐ Dissociative disorder
- ☐ Somatic symptom disorder
- ☐ Feeding- and/or eating disorder
- ☐ Disruptive, impulse-control, and/or conduct disorder
- ☐ Substance-related disorder and/or addiction
- ☐ Neurocognitive disorder
- ☐ Personality disorder

If yes, specify: _____

- ☐ Gender dysphoria, paraphilic disorder, and/or sexual dysfunctions
- ☐ Insecure attachment
- ☐ Abuse, mistreatment, and/or neglect
- ☐ Physical illness
- ☐ Other disorders/conditions

If yes, specify: _____

9.

DSM-5-TR autism spectrum disorder

Yes No

Diagnosis determined by: _____

- Function: ☐ (Clinical) psychologist
- ☐ Clinical neuropsychologist
- ☐ Psychiatrist
- ☐ Nurse practitioner mental healthcare
- ☐ Other: _____

10.

Current severity levels of support needs are specified (see p. 66

Yes No

If yes, specify the current severity level for social communication:

- ☐ Level 3 'Requiring very substantial support'
- ☐ Level 2 'Requiring substantial support'
- ☐ Level 1 'Requiring support'

If yes, specify the current severity level for restricted, repetitive behaviors:

- ☐ Level 3 'Requiring very substantial support'
- ☐ Level 2 'Requiring substantial support'
- ☐ Level 1 'Requiring support'

Form for current severity levels for DSM-5-TR autism spectrum disorder

In order to score the severity levels of support needed for the domains 'social communication' and 'restricted, repetitive behaviors' with 'Yes', the associated behavioral features of the domains must be answered with 'Yes' for one of the three current severity levels.

Severity level 3

'Requiring very substantial support'

Social communication

Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others.

For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.

Yes No

Yes No

Yes No

Yes No

Restricted, repetitive behaviors

Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres of life. Great distress/difficulty changing focus or action.

Yes No

Yes No

Yes No

Yes No

Severity level 2

'Requiring substantial support'

Social communication

Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others.

For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and who has markedly odd nonverbal communication.

Yes No

Yes No

Yes No

Yes No

Yes No

Restricted, repetitive behaviors

Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.

Yes No

Yes No

Yes No

Yes No

Yes No

Severity level 1 'Requiring support'

Social communication

Without supports in place, deficits in social communication cause noticeable impairments.

Yes No

Yes No

Difficulty initiating social interactions,
and clear examples of atypical or unsuccessful responses to
social overtures of others.

Yes No

Yes No

May appear to have decreased interest in social interactions.

Yes No

*For example, a person who is able to speak in full sentences
and engages in communication but whose to-and-fro conversation
with others fails, and whose attempts to make friends are odd and
typically unsuccessful.*

Restricted, repetitive behaviors

Yes No

Inflexibility of behavior causes significant interference
with functioning in one or more contexts.

Yes No

Difficulty switching between activities.

Yes No

Problems of organization and planning hamper independence.

Yes No



Vuijk, R. (2024). *Dutch Interview for Diagnostic assessment Autism spectrum disorder in adults (NIDA) - Manual and Interview*. English translation (R. Vuijk, N. Jassim, & K. Klugkist) of 'Nederlands Interview voor Diagnostiek Autismespectrumstoornis bij volwassenen (NIDA) - Handleiding en Interview (derde, geheel herziene druk)'. AutismeSpectrumNederland and Sarr Autisme Rotterdam.

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