Diagnostic Simplification in the DSM-V and the Under-recognition of Autism in Women

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Abstract

This structured narrative review examines whether the unification of pervasive developmental disorders into a single autism spectrum disorder (ASD) in DSM-V reduced gender-specific criteria and contributed to under-recognition of autism in women and girls. Working from DSM-IV-TR, DSM-V-TR and twenty peer-reviewed papers, the review finds no evidence that gender-specific 'must-meet' criteria were removed. DSM-IV-TR never contained them, and the gender discussion slightly lengthened in DSM-V-TR. Remapping studies show a sensitivity drop under DSM-V rules, particularly for former PDD-NOS cases, while clinic and surveillance data show continued rises in identification that were steeper for females. Under-recognition appears better explained by phenotype differences, male-normed instruments and lower teacher concern than by any reduction of manual wording. Diagnostic tools shape not only clinicians' capacity to identify and support autistic people, but also whose experiences become visible in clinical practice and research. The papers document recognition gaps clearly. They say almost nothing about what happens after the label is given or withheld. A late or missed diagnosis can mean years without adapted support at school, a longer trail of other labels in adulthood, and reduced access to services that still treat the diagnosis as a key.

Introduction: Diagnostic Simplification in the DSM-V and the Under-recognition of Autism in Women

Diagnostic manuals function as more than reference texts. They operate as gates that determine which individuals receive a recognised label and which leave clinical encounters still unexplained. They also shape which experiences are treated as central to a condition and which remain on the side or secondary. When the autism chapter of the Diagnostic and Statistical Manual changes, the consequences extend beyond classification itself. Referral pathways, access to support and the composition of research samples can all shift. Examining contemporary diagnostic tools matters not only because they influence clinicians' ability to identify and support autistic people, but because they help determine whose experiences become visible within clinical and research contexts.

In 2013 the older category of pervasive developmental disorders was replaced by a single autism spectrum disorder with three levels of support need (Volkmar & McPartland, 2014; American Psychiatric Association, 2022). This present review draws on the two text-revision manuals available, DSM-IV-TR and DSM-V-TR. The 2000 Pervasive Developmental Disorders (PDD) chapter was set beside the 2022 Autism Spectrum Disorder (ASD) chapter, and the twenty peer-reviewed papers are read considering both. Volkmar and McPartland (2014) summarize the structural change as one spectrum, a social-communication domain that must be fully met, a more flexible restricted and repetitive domain, and a rule that a well-established DSM-IV PDD diagnosis should convert to ASD.

The starting concern for this project was that unification had arguably reduced or narrowed the gender description of autism and that this contributed to the under-recognition of women. That concern is reasonable to test, but it is not yet a demonstrated finding. The review

therefore addresses three aims. First, it compares the gender-related text and the 'must-meet' criteria of the two manuals to ask whether gender-specific criteria were reduced. Second, it examines whether the DSM-V algorithm was less sensitive than DSM-IV-TR and whether any drop, or any change in gender wording, can be linked to under-diagnosis of females. Third, it considers gaps between recognition and care. Across these aims the review proceeds in the acknowledgement that diagnostic tools influence both clinical identification and the range of experiences that enter clinical and research samples.

The papers do not all point the same way. Remapping studies, in which older records or dual checklists are rescored under DSM-V rules, generally find that some individuals lose the diagnosis, particularly those previously classified as Pervasive Developmental Disorder – Not Otherwise Specified or PDD-NOS (Kulage et al., 2014; Kulage et al., 2020; Maenner et al., 2014; Mazurek et al., 2017). Clinic records and public surveillance, by contrast, continued to identify more people after 2013, with relative increases often steeper for females (Russell et al., 2022; Grosvenor et al., 2024; Shaw et al., 2025). These two patterns can coexist. One reflects a fixed algorithm applied to notes written under earlier rules. The other reflects changes in awareness, practice and recording.

Identification rates continue to rise. In the 2022 surveillance year, 32.2 eight-year-olds per 1,000 met the case definition, approximately one in 31 (Shaw et al., 2025). Across twelve US healthcare systems, the recorded diagnosis rate moved from 2.3 to 6.3 per 1,000 between 2011 and 2022, a relative increase of 175% (Grosvenor et al., 2024). A male majority remains. Shaw et al. reported 49.2 boys against 14.3 girls per 1,000, a ratio of 3.4, down from 4.2 in 2018. Loomes et al. (2017) pooled 54 studies and placed the overall male-to-female odds at 4.20, falling to 3.32 in higher-quality work. Zeidan et al. (2022) found a median global ratio of 4.2. In

UK primary-care records the male share of diagnosed cases declined only from 81.67% in 1998 to 77.49% in 2018 (Russell et al., 2022). Women and girls remain a minority of identified cases. Whether that minority reflects the 2013 unification, the design of instruments and school gatekeeping, or a genuine male predominance is the question the remainder of this review addresses.

A brief note on method is needed so that the scope is not overstated. This is a structured narrative literature review with thematic synthesis, limited to twenty peer-reviewed papers plus DSM-IV-TR and DSM-V-TR (American Psychiatric Association, 2000, 2022). Themes were derived from the manuals and papers themselves: the wording of the two chapters, the consequences of applying DSM-V rules to earlier cases, patterns of presentation and counting in girls and women, and the point at which the trail from recognition to care becomes silent. Where a paper does not address a given issue, that silence is treated as information.

Theme 1: Gender Description and Criteria in the Two Manuals

The first aim asks whether the move from DSM-IV-TR to DSM-V reduced gender-specific criteria. The most direct way to answer it is to examine what each chapter actually contains. The expectation going into the comparison was that the newer manual would say less about girls. That is not what the pages show.

Pervasive Developmental Disorders in DSM-IV-TR

DSM-IV-TR does not offer a single autism diagnosis. It lists five pervasive developmental disorders: Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified or PDD-NOS (American Psychiatric Association, 2000). The group is defined by severe and pervasive

impairment in reciprocal social interaction and communication, or by stereotyped behaviour, interests and activities. Asperger's Disorder is not assigned if Autistic Disorder criteria are already met. There is no three-level severity specifier. Associated intellectual impairment, still termed Mental Retardation in this edition, ranges from mild to profound.

The sex-related text is brief and is not framed as a warning that girls may be overlooked. Under Autistic Disorder the manual states that rates are four to five times higher in males and that females with the disorder are more likely to show more severe Mental Retardation (American Psychiatric Association, 2000). That is a severity claim, not a camouflage claim. For Asperger's Disorder the statement is less precise: the condition is diagnosed much more frequently (at least five times) in males. Rett's Disorder is reported only in females. Childhood Disintegrative Disorder and Asperger's are described as more common in males. PDD-NOS carries no sex or gender features paragraph.

Nothing in the chapter indicates that females may present with better conversation, more social interests or learned masking, or that girls without intellectual disability may go unrecognised. The criteria lists themselves do not differ by sex. Gender appears only as medical data and, in the case of Rett's, as a reported sex restriction. It does not appear as a separate diagnostic pathway. In that sense the manual both described a predominantly male condition and helped to keep female presentations outside the centre of clinical attention.

Autism Spectrum Disorder in DSM-V-TR

DSM-V-TR replaces the five named disorders with a single diagnosis of autism spectrum disorder (American Psychiatric Association, 2022). Persistent deficits in social communication and social interaction must be present across all three A subcriteria, currently or by history.

Restricted and repetitive patterns require at least two of four B subcriteria, one of which may be sensory reactivity. Symptoms belong to the early developmental period, although they may not become fully apparent until social demands exceed limited capacities, or they may be masked by learned strategies. Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder or PDD-NOS are to be given ASD. Specifiers address intellectual impairment, language, known medical or genetic factors and additional conditions. Severity is rated on three levels of current support need, AS01, AS02, and AS03, with 03 being the most heavily impaired grouping.

The gender-related text is slightly longer, not shorter. Diagnostic features note that manifestations vary with severity, developmental level, chronological age and possibly gender. Nonverbal communication is to be judged against norms for age, gender and culture. The prevalence paragraph places US frequencies between 1% and 2% and gives a global male-to-female ratio of about 3:1 in well-ascertained samples, with an explicit statement of concern about under-recognition of autism spectrum disorder in women and girls (American Psychiatric Association, 2022). That statement did not appear in the DSM-IV-TR chapter.

A dedicated Sex- and Gender-Related Diagnostic Issues section follows. ASD is described as diagnosed three to four times more often in males, with a later average age at diagnosis in females. Clinic samples find females more likely to show accompanying intellectual developmental disorder and epilepsy, which the manual interprets as a hint that girls without intellectual impairments or language delays may go unrecognized because their social and communication difficulties appear subtler or are actively hidden through masking. Females may display better reciprocal conversation, greater likelihood of sharing interests, better integration of verbal and nonverbal behaviour, and greater ability to modify behaviour according to situation,

even when social understanding remains limited. In fact, attempts to mask autistic behaviour, for example by copying the dress, voice and manner of socially successful women, may further complicate diagnosis. Repetitive behaviours may be less evident, and special interests may appear more social or more normative while remaining unusual in intensity.

None of this constitutes a sex-specific criterion. A woman must still meet all three social-communication subcriteria and two of the four restricted and repetitive subcriteria. The chapter has expanded the description of how those criteria may be met. It has neither added nor removed a female algorithm, because DSM-IV-TR never contained one. The expansion does, however, make female presentations more explicitly available to clinicians and researchers, which is relevant to the question of whose experiences are represented.

What the comparison shows

First et al. (2022) discuss the text revision itself. They note that DSM-V-TR clarified criterion A because the earlier phrase "as manifested by the following" could be read as requiring one of three or all three. The Working Group's intention had always been the higher threshold, so the wording was amended. A Sex and Gender Review Group examined every chapter. First et al. list terminology updates for gender dysphoria but do not report any reduction in ASD gender text. The clarification they describe focuses the social-communication rule rather than reducing the gender discussion.

Hiller et al. (2014) approached the two manuals from the opposite direction. They coded diagnostic reports for 69 girls and 69 boys already diagnosed with high-functioning ASD, applying the broad criteria of both DSM-IV-TR and DSM-V. Official diagnosis had been made under DSM-IV-TR. No sex differences appeared on the broad criteria themselves, yet clear

differences emerged in how girls and boys met them. Girls were more likely to integrate verbal and nonverbal behaviour, sustain reciprocal conversation and initiate friendships they later struggled to maintain. They showed fewer and different restricted interests. Teachers reported substantially fewer concerns for girls than for boys. The study does not compare the gender paragraphs of the manuals. It simply shows that among children who already carry the label the same items can be filled by different everyday presentations.

The first aim therefore yields a fairly clear answer, and it is not the one the starting concern seemed to expect. There was no reduction in gender-specific criteria, because no sex-specific must-meet criteria existed in either manual (American Psychiatric Association, 2000, 2022). Gender-related discussion expanded in DSM-V-TR. Under-recognition of women and girls is named, as is masking. The unification of the PDDs remains a substantial classification change (Volkmar & McPartland, 2014). Comparison of the 2013 DSM-V with the 2022 text revision on gender wording is also impossible here, because only the latter is available.

Theme 2: Sensitivity of the DSM-V Algorithm and Patterns of Identification

The second aim is harder to settle. It asks whether the DSM-V algorithm captured fewer people than DSM-IV-TR, and whether any reduction was linked to sex. The evidence here is mixed. In places it is also more difficult to interpret than the manual comparison. This matters because changes in sensitivity affect not only individual access to support but also which groups appear in clinical and research samples.

Remapping studies

Kulage et al. (2014) reviewed 14 studies that applied DSM-V or late-draft criteria to samples previously classified under DSM-IV-TR. Decreases ranged from 7.3% to 68.4%. The

pooled decrease was 31% for ASD overall, 22% for autistic disorder and 70% for PDD-NOS. The estimate for Asperger's was also high. The authors concluded that DSM-V would likely reduce the number of people diagnosed and that the PDD-NOS group would bear the heaviest loss.

Their 2020 update of 33 studies softened the figures. The pooled decrease was 20.8% for ASD, 10.1% for autistic disorder, 23.3% for Asperger's and 46.1% for PDD-NOS. Roughly 29% of those who were DSM-IV positive and DSM-V negative might meet criteria for Social Communication Disorder. Neither review broke the losses down by sex. That limits how far the findings can be pushed on the gender question.

Maenner et al. (2014) applied a DSM-V algorithm to 6,577 eight-year-olds who already met DSM-IV-TR surveillance criteria. 81.2% still met DSM-V. Capture rates looked similar for boys and girls, though higher when intellectual disability was present. Mazurek et al. (2017) found 93% agreement in a prospective referred sample of 439 children, with sensitivity of 0.89. Female sex was linked to discordance: females made up 18% of the group meeting both manuals and 40% of the group meeting DSM-IV only. That is the clearest sex-linked difference in the remapping set. It comes from a referred sample rather than a population one, so it is hard to know how far it generalizes.

Volkmar and McPartland (2014) review earlier field-trial numbers that pointed in the same direction, with particularly low sensitivity for Asperger's and PDD-NOS. Those figures form part of the historical concern. The present review does not examine the original McPartland paper itself and can only treat them as secondary.

After 2013 field data moved the other way. Russell et al. (2022) found recorded autism incidence in UK primary care rose 787% between 1998 and 2018, with a greater relative increase for females. Grosvenor et al. (2024) reported a 175% rise across twelve US healthcare systems from 2011 to 2022, again steeper for females. Shaw et al. (2025) gave a 2022 prevalence of 32.2 per 1,000 and a male-to-female ratio of 3.4, down from 4.2 in 2018. Zeidan et al. (2022) found a median global ratio of 4.2.

It is possible to hold both sets of findings at once. Remapping shows case loss on paper, especially among former PDD-NOS cases. Clinics and surveillance kept identifying more people, including more females. The two are not necessarily in conflict. One measures a fixed algorithm on old notes. The other measures what services actually record as practice changes. Still, this feels less conclusive than the manual comparison. The sensitivity drop is real in the remapping. The field numbers do not behave as if identification collapsed after 2013. The sex-linked evidence remains less robust than one would like. Because diagnostic thresholds help determine who enters clinical and research samples, the unresolved elements of this theme have implications beyond individual case counts.

Theme 3: Female Presentation, Sex Ratios and Recognition Gaps

If the remapping numbers cannot fully explain under-recognition, other factors have to be considered. This section looks at how girls and women present, how often they are counted, and whether any of that pattern can be explained by shorter gender wording in the manual. The last possibility can be set aside fairly quickly. The wording is not shorter. What remains is the question of how diagnostic tools and everyday gatekeeping shape which experiences become visible.

The Scale of the Male Majority

Loomes et al. (2017) remain the strongest ratio paper in this review. Across 54 prevalence studies covering 53,712 people with ASD, the overall male-to-female odds ratio was 4.20. In high-quality studies it fell to 3.32. In population-screening studies it was 3.25. In studies that relied on existing clinical diagnosis it rose to 4.56. The authors conclude that the true ratio is closer to three to one than four to one, and that girls who meet criteria are at elevated risk of not receiving a clinical diagnosis. That is a claim about diagnostic practice, not about the wording of DSM-V and is tied to representation. If girls who meet criteria are systematically less likely to receive a diagnosis, then clinical and research samples will continue to under-represent their experiences.

Lai et al. (2015) set the broader scene. A ratio of 4–5:1 is widely cited. It tends to be lower when intellectual disability is present and higher at the high-functioning end. They argue that the familiar male bias may be partly produced by under-recognition of higher-functioning females, by ascertainment bias and by the instruments themselves. Even after those problems are admitted, a male predominance remains. Recent surveillance figures seem to bear that out. Shaw et al. (2025) report 3.4 boys for every girl at age eight. Zeidan et al. (2022) still find a median of 4.2 worldwide. Russell et al. (2022) find that more than three-quarters of diagnosed cases in UK primary care were male in 2018. The male majority itself is not in dispute. How much of it reflects missed girls rather than a lower true prevalence in females is still open.

Phenotype and Recognition

Hiller et al. (2014) are useful here as a phenotype study. Among already-diagnosed high-functioning children, girls were more likely to integrate verbal and nonverbal behaviour, sustain

reciprocal conversation and initiate friendships they could not maintain. Restricted interests were fewer and different. Teachers perceived a quieter problem. The authors suggest that girls may present a surface picture unlike the classic male prototype and may appear less impaired at school. Because the sample is already diagnosed, it cannot speak to girls who never reached assessment.

Van Wijngaarden-Cremers et al. (2014) synthesized 22 studies. Boys showed more repetitive and stereotyped behaviour from age six onward, but not before. Social behaviour and communication did not differ by sex. Females with average-to-high intelligence were underrepresented. The authors close by stating that ASD is defined according to the male phenotype and that this may produce ascertainment bias. What the synthesis itself supports is a sex difference in repetitive behaviour after early childhood and an under-count of more intellectually able females.

Edwards et al. (2024) broke restricted and repetitive behaviour into narrower descriptions. Autistic males showed higher stereotyped behaviour and more restricted interests. The differences were small. No clear sex difference emerged for sensory features or insistence on sameness. Qualitative differences appeared in the content of interests. The authors suggest that such differences may contribute to under-recognition and may not be well captured by current instruments.

Beggiato et al. (2017) examined individual autism diagnostic interview – revised or ADI-R items. Several items differed by sex, including four that sit on the diagnostic algorithm. They argue that the resulting gender bias may help underestimate female prevalence, and they note that neither DSM-IV-TR nor DSM-V treats core symptoms as requiring sex-specific criteria.

Cruz et al. (2025) put phenotype and camouflaging together and found that females used more compensation and masking across the studies they reviewed. Instruments such as the autism diagnostic observation schedule or ADOS, and ADI-R were validated mainly in males and still lack sex-based norms. Kaat et al. (2021), looking at already-diagnosed children, found only small sex differences on standard measures, which is consistent with the idea that the diagnosed group has already passed through male-normed filters.

Whitlock et al. (2020) tested the school gate experimentally. Primary educators shown vignettes were less sensitive to a female autism phenotype and to girls in general. When the presentation was classically male, the gender of the child in the vignette made little difference. The study is hypothetical, so it measures estimated recognition rather than actual referral. It remains the closest experimental picture of gatekeeping in the set and sits next to Hiller et al.'s finding that teachers already report fewer concerns for diagnosed girls.

Taken together, under-recognition looks more like a problem of presentation, instruments and school gatekeeping than a problem of the manual deleting gender text. The wording is not shorter. Maenner et al. found similar capture rates for boys and girls under DSM-V. Mazurek et al. found female over-representation among discordant cases. Field rates for females rose after 2013. Once a child is already diagnosed, instrument sex differences can look modest. The more persuasive claim is not that the manual deleted girls. It is that girls whose presentation diverges from the familiar male picture remain harder to recognise, especially before they reach a specialist clinic. That difficulty has consequences for representation. The experiences that reach clinical and research samples continue to be skewed toward those who match the more familiar presentation.

Discussion and Conclusions

This review set out to examine three linked aims. The answers are less dramatic than the initial concern implied, and they are not all equally secure. Across them, however, runs a consistent implication. Contemporary diagnostic tools influence both clinicians' capacity to identify and support autistic people and the range of experiences that become visible in clinical practice and research.

On the first aim the evidence is relatively solid. Gender-specific criteria were not reduced when the PDDs were unified, because they never existed as sex-specific must-meet requirements. DSM-IV-TR supplied ratios, a severity note about females and Mental Retardation, and a female-only account of Rett's (American Psychiatric Association, 2000). DSM-V-TR retained a single algorithm for both sexes and expanded the sex- and gender-related discussion to include later diagnosis, masking, more social interests and explicit under-recognition of women and girls (American Psychiatric Association, 2022). First et al. (2022) describe a clarification that all three social-communication subcriteria are required. They do not describe a reduction in gender text. Unification itself was a genuine classification change (Volkmar & McPartland, 2014). Reduction of gender description is simply not what the two chapters show. The expansion of gender discussion in DSM-V-TR does, at least on paper, make female presentations more available to clinicians and researchers.

The second aim is more awkward. Remapping studies do show a sensitivity drop, especially for PDD-NOS (Kulage et al., 2014, 2020; Mazurek et al., 2017; Maenner et al., 2014). Early field-trial figures pointed the same way. Field diagnosis, however, did not contract. Recorded identification rose, and the rise was steeper for females (Russell et al., 2022; Grosvenor et al., 2024; Shaw et al., 2025). Women and girls remain a minority of identified

cases (Loomes et al., 2017; Zeidan et al., 2022; Shaw et al., 2025). It is possible to read the remapping loss and the field rise as compatible. The sex-linked evidence inside the remapping set is thinner than the rest of the picture, though, and the theme as a whole feels less resolved than the manual comparison. Because diagnostic thresholds help determine who enters clinical and research samples, the unresolved elements of this theme have implications for representation as well as for individual case counts.

On the third aim the papers are clearer about recognition than about care. Whitlock et al. (2020) show that primary educators are less sensitive to autism in girls and to a female phenotype. Hiller et al. (2014) show that even after diagnosis teachers report fewer concerns for girls. Cruz et al., Beggiato et al. and Lai et al. point to male-normed instruments and a research base that has mostly studied boys. Van Wijngaarden-Cremers et al. and Edwards et al. note that repetitive behaviour, the domain that still helps cases cross the threshold, is the domain in which boys are more visible after early childhood. Loomes et al. put a number on the cost of those filters: screening studies identify more girls than studies that wait for clinical diagnosis. All of that supports a recognition gap.

What the papers do not support is any claim about what happens after the label is given or withheld. No study in the reviewed set measured treatment hours, education-plan uptake or service retention. That silence is not a minor gap. A girl who is identified at sixteen rather than at six has already lost years in which a school might have adapted its expectations and support. A woman named in adulthood may arrive with a long sequence of other labels already attached. Those steps are inferred from the recognition literature and are not counted here.

Kulage et al. (2014, 2020) raise a separate service concern that is not sex-specific. If remapping removes the label from some impaired individuals, particularly former PDD-NOS cases, those individuals may lose access to services that still use the diagnosis as a key. Roughly 29% of the DSM-IV-positive, DSM-V-negative cases might receive a Social Communication Disorder diagnosis instead. The remainder may receive none. Mazurek et al. show that female sex is over-represented in that residual group within a referred sample. That is as close as the set comes to a sex-linked service-eligibility issue, and even then the measured outcome is the label rather than subsequent care.

Shaw et al. (2025) offer a more hopeful note on identification. The ADDM male-to-female ratio has fallen from 4.2 to 3.4 across recent surveillance years, which they read as possible improvement in finding girls. Grosvenor et al. and Russell et al. also show female identification rising faster than male identification. A falling ratio is not the same as equal access to support after diagnosis, but it does suggest that the recognition gap is not fixed. If identification continues to broaden, the range of experiences represented in clinical and research samples may also broaden.

The main limitation of the whole exercise is the number of sources. A wider search might have located studies that examined the care-access cell or that explore sex differences in remapping more carefully. Within the materials used, the pattern is reasonably consistent on the manuals and on recognition pathways, weaker on the sensitivity question, and silent on what support follows diagnosis. The manuals were approached with an expectation of reduction in gender description. What appeared instead was a merger accompanied by a longer gender note. The remapping papers were approached with an expectation of a simple fall in cases. Girls whose presentation diverges from the familiar male picture remain easier to miss. The reviewed

studies document that pattern. They do not document that DSM-V deleted them. They do, however, illustrate why examining diagnostic tools remains important. Those tools shape both the support that reaches autistic people and the experiences that become visible in the literature that guides future practice.

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