DSM-5 (Criteria and Major Changes for SLP-Related Conditions)	ASHA Comments* (ASHA Recommendations Compared to DSM-5 Criteria)	Potential Practice Implications
Austism Spectrum Disorder (ASD)		
Individuals meeting the criteria will be given a diagnosis of "autism spectrum disorder" with three levels of severity based on degree of support needed. Diagnostic criteria include deficits in social communication and social interaction; and restricted, repetitive patterns of behavior, interest or activities, which cause significant impairments in daily functioning. • Eliminates pervasive developmental disorder and its subcategories (autistic disorder, Rett's disorder, childhood disintegrative disorder, Asperger's disorder, pervasive developmental disorder-not otherwise specified [PDD-NOS]). Rett syndrome, a genetic disorder, is not included in DSM-5, although girls with Rett syndrome often have ASD symptoms and may be diagnosed with ASD if they meet the criteria. • Omits criterion related to delay in or lack of development of spoken language. Rather, the evaluator is to specify whether the ASD occurs "with or without accompanying language impairment." • Changes the age of onset from "prior to age 3 years" in DSM-IV to symptoms present "in the early developmental period."	DSM-5 consolidated subcategories in ASD. ASHA supported this change due to lack of evidence for discrete categories. ASHA recommended including disorders of language content (semantics), form (phonology, syntax) and use (pragmatics, social communication) in the diagnostic criteria for ASD. DSM-5 diagnostic criteria do not reflect the significance of language content and form in defining ASD. However, the severity specifiers and diagnostic features capture language deficits in more detail. ASHA suggested that DSM-5 criteria indicate that nonverbal communication behaviors vary within and across cultures. Although the ASD diagnostic criteria in DSM-5 do not mention cultural variation, the diagnostic features, which describe the criteria in greater detail, indicate that nonverbal communication should be assessed "relative to cultural norms." Sections detailing culture and gender-related diagnostic issues also were added in DSM-5.	Under new DSM-5 criteria, individuals will receive a diagnosis of ASD, rather than previous subcategories. There is concern that those who are higher functioning may not receive an ASD diagnosis and may not get the services they need. Social (pragmatic) communication disorder is a more appropriate diagnosis than ASD for a client who has difficulties with social skills but doesn't show restricted or repetitive patterns of behavior. SLPs will be instrumental in making this differential diagnosis. Because the language component is downplayed in the ASD criteria, SLPs will need to advocate for the inclusion of language in intervention plans for those with ASD. SLPs will need to ensure that people with ASD receive a comorbid diagnosis of "language disorder" (a component of "communication disorders") when they meet the criteria for both conditions. There is a need to ensure that services aren't limited to those with higher severity levels. The more descriptive and clear DSM-5 criteria for ASD may benefit children by leading to earlier diagnosis and intervention.

Communication Disorders		
Diagnostic categories for communication disorders include "Language Disorder," "Speech Sound Disorder," "Childhood-Onset Fluency Disorder (Stuttering)," "Social (Pragmatic) Communication Disorder," and "Unspecified Communication Disorder." This represents a change from the DSM-IV categories of "Expressive Language Disorder" and "Mixed Receptive-Expressive Language Disorder." **Language Disorder.** The diagnostic criteria for language disorder include "persistent difficulties in the acquisition and use of language across modalities (i.e., spoken, written, sign language, or other) due to deficits in comprehension or production," language abilities that are "substantially and quantifiably" below age expectations. **Social (Pragmatic) Communication Disorder.** The diagnostic criteria for social (pragmatic) communication disorder are "persistent difficulties in the social use of verbal and nonverbal communication," which include deficits in "using communication for social purposes… ," "impairment in the ability to change communication to match context or the needs of the listener…," "difficulties following rules for conversation and storytelling…," and "difficulties understanding what is not explicitly stated…and nonliteral or ambiguous meaning of language…." **Speech Sound Disorder.** The key diagnostic criterion for speech sound disorder includes "persistent difficulty with speech sound production that interferes with speech intelligibility or prevents verbal communication	ASHA recommended including a statement that a regional, social, or cultural or linguistic variation (e.g., dialect) of language is not a language disorder. DSM-5 indicates that "regional, social, or cultural/ethnic variations of speech should be considered before making the diagnosis." DSM-5 also states in the introduction to this section that speech, language, and communication assessments "must take into account the individual's cultural and language context, particularly for individuals growing up in bilingual environments. " Also indicated is that standardized measures must be "relevant for the cultural and linguistic group." ASHA did not recommend having a separate category for social communication disorder. ASHA indicated that difficulties in use of language (e.g., impairments in discourse) were already part of the criteria for a language disorder. However, the criteria for "Language Disorder" were reframed and were defined primarily around vocabulary and grammar. "Social (Pragmatic) Communication Disorder" includes verbal and nonverbal communication in a social context. ASHA recommended indicating that speech sound disorder may co-occur with a language disorder. DSM-5 accepted this recommendation. ASHA asked that diagnostic criteria for cluttering be added. However, cluttering is not included. ASHA recommended that motor speech disorders, voice disorders and resonance disorders not be included in DSM-5 because	It is essential that individuals with other conditions, particularly ASD, specific learning disorder, ADHD and intellectual disability, also be diagnosed with a communication disorder when they meet the diagnostic criteria for both. SLPs will need to make sure to that individuals with ASD be assessed for a language disorder. Individuals with social (pragmatic) communication disorder, however, cannot be dually diagnosed as having ASD. ASD must be ruled out before a diagnosis of social (pragmatic) communication can be made. SLPs will be key team players in making these diagnoses. Diagnosis of social communication, including pragmatics, has been and will continue to be a challenge, and we clearly need more research in this area. Assessment needs to be contextually based and involve multiple settings and communication partners. Social communication skills do not fit easily within a single assessment tool. Multiple observations, checklists, structured tasks, and assessment measures are needed. Recognition of cultural and linguistic variations is paramount, particularly for this area of assessment. Some may be concerned that individuals diagnosed with social (pragmatic) communication disorder may be given a lower priority with respect to workload than individuals diagnosed with ASD. However, services should be based on need, not on diagnostic labels or severity levels.

of messages." **Childhood-Onset Fluency Disorder (Stuttering).** The diagnostic criteria for childhood-onset fluency disorder (stuttering) are "disturbances in the normal fluency and time patterning of speech…" and the disturbance causes "anxiety about speaking…." The onset of symptoms for communication disorders is in the "early developmental period." However, social communication deficits may continue to unfold with increasing social communication demands. Adult-onset fluency disorders are not included in DSM-5.	they are physiological problems rather than mental or developmental disorders. DSM-5 does not include these disorders. ASHA suggested refraining from using "developmental" in the description of childhood-onset fluency disorder because this disorder is not developmental in nature, but rather is applicable to individuals whose stuttering has an observed onset during childhood. DSM-5 indicates that the onset of symptoms is in the early developmental period and indicates that childhood-onset fluency disorder is also called "developmental stuttering," but does not use the term "developmental" as a diagnostic criterion or in the description of the diagnostic features.	
Intellectual Disability (Intellectual Developmental Disorder)		
• Change in terminology from "Mental Retardation" to "Intellectual Disability (Intellectual Developmental Disorder)." • Diagnostic criteria include deficits in intellectual functions "confirmed by both clinical assessment and individualized, standardized intelligence testing" and deficits in adaptive functioning. This represents a move away from a specific IQ level and expands the role of clinical assessment. • Onset is in the "developmental period." In DSM-IV, onset was indicated as before 18 years. • DSM-IV had distinct classifications of mild,	• ASHA supported the change from "Mental Retardation" to "Intellectual Disability." ASHA agreed with the need for alignment with the American Association of Intellectual and Developmental Disabilities (AAIDD) terminology and other professionals and consumers who use this more contemporary terminology. • ASHA recommended the elimination of classification by IQ and severity level. • ASHA recommended use of the AAIDD definition, which characterizes intellectual disability by "significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive	• Individuals with intellectual disabilities may have a co-occurring condition such as communication disorder, specific learning disorder, or ASD when all of the diagnostic criteria are met. SLPs will play a pivotal role in making these differential diagnoses. • SLPs will be critical members of a diagnostic and intervention team to ensure that individuals receive ongoing support, AAC systems, and involvement of communication partners. • More individuals may be diagnosed with intellectual disability because the diagnosis does not require a specific IQ score.

moderate, severe, and profound "mental retardation" based on IQ level. DSM-5 has a single category of intellectual disability rather than divisions by severity level. There are specifiers now for various levels of severity that are defined by adaptive functioning across conceptual, social, and practical domains. • The category of "Global Developmental Delay" may apply for children under the age of 5 years when severity level cannot be assessed reliably. "Unspecified Intellectual Disability (Intellectual Developmental Disorder)" is limited to individuals older than 5 years when assessment is "difficult or impossible" due to associated sensory, physical, or other conditions. • The need for assessment tools for intellectual and adaptive functioning that are "culturally appropriate" is mentioned in the section on diagnostic features.	behaviors…." (www.aaidd.org). • ASHA recommended including assessment of support needs such as augmentative and alternative communication systems (AAC) and involvement of communication partners. DSM-5 recognizes the need for "ongoing support" to address limits in adaptive functioning. The diagnostic features indicate that standardized measures should be used with "knowledgeable informants."	
Major and Mild Neurocognitive Disorders		
• Dementia is no longer a separate diagnostic category; replaced by major and mild neurocognitive disorders (NCD). • "Dementia" as described in DSM-IV is classified under major NCD. • Mild cognitive impairment can now be diagnosed and coded under the new "mild NCD" sub-category. • The term "dementia" can be used to reflect	• ASHA supported the change of diagnostic category from "Delirium, Dementia, Amnestic, and Other Geriatric Cognitive Disorders" to "Neurocognitive Disorders" because it is broader in scope and includes cognitive deficits related to traumatic brain injury. • ASHA did not support the differentiation between "major" and "mild" neurocognitive because the differences between the categories appear to be	• May increase referrals of individuals with mild NCD disorders for cognitive services. • Clinicians and consumers may be confused when the severity markers are applied to a major NCD. For example, it is now possible to receive a diagnosis of a "mild" major NCD.

etiological subtypes (e.g., Alzheimer's dementia). • Diagnostic criteria for different etiological subtypes are either elaborated (vascular & Alzheimer's disease) or revised and separately delineated (frontotemporal NCD, Lewy bodies, traumatic brain injury (TBI), Parkinson's disease, HIV infection, Huntington's disease, prion disease, substance/medication-induced NCD, another medical condition, multiple etiologies and unspecified). • Cognitive domains (deficits in), which are the basis of the NCD diagnosis, are clearly specified.	arbitrary. • ASHA recommended that the severity specifiers be excluded for neurocognitive disorders since a diagnosis such as "severe" mild NCD would be confusing. As per these recommendations, the severity specifiers for mild NCD have been excluded. However, the severity markers of mild, moderate and severe are included as specifiers for major NCD. • ASHA did not support describing deficits in mild NCD as "insufficient to interfere with independence." ASHA's recommended revisions were accepted. • ASHA recommended retaining the explicit description of symptoms of mild TBI provided in DSM-IV, and adding "difficulty concentrating" as a feature of mild TBI. Both of these recommendations were accepted.	
Selective Mutism		
• Now classified as an anxiety disorder (rather than "Other Disorder of Infancy, Childhood , or Adolescence" in DSM-IV) • No change in the diagnostic criteria.	ASHA did not make recommendations pertaining to the diagnostic criteria for selective mutism.	SLPs will continue to be involved as team members in the diagnosis and treatment of selective mutism.
Specific Learning Disorder		
• Characterized as "difficulties learning and using academic skills." Diagnostic criteria include difficulty with word reading, understanding the meaning of what is read, word meaning, spelling, written expression,	• ASHA expressed concern about the omission of oral language as a diagnostic criterion for specific learning disorder. DSM-5 indicates that a specific learning disorder is "frequently, but not invariably	• Omission of reference to oral language significantly misrepresents the constellation of learning disabilities. As a consequence, individuals may be excluded from receiving the services they need and research

number use and calculation, and mathematical reasoning. Combines diagnoses, which were separate in DSM-IV, of reading disorder, disorder of written expression, mathematics disorder, and learning disorder not otherwise specified. • Determines academic performance through standardized achievement measures and comprehensive clinical assessment. Notes that "clinical synthesis" should occur based on the individual's developmental, medical, family, and educational histories, school reports, and psycho-educational assessment. • Affected academic skills must be substantially and quantifiably below those expected based on chronological age (or average achievement that is sustainable only by extraordinary high levels of effort or support). • Deficits must cause significant interference with academic or occupational performance, or with activities of daily living. • Severity levels are specified separately for impairments in reading, written expression, and mathematics. • Does not include disorders of spoken language (speaking and listening) as a diagnostic criterion.	preceded, in preschool years, by delays in attention, language or motor skills that may persist and co-occur with specific learning disorder." • ASHA argued against the use of standardized measures as the sole basis for diagnosis of specific learning disorder. DSM-5 recognizes the need to include multiple sources of data to make an accurate diagnosis. ASHA supports the use, when available, of culturally and linguistically appropriate, age-appropriate, and psychometrically sound standardized measures as part of an assessment battery in which assessments are conducted with fidelity and repeated over time. Use of inappropriate measures can lead to an increase in false positives and false negatives in diagnosing any disorder. • ASHA stressed the need to use culturally and linguistically appropriate measures. DSM-5 includes a section on "culture-related diagnostic issues" for a specific learning disorder. This section includes assessment considerations for English language learners and the need to consider cultural and linguistic contextual factors for assessment. • ASHA preferred the term specific learning disability, well-established clinical and research term, rather than specific learning disorder. Disability addresses the impact of a disorder and represents a lifelong problem. However, DSM-5 recognizes that a specific learning disorder "…can have	populations may be identified inaccurately. SLPs will need to be vigilant about ensuring that individuals with a specific learning disorder, who also meet the diagnostic criteria for a language disorder, receive both diagnoses. • SLPs who are part of the diagnostic team should emphasize that language can be in any modality, such as spoken, manually coded (e.g., signing, cued speech), or other type of augmentative and alternative communication system. • Because a specific learning disorder comprises multiple disorders, it is important that SLPs and other professionals recognize that need for comprehensive assessment and multiple intervention strategies, which may change over time.

	negative functional consequences across the lifespan….”	

***Note:** ASHA provided comments during the three public comment periods.

References and Resources

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders, Fifth Edition. Arlington, VA: American Psychiatric Association.

American Psychiatric Association, DSM-5 Resources, www.dsm5.org

- Highlights of Changes from DSM-IV-TR to DSM-5 http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf
- Frequently Asked Questions on the DSM-5 http://www.dsm5.org/about/Pages/faq.aspx
- Fact Sheets on What’s New http://www.dsm5.org/