The American-Speech-Language-Hearing Association (ASHA) 2011 President Paul R. Rao submitted the following comments on ASHA’s behalf related to the anticipated May 2013 publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Comments were posted on the DSM-5 website: www.dsm5.org.

Learning Disabilities

Proposed Changes
Changing subcategories of learning disabilities (currently learning disorders) to dyslexia (currently reading disorder) and dyscalculalia (currently mathematics disorder), and eliminating the disorder of written expression as a subcategory.

Concern 1:
This proposed change, by focusing only on specific academic disabilities, could lead to the definition of learning disabilities (LD) becoming too narrow, raising the potential for some individuals to be excluded from the services they need. The proposed definition is so narrow that it doesn’t consider the complexity of the disorder. Furthermore, it does not address the need for assessment tools to be age and linguistically appropriate. Such a definition significantly limits and misrepresents the constellation of learning disabilities that we see in our clients and patients, particularly in the school-aged population.

Recommendations
- The definition of LD should be expanded to include problems related to oral and written language, listening, reasoning, and reading comprehension.
- Oral language problems should be included among the deficit areas in the proposed definition, not just in the rationale for the proposed change.
- The definition of LD should indicate that sources of information other than standardized measures should be administered with fidelity and repeated over time. Examples of such sources of information include structured observation, rating scales, criterion-referenced measures, data from a Response-to-Intervention multi-tiered instructional program, or other nonstandardized measures (e.g., analysis of oral and written language samples for conversation, expository, and narrative discourse)
- Standardized measures should not be required for diagnosis.

Rationale/Background
Broader Definition Needed
ASHA is one of the members of the National Joint Committee on Learning Disabilities (NJCLD). We strongly recommend using the definition of LD developed by the NJCLD as the basis for the LD criteria:¹

*Learning disabilities* is a general term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical abilities. These disorders are intrinsic to the individual, presumed to be due to central nervous system dysfunction, and may occur across the life span. Problems in self-regulatory behaviors, social perception, and social interaction may exist with learning disabilities but do not by themselves constitute a learning disability. Although learning disabilities may occur concomitantly with other handicapping conditions (for example, sensory impairment, mental retardation, serious emotional disturbance), or with extrinsic influences (such as cultural differences, insufficient or inappropriate instruction), they are not the result of those conditions or influences.

The DSM-V rationale indicates that there are “no previous general criteria for learning disorders.” However, the NJCLD definition is widely used and recognized by a range of organizations and practitioners that provide services to individuals with learning disabilities. The NJCLD definition recognizes that learning disabilities are heterogeneous, are intrinsic to the individual, are not limited to academic skills, and can occur across the life span. Oral language problems are the core deficit in many individuals with LD.

Assessment Concerns
Consistent with requirements of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004), we support the use of a variety of assessment tools and strategies for gathering relevant functional, developmental, and academic information when evaluating a child for services. We also support the use of a culturally appropriate, and psychometrically sound standardized measure of academic achievement. However, we do not think that a standardized measure should be required. Standardized tests are not always available, especially for populations such as English language learners.

Concern 2:
The subcategories are too limited and give the impression that the only important areas for LD are mathematics and the mechanics of reading (thus ignoring the importance of oral language, reading comprehension, and disorders of written expression). Narrowing the subcategories and using the terms “dyslexia” instead of reading disorder or “dyscalculia” rather than mathematics disorder may send the message that only a very specific type of assessment specialist/evaluator

(e.g., academic language therapist) is required. However, other professionals, including speech-language pathologists, need to be included to render a diagnosis of LD. A more narrow definition implies that a multidisciplinary team diagnostic approach may not be required and/or be considered as necessary.

**Recommendations**

- Reading comprehension should be included in the definition of dyslexia and/or the main definition of learning disabilities at a minimum, and ideally, oral language should be a part of the definition.
- Include disorders of written expression (with the current definition) as a subcategory of learning disabilities.
- Maintain the current subcategories of reading disorder, mathematics disorder, and disorders of written expression.

**Rationale/Background**

Limitations of Dyslexia

Though we support the change in terminology from learning disorders to learning disabilities, we prefer the current subcategories of reading disorder, mathematics disorder, and disorders of written expression.

While dyslexia is important, the proposed definition of dyslexia is limited to decoding and does not address reading comprehension. Reading comprehension, understanding the sound-symbol system/s, and inferencing can influence reading as well. Academic skills include oral and written language, reading and mathematics, as well as social, thinking, and reasoning and organizing skills. Our recommended changes are consistent with the IDEA 2004 definition of learning disabilities.

**Disorders of Written Expression**

Individuals with LD struggle with the most important aspect of written language—getting thoughts from the brain and clearly expressing them on paper or on the computer. While people with disorders of written expression may exhibit other learning disabilities, many of them exhibit disorders of written language in isolation (Assouline, Nicpon, & Whiteman, 2010; Watkins, 2005; Watkins, Kush & Schaefer, 2002). Therefore, disorders of written expression should continue to be included as a distinct subcategory of learning disabilities.

Numerous research findings support the efficacy of strategic writing instruction and self-regulation training for students with LD (Bui, Schumaker & Deshler, 2006; Gersten & Baker, 2001; Goddard & Sendi, 2008). If students with disorders of written expression are not identified, they may not have access to these valuable interventions.

**References**


Intellectual Disabilities

Proposed Changes
Changing the definition of intellectual disabilities (currently mental retardation) and eliminating classification by IQ and severity level (i.e., mild, moderate, severe, profound).

Concern:
The proposed change lacks an important element regarding assessment of support needs.

Recommendation
Include assessment of support needs such as augmentative and alternative communication systems and involvement of communication partners.

Rationale/Background
We support the change from mental retardation to intellectual disability. We agree with the need to align the criteria with the new definition proposed by the American Association of Intellectual and Developmental Disabilities (AAIDD; see http://www.aaidd.org):

Intellectual disability is a disability characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills. This disability originates before the age of 18.

Assessment of communication supports is consistent with the AAIDD definition and is critical to ensure full assessment of adaptive behavior, which would require a means for communicating at home, school, on the job, and in the community.

Autism

Proposed Changes

- Subsuming pervasive developmental disorder into autism spectrum disorder.
- Eliminating subcategories of autism (e.g., Asperger’s syndrome, Rett’s, childhood disintegrative disorder)
- Changing the criteria for defining autism.

Concern:
The proposed changes overlook the importance of language content, form, and use in defining ASD.

Recommendation
Change Criterion 1.a. to “Marked deficits in nonverbal and verbal language that have an impact on social interaction.”
Rationale/Background
We support the proposed change related to the elimination of subcategories due to lack of evidence for discrete categories. We also support the proposed new criteria for defining autism: Deficits in social communication and interactions and restrictive and repetitive patterns of behavior, interests, and activities.

However, we suggest changes to the proposed criterion that specifies “marked deficits in nonverbal and verbal communication used for social interaction.”

Disorders of language (in its entirety) are a hallmark of autism. Any component of language content (i.e., semantics), form (i.e., phonology and syntax), and use (i.e., pragmatics, social communication) may be problematic in people with ASD. To isolate language use for diagnostic purposes does not accurately describe the fundamental nature of language impairment in autism. All of the nonverbal (e.g., facial expression, prosody, gestures, paralinguistic features of communication) and verbal components of language have an impact on social interaction and need to be reflected in the criteria.

Thus, we recommend the following change (highlighted area) to the criteria:

1. Clinically significant, persistent deficits in social communication and interactions, as manifest by all of the following:
   a. Marked deficits in nonverbal and verbal language that have an impact on social interaction;
   b. Lack of social reciprocity;
   c. Failure to develop and maintain peer relationships appropriate to developmental level.

Cognitive Disorders

Proposed Changes
Changing category name from Delirium, Dementia, Amnestic, and Other Geriatric Cognitive Disorders to Neurocognitive Disorders.

Concern:
The use of the terms major and minor to describe the levels of neurocognitive disorders is problematic, as the latter can connote a lack of importance or significance.

Recommendation
Use one term—neurocognitive disorder—and do not distinguish between two levels of severity.

Rationale/Background
We support this overall change in the category name as it reflects a more encompassing approach to cognitive disorders and now includes those related to traumatic brain injury. Regarding the proposed major and minor levels, however, the diagnostic criteria are the same. The only
distinction is severity, so one term—*neurocognitive disorder*—without specifying levels should suffice.

The new diagnostic criteria do not require memory impairment as a primary factor. We also recognize that other cognitive areas may be more affected in disorders other than the Alzheimer’s disease subtype and support this change.