

Autism Spectrum Disorder (ASD)

DSM-5 Diagnostic Criteria and Changes

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.”

ASHA Comments* (ASHA recommendations compared with DSM-5 criteria)

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.

Potential Practice Implications

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.

* ASHA provided comments to the APA during the three public comment periods (www.asha.org/SLP/DSM-5)

Communication Disorders

DSM-5 Diagnostic Criteria and Changes

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 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.

ASHA Comments* (ASHA recommendations compared with DSM-5 criteria)

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 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.

Potential Practice Implications

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.

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