ASHA'S RECOMMENDED REVISIONS TO THE DSM-5

June 2012
Comments

On behalf of more than 150,000 members who are audiologists, speech-language pathologists, and speech, language, and hearing scientists, the American Speech-Language-Hearing Association respectfully submits the enclosed report and recommendations for consideration.

ASHA's Recommended Revisions to the DSM-5

June 2012

The American-Speech-Language-Hearing Association (ASHA) 2012 President Shelly Chabon submits 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*).

Contents

A 08 Specific Learning Disorder

- Omission of Oral Language
- Assessment of Specific Learning Disorder
- Moving From *Disability* to *Disorder* Terminology

A 00 Intellectual Developmental Disorder

- Moving From *Disability* to *Disorder* Terminology
- Assessment of Support Needs

A 05 Autism Spectrum Disorder

- Lack of Inclusion of *Language* in the Diagnostic Criteria
- Omission of Verbal Communication and Cultural Variations

A 02 Language Disorder

- Omission of *Specific Language Impairment* Specifier

A 03 Speech Disorder

- Inappropriate Inclusion of Motor Speech Disorders, Voice Disorders, and Resonance Disorders

A 04 Social Communication Disorder

- Separation of Social Communication Disorder

S 03 Mild Neurocognitive Disorders and S 04 Major Neurocognitive Disorders

- Unnecessary Distinction in Severity
- Unclear Diagnostic Criteria for Cognitive Deficits and Independence

S XX.04 Neurocognitive Disorder Due to Traumatic Brain Injury

Diagnostic Criteria and Severity Description for TBI

Other

Requested Input on the Cultural Formulation Interview

Requested Input on the Definition of *Mental Disorders*

A 08 Specific Learning Disorder

Omission of Oral Language: Concern and Ramifications

ASHA is very concerned about the omission of oral language as a specific feature specifier for Specific Learning Disorder. This omission is egregious and significantly misrepresents the constellation of learning disabilities. Without modification of this section, individuals will be excluded from receiving the services they need and research populations will be inaccurately identified.

Rationale for Concern

Language (listening and speaking) disorders are defining features of learning disabilities. Therefore, the proposed revision fails to accurately characterize one of the central components of learning disabilities.

The language component is in fact recognized in the *DSM-5* rationale:

> Learning disorders interfere with the acquisition and use of one or more of the following academic skills: oral language, reading, written language, mathematics.

Despite the fact that there is a section on Communication Disorders in the *DSM-5*, Oral Language Disorder also should be included in the Specific Learning Disorder section as one of the feature specifiers because it is a fundamental characteristic of learning disorder.

Recommendation

Include *Language (listening and speaking)* as a specifier under Specific Learning Disorder. We also suggest adding a statement 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.

A 08 Specific Learning Disorder

Assessment of Specific Learning Disorder: Concerns and Ramifications

ASHA disagrees that standardized measures should be required for assessment of Specific Learning Disorder or that such measures can serve as the sole basis for diagnosis. The use of standardized measures that are not valid for certain populations can lead to an increase in false positives and false negatives in diagnosing Specific Learning Disorder.

Rationale for Concern

We applaud the stated approach to assessment in the proposed *DSM-5*, which recognizes the need to include multiple sources of data to make an accurate diagnosis.

> A diagnosis of Specific Learning Disorder is made by a clinical synthesis of the individual's history (development, medical, family, education), psycho-educational reports of test scores and observations, and response to intervention…

However, one of the diagnostic criteria in the proposed *DSM-5* is the requirement for "scores on individually-administered, standardized, culturally and linguistically appropriate tests of academic achievement in reading, writing, or mathematics." This requirement is inconsistent with the statement included in the proposed *DSM-5* that indicates the importance of using multiple sources of information to make the diagnosis.

Standardized measures are not valid, available, or appropriate for some populations. The use of a variety of assessment tools and strategies for gathering relevant, functional, developmental, and academic information is warranted, but a requirement for use of standardized measures is not warranted.

Recommendation

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.

ASHA suggests that the use of norm-referenced, criterion-referenced, or curriculum-based performance measures of achievement, as well as observations and data from a student's response to intervention and instruction (which are included in the proposed revision), be added to Section B to read as follows (changes in **bold**):

> B. Current skills in one or more of these academic **domains** are well-below the average range for the individual's age or intelligence, cultural group or language group, gender, or level of education, as indicated by multiple sources of data, such as scores on

individually administered, standardized, culturally and linguistically appropriate tests of academic achievement in **oral language,** reading, writing, or mathematics; **norm-referenced, criterion-referenced, or curriculum-based performance measures of achievement; structured observations; and data from a student's response to intervention and instruction.**

A 08 Specific Learning Disorder

Moving From *Disability* to *Disorder* Terminology: Concerns and Ramifications

The use of the term *Specific Learning Disorder* instead of *Learning Disability* or *Specific Learning Disability* is inappropriate, inaccurate, and contrary to already well-established terms used for clinical and research populations.

Disability represents a lifelong problem, so it is essential that we recognize not just the disorder but also the disability that subsumes the disorder. *Specific Learning Disability* comprises multiple disorders; this is evidenced by the fact that the disability itself may persist despite the intervention for, and even resolution of, individual component disorders that make up or contribute to the disability.

Adopting terminology that does not acknowledge this distinction as it applies to learning disability would result in treatment merely focusing on symptoms, which would have serious, negative effects on therapeutic outcomes.

Rationale for Concern

ASHA is one of the members of the National Joint Committee on Learning Disabilities (NJCLD).[1] ASHA strongly recommends using the definition of *Learning Disabilities* (*LD*) developed by the NJCLD as the basis for the *LD* criteria:

> *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-5* 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.

[1] Members of the NJCLD are American Speech-Language-Hearing Association, Association for Higher Education and Disability, Association of Educational Therapists, Council for Learning Disabilities, Division for Communicative Disabilities and Deafness/Council for Exceptional Children, Division of Learning Disabilities/Council for Exceptional Children, International Dyslexia Association, International Reading Association, Learning Ally, Learning Disabilities Association of America, National Association of School Psychologists, and National Center for 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. Indeed Oral Language Disorder is included as a defining feature in the definition of LD by the NJCLD and by the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004).

Recommendation

ASHA strongly urges the American Psychiatric Association to change the *DSM-5* terminology from *Specific Learning Disorder* to *Learning Disability* or *Specific Learning Disability* to be consistent with the National Joint Committee for Learning Disabilities and IDEA 2004 definitions.

A 00 Intellectual Developmental Disorder

Overarching statement about Intellectual Developmental Disorder section: ASHA fully supports the proposal submitted by the American Association on Intellectual and Developmental Disabilities (AAIDD) regarding the use of the term *Intellectual Disabilities*, the revision of the diagnostic criteria, and the elimination of the severity grid. ASHA also recommends the addition of assessment of support needs.

A 00 Intellectual Developmental Disorder

Moving From *Disability* to *Disorder* Terminology: Concerns and Ramifications

As with the *Specific Learning Disorder* terminology already discussed, the proposed *DSM-5* reflects a worrying trend away from recognition of the difference between *disorder* and *disability.* ASHA asserts that such a distinction is fundamental to proper service delivery.

The proposed *DSM-5* use of the term Intellectual Developmental *Disorder* instead of *Disability* would have a significant impact on service eligibility, and ramifications would be felt in civil and criminal justice arenas as well.

Rationale for Concern

The evolution of terminology to characterize deficits in the development of intellectual function is well chronicled. In fact, the disorder known for so many years as *Mental Retardation* has been covered in the 11 editions (going back to 1910) of AAIDD's terminology and classification manual.

AAIDD has thoroughly researched *Intellectual Disability* and developed a professionally accepted and widely used definition of the term. In addition, "Rosa's Law," signed by President Obama in 2010, officially replaced *Mental Retardation* with *Intellectual Disability.* It would be a major divergence if the *DSM-5* were to unilaterally change what is now the official terminology used in federal health, education, and labor laws by moving to *Disorder* instead of *Disability*.

Recommendation

ASHA strongly urges use of the term *intellectual disabilities* in the *DSM-5*, which would be consistent with the AAIDD definition and which, as indicated in the *DSM-5* rationale, is "widely used."

A 00 Intellectual Developmental Disorder

Assessment of Support Needs: Concerns and Ramifications

The *DSM-5* recognizes that individuals with intellectual disabilities have support needs with the statement that "The limitations result in the need for ongoing support at school, work, or independent life." However, the proposed revision lacks the important element of the assessment of these support needs. A separate statement should be added calling for an assessment process to determine the types and levels of supports that are necessary. This addition 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.

Rationale

Assessment of support needs is consistent with the AAIDD definition "… assessments must also assume that limitations in individuals often coexist with strengths, and that a person's level of life functioning will improve if appropriate personalized supports are provided over a sustained period."

AAIDD emphasizes the need for a supports approach to evaluate"…the specific needs of the individual and then suggests strategies, services, and other supports that will narrow the gap between the individual's personal competence and the demands of their living situation."

Recommendation

ASHA recommends inclusion of assessment of support needs such as augmentative and alternative communication systems and involvement of communication partners as part of the diagnostic criteria (changes in **bold**).

> Impairment in adaptive functioning for the individual's age and sociocultural background. Adaptive functioning refers to how well a person meets the standards of personal independence and social responsibility in one or more aspects of daily life activities, such as communication, social participation, functioning at school or at work, or personal independence at home or in community settings. The limitations result in the need for ongoing support at school, work, or independent life, **thus warranting assessment of support needs, in areas such as augmentative and alternative communication systems and involvement of communication partners.**

A 05 Autism Spectrum Disorder

Lack of Inclusion of *Language* in the Diagnostic Criteria: Concerns and Ramifications

ASHA supports the proposed revision for autism spectrum disorder related to the elimination of subcategories due to lack of evidence for discrete categories. However, ASHA is concerned that the absence of a language component overlooks the importance of language form and content in defining autism spectrum disorder.

If a language disorder is not part of the ASD criteria, children with ASD could be misidentified as only having a language disorder and would not receive all of the interventions that they need.

If language disorder is not part of the ASD criteria, all children with ASD would also have to be diagnosed as having a language disorder because by definition ASD encompasses language disorders.

Rationale

Disorders of language are a hallmark of autism and include all language components to some degree: content (i.e., semantics), form (i.e., phonology, morphology, syntax), and use (i.e., pragmatics, social communication) in all modalities (e.g., oral and sign). To collapse the diagnostic criteria to only include social language use would result in an inaccurate description of the fundamental nature of autism. Language disorders are a distinct element of ASD.

In the proposed revision of the diagnostic criteria for ASD, the following rationale is provided for elimination of the criteria related to spoken language:

> Delays in language are not unique nor universal in ASD and are more accurately considered as a factor that influences the clinical symptoms of ASD, rather than defining the ASD diagnosis.

ASHA concurs that delays in language are not unique to ASD. However, the literature clearly indicates that spoken language disorders are a hallmark feature of ASD and are often the critical indicators for early identification of ASD. Some children with ASD demonstrate unaffected early language development and their problems manifest themselves only with higher order language tasks, whereas other children demonstrate profound language deficits from the onset of the language acquisition process.

Even children with ASD who are verbal do not possess a generative language system (infinite capacity with finite means). They have not internalized the rules for generating novel language forms. Lack of generative language persists over time in children with ASD.

Although social communication is an important component of ASD, deficits in language form and content also are defining features and need to be included as diagnostic criteria. Failure to include spoken language in the diagnostic criteria would result in a fundamental mischaracterization of ASD that would run counter to an extensive body of research, such as the following major studies:

Form (Morphology and Syntax)

Eigsti, I. M., Bennetto, L., & Dadlani, M. B. (2007). Beyond pragmatics: Morphosyntactic development in autism. *Journal of Autism and Developmental Disorders, 37,* 1007–1023.

Giacomo, A., & Fombonne, C. (1998). Parental recognition of developmental abnormalities in autism. *European Child & Adolescent Psychiatry, 7,* 131–136.

Prud'hommeaux, E. T., Roark, B., Black, L. M., & van Santen, J. (2000). *Classification of atypical language in autism*. Beaverton, OR: Center for Spoken Language Understanding, Oregon Health & Science University.

Content (Semantics)

Mawhood, L., Howlin, P., & Rutter, M. (2000). Autism and developmental receptive language disorder—A comparative follow-up in early adult life. I: Cognitive and language disorders. *Journal of Child Psychology and Psychiatry, 41,* 547–559.

McDuffie, A., Yoder, P., & Stone, W. (2005). Prelinguistic predictors of vocabulary in young children with autism spectrum disorders. *Journal of Speech, Language, and Hearing Research, 48*, 1080–1097.

Smith, V., Mirenda, P., & Zaidman-Zait, A. (2007). Predictors of expressive vocabulary growth in children with autism. *Journal of Speech, Language, and Hearing Research, 50,* 149–160.

Recommendation

Add a fifth diagnostic criterion for autism spectrum disorder: Deficit in oral language.

A. Persistent deficits in comprehension and expression of language across contexts and modalities (e.g., spoken and manually coded), not accounted for by general developmental delays, and manifested as deficits in language form (phonology, morphology, syntax) and language content (semantics) ranging from limited language acquisition to total lack of comprehension and expression of language (as defined in section on language disorders).

Continue numbering the other criteria as B through E.

A 05 Autism Spectrum Disorder

Omission of Verbal Communication and Cultural Variations: Concerns and Ramifications

Verbal communication is included in the *DSM-5* rationale and in the severity chart, but it is omitted in the proposed diagnostic criteria. Omission of verbal communication and lack of attention to cultural variations in nonverbal communication could lead to misdiagnosis.

Rationale

Verbal, as well as nonverbal, components of language need to be reflected in the diagnostic criteria because both are core characteristics of ASD. It is also important to indicate in *DSM-5* that nonverbal behaviors vary widely within and across cultures (e.g., sustained eye contact is considered to be rude in some cultures, but is desired in others). It is critical that assessments be culturally and linguistically appropriate.

Recommendation

Add *verbal* to the proposed diagnostic criteria in A 05, A. 2. Also, add a statement about cultural variation (changes in **bold**):

> Deficits in nonverbal **and verbal** communicative behaviors used for social interaction; ranging from poorly integrated verbal and nonverbal communication, through abnormalities in eye contact and body-language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures," **recognizing that nonverbal behaviors vary within and across cultures.**

A 02 Language Disorder

Omission of *Specific Language Impairment* as a Specifier

The previous revision of *DSM-5* on the comments website included specifiers of *Late Language Emergence* and *Specific Language Impairment*. ASHA supports the *Late Language Emergence* specifier but recommends the omission of *Specific Language Impairment* (SLI) as a specifier of a language disorder.

Rationale

ASHA approves of the diagnostic criteria (A through E) for language disorder. We applaud *DSM-5* for recognizing the multiple components of spoken and written language, the need for multiple sources of information, and the recognition that "A regional, social, or cultural/ethnic variation (e.g., dialect) of language is not a Language Disorder."

However, we question the inclusion of SLI as a specifier. SLI is a controversial diagnosis that is not available in the vast majority of clinical settings. It is widely used in research, but consensus among language scientists on the robustness and validity of the category has not been reached.

Nonverbal IQ is required to make the diagnosis of SLI, and this information is not available in many or most clinical settings. It is not best practice to rely on formal testing to make a diagnosis. The problems with formal tests are well-known and pervasive. For example, culturally and linguistic appropriate measures are not available for many children who are L2 English learners and speakers of nonstandard dialects. Therefore the diagnosis will not apply to many groups of children.

In addition, a relatively small number of papers representing a relatively narrow view have been cited to support the proposed categories. The science is not sufficiently advanced and the controversies surrounding this label have not been laid to rest. Issues include the fact that nonverbal IQ declines with age (L. Leonard, 1998, *Specific Language Impairment*, Cambridge, MA: MIT Press), thus rendering the concept of the relation between IQ and language more difficult to understand, and the concern with the use of 85 as a cut-off IQ for normal functioning, which is higher than that used for determination of intellectual impairment.

Recommendation

ASHA recommends omitting *Specific Language Impairment* as a specifier of a language disorder.

A 03 Speech Disorder

Inappropriate Inclusion of Motor Speech Disorders, Voice Disorders, and Resonance Disorders: Concerns and Ramifications

Motor speech disorders, voice disorders, and resonance disorders are physiological problems rather than mental or developmental disorders. Therefore, inclusion of such disorders in a manual of mental disorders and in a section on neurodevelopmental conditions is unwarranted. Inclusion in the *DSM-5* would result in a gross misrepresentation of the underlying etiologies of these disorders and incorrect characterization of them for research and reimbursement purposes.

Rationale

Speech-language pathologists are the professionals best educated and best equipped to treat motor speech, voice, and resonance disorders. Thus, diagnosis and assessment of these disorders should be left to them and their governing bodies.

Motor speech, voice, and resonance disorders are described in the *ICD-9-CM* under chapter 16, Symptoms, Signs, and Ill-Defined Conditions, where most organic speech, language, and voice disorders are classified. Therefore, these conditions should not be included in *DSM-5*, which focuses on mental disorders.

Recommendation

Omit motor speech disorders, voice disorders, and resonance disorders from the diagnostic criteria and from the specifiers of speech disorders. The criteria for the childhood onset fluency disorder specifier are not posted on the *DSM-5* comments website at this time. When these criteria are written, ASHA urges APA to refrain from using “developmental” in the description because this disorder is not developmental in nature, but rather is applicable to individuals whose stuttering has an observed onset during childhood. ASHA recommends that diagnostic criteria be included for cluttering, which is another type of fluency disorder. Cluttering is characterized by a rapid and/or irregular speech rate, and excessive disfluencies, which are usually of the more typical type (revisions and overuse of fuller words, such as "*um*"). The speech of a person who clutters often contains pauses in unusual places and unusual prosody. Other symptoms may include language or phonological errors.

A04 Social Communication Disorder

Separation of Social Communication Disorder: Concerns and Ramifications

ASHA finds the rationale for separating social communication disorder to be incorrect because a language disorder includes pragmatics and social communication. Including a distinct diagnosis of social communication disorder will result in misdiagnoses for many individuals because, in reality, these individuals have a language disorder. They may have more difficulty with language use than other aspects of language, such as form or content. However, at the root is a language disorder.

Rationale

Language impairment can affect the domains of vocabulary; grammar; narrative, expository, and conversational discourse; and other pragmatic language abilities individually or in any combination. The need for a separate category is not clear. Social communication disorder is an impairment of language use and is diagnosed based on difficulty in the social uses of verbal and nonverbal communication in naturalistic contexts, which affects the development of social relationships and discourse comprehension and cannot be explained by low abilities in the domains of word structure and grammar or general cognitive ability.

Culture variations may influence nonverbal language in a number of areas, including eye contact, proximity, and pragmatics (e.g., directness and loudness). Cultural variations should not be considered a social communication disorder.

The utility of the diagnosis seems to rest in identifying children with pragmatic language impairments who either do not have the diagnosis of ASD or do not meet the criteria for diagnosis of ASD because this category excludes those diagnosed with ASD.

The Language Disorder diagnosis specifically states the disorder can occur in any realm; the fact that some have found individuals with intact abilities in other realms than pragmatics does not mean those children are not language impaired, which a separate diagnostic category clearly implies. This category appears to be based on a discrepancy between total language ability and social communication ability. This clinical profile is not sufficiently marked to warrant separating it from the primary diagnosis of language disorder.

Recommendation

Do not include or refer to a social communication disorder as a distinct diagnostic category. It should be part of the definition of a language disorder.

S 03 Mild Neurocognitive Disorders and S 04 Major Neurocognitive Disorders

Unnecessary Distinction in Severity: Concerns and Ramifications

ASHA prefers the use of the terms *major* and *mild* to describe the levels of neurocognitive disorders rather than the previously proposed terms *major* and *minor*. However, we do not think it is necessary to make this distinction as part of the diagnostic criteria.

If severity levels are applied within the diagnosis of Mild Neurocognitive Disorder or Major Neurocognitive Disorder, a person will essentially have two levels of severity, such as a moderate mild neurocognitive disorder. Such a description would be confusing and not helpful. It would be more appropriate to have one category of neurocognitive disorder and then assign severity levels within that category.

Rationale

We support the overall change in the category name to *Neurocognitive Disorders*, as the term reflects a more encompassing approach to cognitive disorders and now includes those related to traumatic brain injury. Regarding the proposed *major* and *mild* levels, however, the diagnostic criteria are the same. The only distinction is severity, so one term—*Neurocognitive Disorder*—without specifying levels should suffice. Severity levels will be described in *DSM-5* for each neurocognitive disorder. Therefore, inclusion of the severity levels of *major* and *mild* in the diagnostic criteria is not necessary.

Recommendation

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

S 03 Mild Neurocognitive Disorders and S 04 Major Neurocognitive Disorders

Unclear Diagnostic Criteria for Cognitive Deficits and Independence: Concerns and Ramifications

The wording for Mild Neurocognitive Disorder concerning cognitive deficits and independence is not clear.

Those with a mild neurocognitive disorder often experience difficulty functioning independently, unless supports (e.g., strategies or accommodations) are in place. Therefore, to indicate that cognitive deficits are "insufficient to interfere with independence" is misleading and may result in lack of appropriate and needed services for these individuals.

Rationale

The diagnostic criterion indicating that "greater effort, compensatory strategies, or accommodations may be required" seriously negates the impact that even a mild disorder can have on a person's functioning.

Recommendation

Change the wording of diagnostic criterion B as follows:

> ***Current***
>
> The cognitive deficits are insufficient to interfere with independence (i.e., instrumental activities of daily living [more complex tasks such as paying bills or managing medications] are preserved), but greater effort, compensatory strategies, or accommodation may be required to maintain independence.
>
> ***Recommended Change***
>
> The cognitive deficits **interfere with independence** (i.e., instrumental activities of daily living [more complex tasks such as paying bills or managing medications] **are compromised**); greater effort, compensatory strategies, or accommodations **are required** to maintain independence.

S XX.04 Neurocognitive Disorder Due to Traumatic Brain Injury

Diagnostic Criteria and Severity Description for TBI: Concern and Ramifications

The definition and description of *traumatic brain injury* in the proposed *DSM-5* is neither correct nor useful. TBI can cause impairments in social and occupational functioning and may worsen academic performance. Educators, health care providers, families, and third party payers, need to be aware of the difficulties experienced by individuals with TBI.

With regard to the severity description, the Glasgow Coma Scale cut-offs for different levels of TBI are provided, which can be helpful in making an initial diagnosis, but it is not sufficient for making a definitive diagnosis of the neurocognitive disorder.

Rationale for Concern

DSM-IV-TR details the variety of symptoms commonly experienced by individuals with TBI (e.g., becoming fatigued easily, disordered sleep, headache). It would be preferable to use the definition provided in the *DSM-IV-TR* as it actually describes TBI. The two points, that TBI can cause impairments of social and occupational functioning and that it may worsen academic performance in school-aged children, are not included in the proposed *DSM-5*. Though hard neurologic signs are not always or even typically evident in cases of TBI, the symptoms and difficulties individuals with TBI experience can cause significant challenges in social, occupational, and/or academic pursuits and, therefore; it seems in alignment with the goals of the *DSM* to include a description of the major symptoms and challenges commonly faced by individuals with TBI just as is done for every other disorder listed in the proposed *DSM-5*.

Recommendations

Use the definition provided in the *DSM-IV-TR*:

> The disturbance causes significant impairment in social or occupational functioning and represents a significant decline from a previous level of functioning. In school-age children, the impairment may be manifested by a significant worsening in school or academic performance dating from the trauma.

The severity scale should apply to the neurocognitive aspects of TBI and not just to the etiology.

Requested Input on the Cultural Formulation Interview

1. Overall, is the intent of the CFI clear?

ASHA appreciates and applauds the effort to determine the influence of a person's background on how he or she perceives illness or injury and on his or her treatment preferences. This information is important and the cultural interview format is appropriate. However, ASHA has concerns with the wording of some of the questions; there is a need to rephrase them with attention to health literacy. In addition, ASHA strongly urges the use of one questionnaire for all patients.

2. Is the content behind every question clear?

Yes. However, it is not clear if the question will elicit the intended information. The questions should be field tested with a wide range of populations to determine if they are gathering the information that they need.

3. Do any of the questions need to be changed [added, eliminated, or re-worded]?

Yes. Some are very hard to understand. At times, the way the questions are asked may be perceived by a patient, client, or his or her family members, as confrontational. Rather than establishing rapport, the questions could lead to the formation of a bad relationship.

Also, Questions 1–3 appear to be repetitive. In Question 1, the patient is using his or her own words to explain the reason for the appointment. In Question 3, the patient is again being asked to describe their problem to others. ASHA recommends that Questions 1–3 be combined with the following probes.

> 1. In your own words, tell me what brought you here today.
>
> PROBE: What troubles you most about this problem?

Questions 5–8 also appear redundant, with all of them addressing what makes the patient's problems worse or better. Questions 7 and 8 attempt to gain more information about cultural norms that might be contributing to these problems. However, there is a high degree of cultural awareness required to distinguish those things that make your problem better from those things in your cultural background that make your problems better. For many individuals, those are one and the same. ASHA suggests combining the questions to read as follows:

> Now, we're going to talk a little bit more about your problem and those things in your life that make it better or worse. Please share whatever comes to mind. For example, this could be having a daily routine, your kids, loved ones, your work. What makes it easier for you? How about anything that makes it worse?

ASHA recommends combining Questions 9 and 10. “What you do for yourself?” might involve contacting other organization or seeking treatments from different service providers, so combining these would prevent duplicative answers.

ASHA suggests rewording Question 11 into a probe for Questions 9 and 10 to read as follows:

> Have any of these treatments been successful for you? What made them successful? Have any of these treatments been unsuccessful? Why?

It is good to gather information about how providers can be most effective; however, Question 12 should be deleted. The ability to establish a good, productive patient–provider relationship might be hindered by having the patient be required to state why the provider may not be effective. In addition, this leads to surface-based judgments at the onset. Cultural competence is the responsibility of the clinician, not of the patient and this question appears to place some of the ownership on the patient.

4. How can the CFI be made even more feasible for use in daily clinical practice?

It would be essential to test out the inventory with different groups to determine the appropriateness of the questions and to see if the intended information is gathered through the use of this instrument. Testing out the questions will also ensure that the literacy levels of the questions aren't too high. It is important that clinicians who might choose to use this inventory do so in a consistent manner. Picking and choosing for whom one might use this inventory may result in disparities when assumptions are made about patients based upon particular features, such as skin color, language, or dress.

5. What would make the CFI even more helpful to your clinical situation, as a patient, clinician, or family member?

Culturally competent services should begin with the clinician. Everyone has a culture and brings it to their service delivery context. Rather than putting patient on the spot, clinicians should focus on their own behavior and not make cultural awareness and sensitivity the patient’s responsibility. The National Center for Cultural Competence and the American Speech-Language-Hearing Association both have cultural competence checklists that may be useful for inclusion in this toolkit.

Requested Input on the Definition of *Mental Disorders*

ASHA recommends the following changes to the proposed *DSM-5* definition of *mental disorders*.

A Mental **Health** Disorder is a ~~health~~ condition characterized by significant dysfunction in an individual's ~~cognitions,~~ emotions~~,~~ or behaviors that reflects a disturbance in the psychological~~,~~ ~~biological,~~ or developmental processes underlying mental functioning. **Mental health disorders are distinct from disorders of cognitive functioning.** Some disorders may not be diagnosable until they have caused clinically significant distress or impairment of performance.

A mental disorder is not merely an expectable ~~or culturally sanctioned~~ response to a specific event such as the death of a loved one. **The diversity of the patients should be respected; the typical variance in cultural norms and behaviors should not be diagnosed as mental health disorders.** Neither ~~culturally~~ deviant behavior (e.g., political, religious, or sexual) nor a conflict that is primarily between the individual and society is a mental **health** disorder unless the deviance or conflict results from a dysfunction in the individual, as described above

Associated Text

The diagnosis of a mental **health** disorder should have clinical utility: it should help clinicians to determine prognosis, treatment plans,~~recommendations to additional~~ **referrals to additional service providers**, and potential treatment outcomes for their patients. However, the diagnosis of a mental **health** disorder is not equivalent to a need for treatment. Need for treatment is a complex clinical decision that takes into consideration such factors as symptom severity, symptom salience (e.g., the presence of suicidal ideation), the patient's distress (mental pain) associated with the symptom(s), disability related to the patient's symptoms, and other factors (e.g., psychiatric symptoms complicating other illness). Clinicians may thus encounter individuals who do not meet full criteria for a mental **health** disorder, but who demonstrate a clear need for treatment or care. The fact that some individuals do not show all symptoms indicative of a diagnosis in these individuals should not be used to justify limiting their access to appropriate care.

This definition of mental **health** disorder was developed for clinical, public health, and research purposes. ~~The inclusion of diagnostic categories such as Gambling Disorder and pedophilic Disorder does not imply that such conditions meet legal or other nonmedical definitions of mental disease, mental disorder, mental defect, or mental disability.~~ Additional information is usually required beyond that contained in the *DSM-5* diagnostic criteria in order to make legal judgments on such issues as criminal responsibility, eligibility for disability compensation, and competency. **The *DSM-5* definitions and diagnostic criteria should not be used to determine**

which professionals are competent to provide a diagnosis. Professionals should be guided by their own ethics code and credentialing process.

Rationale

The inclusion of *biological* in the proposed definition appears to equate mental with neurological disorders, which is inappropriate and may contribute to misdiagnosis and inappropriate treatment. Mental disorders have a long-standing connotation with psychological and behavioral issues that should be the focus of this manual.

ASHA suggests using the terminology *mental health disorders* and differentiating those disorders from *cognitive disorders*. ASHA also recommends that a statement be included in the definition to indicate that the *DSM-5* should not be used to determine which professionals are competent to provide a diagnosis. Professionals should be guided by their own Code of Ethics and credentialing processes.

ASHA strongly urges you to eliminate the terminology *cultural deviance*. Cultures do not promote deviant behavior. A statement related to cultural diversity should be added.