Editorial:

Social (pragmatic) communication disorders and autism spectrum disorder

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With the more and more interest of researchers in the field of developmental paediatrics ,there are more and more specification to find out a particular problem evolving.

Social communication disorder is evolving as a new diagnostic criterion where the subject is not capable enough to participate or realise the inherent thought process in the speech and language of another person. In these subjects, the structural aspect of the speech component is normal but the meaning behind is not clear to them

Any classification of diseases and disorders has been driven by the need for reliability and evidence based. The group of disorders where only the communication part is problematic but there are no clinical features suggestive of restrictive and repetitive behaviour alteration should be categorised in a special group so that they can get benefit of the care provided. In DSM IV, this entity is described as Pervasive Developmental Disorders not otherwiseclassified. In ICD 10, this entity is described as Atypical Autism.

Considering the need for inclusion of this category, DSM V includes a new terminology for this group of patients known as Social (pragmatic) communication disorder (SPCD)

Diagnostic criteria for social (pragmatic) communication disorder (DSM-5). (from the Diagnostic and Statistical Manual of Mental Disorders, fifth edition. Copyright 2013. American Psychiatric Association)

A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following:

A. Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.

B. Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on the playground, talking differently to a child than an adult and avoiding use of overly formal language.

C. Difficulties following rules for conversation and story-telling, such as taking turns in conversation, re-phrasing when misunderstood and knowing how to use verbal and nonverbal signals to regulate interaction.

D. Difficulties in understanding what is not explicitly stated (eg, making inferences). A non-literal or ambiguous means of language—for example, idioms, humour, metaphors, multiple meanings, which depend upon the context for the interpretation.

B. The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement or occupational performance, individually or in combination.

C. The onset of the symptoms is in the early developmental period, but the deficits may not become fully manifest until social communication demands exceed limited capacity.

D. The symptoms are not attributable to another medical or neurological condition, or to low abilities in the domains of word structure and grammar and are not better explained by an autism spectrum disorder, intellectual disability (intellectual developmental disorder), global developmental delay or another mental disorder.

For neurodevelopmental disorders, such as Autism Spectrum Disorder, there is a diversity of causation. Starting from genetic and epigenetic modification of genetic expression due to environmental factors associated with various point mutation leads to the complex disorder Autism Spectrum Disorder where social as well as behavioural factors both are inclusive.

Diagnostic criteria for autism spectrum disorder (DSM-5). (from the Diagnostic and Statistical Manual of Mental Disorders, fifth edition. Copyright 2013. American Psychiatric Association)

A. Persistent deficits in social communication and social interaction across multiple contexts, manifested by the following, currently or by history (examples are illustrative not exhaustive; see text):

A. Deficits in social–emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions or affect; to failure to initiate or respond to social interactions.

B. Deficits in nonverbal communicative behaviours used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

C. Deficits in developing, maintaining and understanding relationships, ranging, for example, from difficulties adjusting behaviour to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

B. Restricted, repetitive patterns of behaviour, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

A. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

B. Insistence on sameness, inflexible adherence to routines, or ritualised patterns of verbal or nonverbal behaviour (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals need to take same route or eat same food every day).

C. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).

D. Hyper- or hypo reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities; or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual develop-

mental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Age of recognition of SPCD

The recognition ideally should be done in the early developmental period but clear-cut demarcation is usually difficult before 4 years of age until social communication demands exceed limited capacity.

Social (Pragmatic) communication disorder is not similar to Autism. Restrictive and repetitive behavior is the main key for differentiation along with social communication disorderare found in Autism Spectrum Disorder. As and when awareness regarding social problems are increasing new classifications and disorders will mushroom. However in India,qualified pediatric psychologist is a rarity and team management of pervasive disorder is remote possibility. Unified efforts are needed to give quality care for children of all strata in our country.