

09 - 31.4e Unspecified Communication Disorder

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COURSE AND PROGNOSIS The course and outcome of social (pragmatic) communication disorder is highly variable and dependent on both the severity of the disorder and potential interventions administered. By age 5 years, most children demonstrate enough speech and language to be able to discern the presence of deficits in social communication. However, in the milder forms of the disorder, social communication deficits may not be identified until adolescence, when language and social interactions are sufficiently complex that deficits stand out. Many children have significant improvement over time; however, even so, some early pragmatic deficits may cause lasting impairment in social relationships and in academic progress. There is a newly growing body of investigations on therapeutic interventions that may affect future outcome and prognosis of social (pragmatic) communication disorder.

TREATMENT There are few data to date to inform an evidence-based treatment for social (pragmatic) communication disorder, or to fully distinguish it from other disorders with overlapping symptoms such as autism spectrum disorder, ADHD, and social anxiety disorder. A randomized controlled trial of a social communication intervention directed specifically at children with social (pragmatic) communication disorder aimed at three areas of communication: (1) social understanding and social interaction; (2) verbal and nonverbal pragmatic skills, including conversation; and (3) language processing, involving making inferences, and learning new words. Although the primary outcome measure in this study did not show significant differences for the intervention group versus the “treatment as usual” group, there were several ratings by parents and teachers that demonstrate potential improvements in social communication skills after a 20-session intensive intervention for social (pragmatic) communication disorder. It is clear that continued investigation is necessary to both validate the preceding results and to promote evidence-based treatments for children with social (pragmatic) communication disorder.

31.4e Unspecified Communication Disorder Disorders that do not meet the diagnostic criteria for any specific communication disorder fall into the category of unspecified communication disorder. An example is voice disorder, in which the patient has an abnormality in pitch, loudness, quality, tone, or resonance. To be coded as a disorder, the voice abnormality must be sufficiently severe to impair academic achievement or social communication. Operationally, speech production can be broken down into five interacting subsystems, including respiration (airflow from the lungs),

phonation (sound generation in the larynx), resonance (shaping of the sound quality in the pharynx and nasal cavity), articulation (modulation of the sound stream into consonant and vowel sounds with the tongue, jaw, and lips),

and suprasegmentalia (speech rhythm, loudness, and intonation). these systems work together to convey information, and voice quality conveys information about the speaker's emotional, psychological, and physical status. Thus, voice abnormalities can cover a broad area of communication as well as indicate many different types of abnormalities. Cluttering is not listed as a disorder in the DSM-5, but it is an associated speech abnormality in which the disturbed rate and rhythm of speech impair intelligibility. Speech is erratic and dysrhythmic and consists of rapid, jerky spurts that are inconsistent with normal phrasing patterns. The disorder usually occurs in children between 2 and 8 years of age; in two thirds of cases, the patient recovers spontaneously by early adolescence. Cluttering is associated with learning disorders and other communication disorders. REFERENCES Adams C, Lockton E, Freed J, Gaile J, Earl G, McBean K, Nash J, Green J, Vail A, Law J. The Social Communication Intervention Project: A randomized controlled trial of the effectiveness of speech and language therapy for school-age children who have pragmatic and social communication problems with or without autism spectrum disorder. *Int J Lang Commun Disord*. 2012;47:233-244. Blumgart E, Tran Y, Craig A. Social anxiety in adults who stutter. *Depress Anxiety*. 2010;27:687-692. Boulet SL, Boyle CA, Schieve LA. Health care use and health and functional impact of developmental disabilities among US children 1997-2005. *Arch Pediatr Adolesc Med*. 2009;163:19-26. Bressman T, Beitchman JH. Communication disorder not otherwise specified. In: Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Sadock BJ, Sadock VA, eds. Philadelphia: Lippincott Williams & Wilkins; 2009:3534. Cantwell DP, Baker LP. Psychiatric and Developmental Disorders in Children with Communication Disorders. Washington DC: American Psychiatric Press; 1991. Cone-Wessen B. Prenatal alcohol and cocaine exposure: Influences on cognition, speech, language and hearing. *J Commun Disord*. 2005;38:279. Gibson J, Adams C, Lockton E, Green J. Social communication disorder outside autism? A diagnostic classification approach to delineating pragmatic language impairment, high functioning autism and specific language impairment. *J Child Psychol Psychiatry*. 2013;54:1186-1197. Huerta M, Bishop SL, Duncan A, Hus V, Lord C. Application of DSM-5 criteria for Autism Spectrum Disorder to three samples of children with DSM-IV diagnoses of pervasive developmental disorders. *Am J Psychiatry*. 2012;169:1056- 1064. Jones M, Onslow M, Packman A, O'Brian S, Hearne A, Williams S, Ormond T, Schwarz I. Extended follow-up of a randomised controlled trial of the Lidcombe Program of early stuttering intervention. *Int J Lang Commun Disord*. 2008;43:649-661. Kefalianos E, Onslow M, Block S, Menzies R, Reilly S. Early stuttering, temperament and anxiety: Two hypotheses. *J Fluency Disord*. 2012; 37:151-163. Koyama E, Beitchman JH, Johnson CJ. Expressive language disorder. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Vol. II. Philadelphia: Lippincott Williams & Wilkins; 2009:3509. Koyama E, Beitchman JH, Johnson CJ. Mixed receptive-expressive language disorder. In: Sadock BJ, Sadock VA, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Vol. II. Philadelphia: Lippincott Williams & Wilkins;

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Revision #1

Created 2026-01-04 19:52:07 UTC by Omar Ayman

Updated 2026-01-04 19:52:07 UTC by Omar Ayman