Social Communication Difficulty

Definition / Supporting Information

Social communication refers to the use of verbal and non-verbal abilities, behaviour's and skills to communicate and interact with others.

Often the main concern of carers or referrers is that a child with social communication difficulty has autism. The term autism describes qualitative differences and impairments in reciprocal social interaction and social communication, combined with restricted interests and/or rigid and repetitive behaviours.

- See Autism spectrum disorder in under 19s: recognition, referral and diagnosis [NICE clinical guideline CG128, Appendix C]

Autism is the focus of this Key Practice Point (KPP), but also see KPP covering Speech and language abnormalities for further details.

Keywords / also known as: autism, autistic spectrum condition

Essential History

This may need to be focused according to clinical circumstances but a thorough evaluation will require appropriate time. Presenting concerns should be seen in the context of a child's overall development.

Ask about:

- What is the problem?
- Who is noticing it?
- What is the effect on the child and family?
- Where do the issues occur?
- When do they occur [and when did they start]?
- Why do they occur [triggers]?
- What languages are used to communicate with the child?
- Medical history
  - See Autism spectrum disorder in under 19's: recognition, referral and diagnosis [NICE clinical guideline CG128, Appendix C]
- Possible core features of autism:
  - Social communication and social interaction difficulties
  - Restricted Interests and/or rigid and repetitive behaviours

The table below adapted from NICE clinical guideline CG128 and NICE Pathways shows some key-features [but is not comprehensive]. The clinical picture varies greatly from one child to the next and can change over time. Some features may be subtle, or

not noticeable over a brief period of observation. Features should be assessed as part of the overall clinical picture, and autism not ruled out if the exact features are not present. Autism may go unrecognized in the verbally able, those with intellectual disability and in girls.

- Associated features of autism
  - Other speech/language difficulties
  - Sleep difficulty
  - Seizures
  - Feeding problems
  - Self-injurious behaviour, outbursts, and aggression
  - Constipation, altered bowel habit, encopresis, and enuresis
- Enquire about features which may suggest co-morbid conditions associated with autism:
  - Attention-deficit hyperactivity disorder (ADHD)
  - Developmental co-ordination disorder
  - Mood disorders
  - Anxiety disorders
  - Obsessive compulsive disorder
  - Tics
  - Tourette's syndrome
- Enquire about features which may suggest alternative diagnoses [see Differential Diagnosis]
- Antenatal history: maternal alcohol, medication, and substance misuse
- Perinatal, birth, neonatal, and other past medical history including behavioural, emotional, and mental health problems
- Family history
  - Autism, hearing and / or speech abnormalities or other developmental conditions
- Psychiatric history in the family
  - Mood and anxiety disorders
  - Psychotic, obsessive compulsive, bipolar, and personality disorders
- Developmental history
  - Ask about delayed milestones and regression
  - Concerns about vision and hearing
- Social and family history:
  - School
    - Learning difficulty or disability?
    - Are supportive structures required?
    - Does the child have an Education, Health and Care Plan (EHCP)?

  - Involvement with social services [eg, Looked After Child and / or safeguarding involvement] or other professional involvement
  - Changes in family structure, housing, living conditions, employment
- A full physical examination should be carried out including looking for:
  - Skin stigmata of neurofibromatosis or tuberous sclerosis using a Wood's light
  - Signs of injury for example self-harm or maltreatment
  - Congenital anomalies and dysmorphic features including microcephaly or macrocephaly
  - Abnormal neurology including subtle features or 'soft signs' [eg, abnormal gait, cranial nerves, or limb and / or trunk abnormalities suggesting other neurological conditions]
  - 'Soft signs' such as functional difficulty with zips, catching and writing may suggest developmental co-ordination disorder or dyslexia

'Red Flag' Symptoms and Signs

Ask about:

- Loss or regression of skills
- Significant self-harm and / or suicidal ideation
- Features suggesting ongoing epileptic seizures

Look for:

- Signs of regression [loss of previously achieved developmental skills]
- Physical signs suggesting an underlying medical condition
  - Skin stigmata suggesting neurofibromatosis or tuberous sclerosis
  - Macrocephaly
  - Microcephaly
  - Other dysmorphic features
- Signs of maltreatment or self-harm

Differential Diagnosis / Conditions

Be aware of the different terminologies used for 'autism' in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) and The International Classification of Diseases, 10th revision (ICD-10) such as 'pervasive development disorder' which are synonymous or broadly equivalent.

See The ICD-10 Classification of Mental and Behavioural Disorders [World Health Organization]

See Autism spectrum disorder in under 19's: recognition, referral and diagnosis [NICE clinical guideline CG128]

- Neurodevelopmental disorder
  - Autism spectrum disorder (ASD), autism, pervasive development disorder, and Asperger syndrome
  - Social communication disorder
  - Speech and language delay or disorder
  - Intellectual disability
  - Global developmental delay
  - Traumatic brain injury
  - Developmental co-ordination disorder
- Mental health and behavioural disorders
  - ADHD
  - Conduct disorder
  - Oppositional defiant disorder
  - Psychosis
  - Mood disorder
  - Anxiety disorder [including selective mutism]
  - Attachment disorders
  - Obsessive- compulsive disorder
- Conditions associated with regression:
  - Rett syndrome
  - Epileptic encephalopathy
- Other conditions
  - Selective mutism
  - Hearing impairment
  - Severe visual impairment
  - Maltreatment
  - Genetic, chromosomal, or mitochondrial disorders (eg, fragile X)

Investigations

- Population screening is not recommended.

To be undertaken by non-specialist practitioners (eg, General Practitioner (GP) Team):

- Consider requesting a hearing test even if neonatal screening was normal.
- Consider collecting information using an autism specific tool or questionnaire
- Consider blood tests if clinically indicated

To be undertaken by specialist practitioners (eg, General Paediatric / Community Paediatric / Neurology Team(s)):

Tests should be based on the clinical picture but could include:

- Hearing test

- Blood tests for developmental delay and / or regression including genetic testing:
  - See Assessment, diagnosis and interventions for autism spectrum disorders [SIGN guideline 145, section 4.5]
- Brain magnetic resonance imaging (MRI)
  - Where there are specific indicators
    - Microcephaly
    - Regression
    - Seizures
    - History of stupor or coma or other specific neurological features
- Electroencephalogram (EEG) where clinically indicated
- Specific assessments for autism:
  - Autism specific tools and assessments can be used to supplement a clinical assessment
    - ADOS-2; ADI; 3di; DISCO, CARS-2
  - Information about an individual should be gathered from different settings

Treatment Approach

See Assessment, diagnosis and interventions for autism spectrum disorders [SIGN guideline 145]

Treatment will vary according to the underlying condition.

This section deals primarily with **autism spectrum disorders**.

To be undertaken by non-specialist practitioners (eg, General Practitioner (GP) Team):

Generally the primary care setting will not initiate autism specific programmes or treatments but will be involved in supporting patients / carers and in monitoring specialist-initiated medical treatments based on agreed shared-care arrangements.

To be undertaken by specialist practitioners (eg, Paediatric / CAMHS / Psychology / Therapy / Specialist Education Support Team(s)):

Non-pharmacological interventions:

- Parent-mediated intervention programmes should be considered for children and young people of all ages to help interaction, promote development and increase parental satisfaction, empowerment and mental health.
- Communication interventions
  - Parent and clinician-led interventions
  - Visual supports
  - Picture exchange communication system
  - Environmental visual supports
- Interventions for social communication and interaction

  - Consider visual prompts
  - Reduced requirements for complex social interactions
  - Routines
  - Timetabling and prompts
  - Reducing sensory irritations
- Behavioural and / or psychological Interventions
  - Access to support trained in the use of applied behaviour-analysis-based technologies should be considered
- Cognitive behavioural therapy may be considered using a group format if available and required to treat anxiety in those with average verbal and cognitive ability
- Occupational therapy advice and support may benefit some children
- Specialist dietitian assessment should be considered in those with significant selective or restricted eating or dysfunctional feeding behaviours

Pharmacological interventions:

Note: there are no long-term studies showing that medication affects the core features of autism but they may be used to treat specific severe symptoms on a short- or medium-term basis. When using medication ensure patients and parents are aware of indications, contra-indications, side-effects, timelines and rationale for use. Medication should be initiated by those trained and experienced in its use and as part of a package of care.

- Antipsychotics should **not** be used to manage the core features of autism
- Second-generation antipsychotics (eg, risperidone) may be considered to reduce irritability and hyperactivity for short-term use [8 weeks]
  - This should be reviewed after 3 to 4 weeks and discontinued if no effect is seen
- Methylphenidate
  - Consider this for managing co-existing ADHD
- Antidepressants
  - Selective serotonin reuptake inhibitors (eg, fluoxetine) can be considered on a case-by-case basis to treat co-morbid conditions
- Melatonin
  - In children with ASD and sleep difficulties where behavioural interventions have not been effective, a trial of melatonin should be considered

When to Refer

Refer to specialist practitioners:

- Autism Team
  - Which may be provided by community paediatrics or Child and Adolescent Mental Health Services (CAMHS) according to local arrangements

    - Children younger than 3 years if there is regression in language or social skills
    - If there are concerns that a child may be presenting with signs of autism [NICE CG128 Appendix C]
- Paediatric or Paediatric Neurology Team(s):
    - Children older than 3 years with regression in language
    - Children of any age with regression in motor skills
    - If a medical condition is suspected
- Speech Therapy and / or Audiology Team(s):
    - If an isolated speech and / or hearing problem is suspected
- CAMHS Team:
    - If a mental health condition is suspected

Refer to specialist practitioners (eg, Local Authority / Social Care Team(s)) where supportive structures around the child and family would be useful.

- Follow local safeguarding protocols

Refer urgently to specialist practitioners (eg, Emergency Department / CAMHS / community paediatrics/Paediatric(s)) if:

- There are concerns about an acute or life-threatening illness, condition or presentation
- Life-threatening self-injurious behaviour or aggression
- There are concerns about safeguarding
    - Follow local safeguarding arrangements

Refer urgently to specialist practitioners (eg, Local Authority / Social Care Team(s)) for safeguarding concerns / suspected neglect / abuse.

- Follow local safeguarding protocols

When to Admit:

Many of the conditions would normally be managed in an outpatient setting.

Consider admissions for:

- Severe malnutrition related to restricted food interests
- Evaluation for gastrointestinal problems
- Evaluation for seizure disorder
- Evaluation for sleep disorder
- Life-threatening self-injurious behaviour or aggression
- Psychopharmacological toxicity
- Concerns about maltreatment

‘Safety Netting’ Advice

Unexpected regression, neurological features, deterioration, extreme behaviour, or unexplained additional features should lead to seeking further medical advice.

Patient / Carer Information

Please note: whilst these resources have been developed to a high standard they may not be specific to children.

- Autism spectrum disorder (ASD) (Web page), the NHS website

Resources

National Clinical Guidance

Assessment, diagnosis and interventions for autism spectrum disorders (Web page), SIGN guideline 145, Scottish Intercollegiate Guideline Network

Autism Spectrum disorder in under 19’s: recognition, referral and diagnosis (Web page), NICE clinical guideline CG128, National Institute for Health and Care Excellence

Medical Decision Support

The ICD-10 Classification of Mental and Behavioural Disorders (PDF), World Health Organization

Diagnostic and Statistical Manual of mental disorders. Fifth Edition. American Psychiatric Association 2013;50–59

Suggested Resources

Please note: these resources include links to external websites. These resources may not have national accreditation and therefore PCO UK cannot guarantee the accuracy of the content.

Methylphenidate for attention deficit hyperactivity disorder (ADHD) (Web page), Medicines for Children

Williams C, W Barry, Young O. How to Live with Autism and Asperger Syndrome. Williams and Wright. Jessica Kingsley Publishers, 2004

Gilberg C. A Guide to Asperger Syndrome. Cambridge University Press, 2002

National Autistic Society (Web page)

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Table 1. Possible features of autism

Age	Social Communication and Social Interaction Behaviours Spoken language	Social Communication and Social Interaction Behaviours Responding, interacting with others, non-verbal communication skills, ideas and imagination	Restricted Interests and / or rigid and repetitive behaviours

<5 years	▪ Delay in language or regression
	▪ When speech is present there may be unusual:
	  ▪ Vocalisation without words
	  ▪ Repetitive speech [words or phrases, echoing others]
	  ▪ Intonation
	  ▪ Reference to self by name, or 'you' or 'he/she' after 3 years
	  ▪ Reduced use of language to communicate
		▪ Reduced / absent response to name being called
		▪ Reduced / absent social smile or response to other's facial expressions and feelings
		▪ Reduced interest: in being given cuddles from carers, in other people, in sharing, in initiating social play, in typically enjoyable situations eg, parties
		▪ Reduced awareness of others personal space or unusually intolerant of others in their space.
		▪ Reduced or absent: use of gestures / facial expressions to communicate, social eye contact
		▪ Reduced and poorly integrated gestures, facial expressions, eye-contact, posture alongside speech to communicate
		▪ Reduced / absent joint attention eg, reduced / absent pointing to share interest
		▪ Reduced / absent imagination, and variety in pretend play
		▪ Unusually negative response to requests from others
			▪ Repetitive movements: spinning, body rocking, hand flapping, finger flicking
			▪ Repetitive or stereotyped play eg, lining up toys, spinning objects
			▪ Over-focused or unusual interests eg, door handles, numbers
			▪ Excessive need to follow own agenda and / or extremes of emotional reactivity to change or new situations.
			▪ Over / under reaction to sensory stimuli eg, texture, sound, smell, taste or visual stimuli.

5-11 years	▪ Limited use of language ▪ Repetitive speech including stereotyped phrases, or conversation on limited topics of interest ▪ Unusual intonation ▪ Talking at, not with others. 'Monologue's' ▪ Responses to others which may seem rude / inappropriate / blunt ▪ Language may be over-familiar / overly formal	▪ Reduced understanding of people's facial expressions, and feelings. Reduced understanding of other's intentions eg, misunderstanding sarcasm, metaphor, taking things literally ▪ Reduced awareness of others personal space or unusually intolerant of others in their space ▪ Reduced social interest in other children / people, or of enjoyable situations. May play alone or not share ▪ Reduced and poorly integrated gestures, facial expressions, eye-contact, posture alongside speech to communicate ▪ Reduced or absent social use of eye-contact ▪ Reduced / absent joint attention eg, reduced/absent pointing to share interest ▪ Limited / abnormal imaginative play ▪ Unusually negative response to requests from others	▪ Repetitive movements: spinning, body rocking, hand flapping, finger flicking ▪ Intense interests / hobbies ▪ Strong adherence to rules which may lead to arguments over infractions ▪ Repetitive behaviours, play and rituals which intrude on daily life ▪ Dislike of change and a preference for routines. Preference for following own agenda ▪ Over / under reaction to sensory stimuli eg, texture, sound, smell, taste or visual stimuli
>11 years	▪ Limited use of language ▪ Repetitive speech including stereotyped phrases or conversation on limited topics of interest ▪ Unusual intonation ▪ Talking at, not with others. 'Monologue's' ▪ Responses to others which may seem rude / inappropriate / blunt ▪ Language may be over-familiar / overly formal	▪ Reduced awareness of others personal space or unusually intolerant of others in their space. ▪ Limited friendships / relationships or difficulty with making / sustaining them with children of the same age ▪ Apparent preference for own company / social isolation ▪ Difficulty with rules and games / turn-taking / 'losing' and flexibility in play. ▪ Understanding others intentions: eg, difficulty with sarcasm/metaphor, taking things literally. ▪ Reduced and poorly integrated gesture / expression / posture / eye contact alongside speech	▪ Repetitive movements: spinning, body rocking, hand flapping, finger flicking ▪ Intense interests / hobbies ▪ Strong adherence to rules which may lead to arguments over infractions ▪ Repetitive behaviours play and rituals which intrude on daily life. ▪ Dislike of change and a preference for routines. Preference for following own agenda. ▪ Over / under reaction to sensory stimuli eg, texture, sound, smell, taste or visual stimuli.