

Language Disorder

Code: 315.32 (F80.2)

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Diagnostic Criteria 315.32 (F80.2)

- A. 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 that include the following:
1. Reduced vocabulary (word knowledge and use).
 2. Limited sentence structure (ability to put words and word endings together to form sentences based on the rules of grammar and morphology).
 3. Impairments in discourse (ability to use vocabulary and connect sentences to explain or describe a topic or series of events or have a conversation).
- B. Language abilities are substantially and quantifiably below those expected for age, resulting in functional limitations in effective communication, social participation, academic achievement, or occupational performance, individually or in any combination.
- C. Onset of symptoms is in the early developmental period.
- D. The difficulties are not attributable to hearing or other sensory impairment, motor dysfunction, or another medical or neurological condition and are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.

Diagnostic Features

The core diagnostic features of language disorder are difficulties in the acquisition and use of language due to deficits in the comprehension or production of vocabulary, sentence structure, and discourse. The language deficits are evident in spoken communication, written communication, or sign language. Language learning and use is dependent on both receptive and expressive skills. Expressive ability refers to the production of vocal, gestural, or verbal signals, while receptive ability refers to the process of receiving and comprehending language messages. Language skills need to be assessed in both expressive and receptive modalities as these may differ in severity. For example, an individual's expressive language may be severely impaired, while his receptive language is hardly impaired at all.

Language disorder usually affects vocabulary and grammar, and these effects then limit the capacity for discourse. The child's first words and phrases are likely to be delayed in onset; vocabulary size is smaller and less varied than expected, and sentences are shorter and less complex with grammatical errors, especially in past tense. Deficits in comprehension of language are frequently underestimated, as children may be good at using context to infer meaning. There may be word-finding problems, impoverished verbal definitions, or poor understanding of synonyms, multiple meanings, or word play appropriate for age and culture. Problems with remembering new words and sentences are manifested by difficulties following instructions of increasing length, difficulties rehearsing strings of verbal information (e.g., remembering a phone number or a shopping list), and difficulties remembering novel sound sequences, a skill that may be important for learning new words. Difficulties with discourse are shown by a reduced ability to provide adequate information about the key events and to narrate a coherent story.

The language difficulty is manifest by abilities substantially and quantifiably below that expected for age and significantly interfering with academic achievement, occupational performance, effective communication, or socialization (Criterion B). A diagnosis of language disorder is made based on the synthesis of the individual's history, direct clinical observation in different contexts (i.e., home, school, or work), and scores from standardized tests of language ability that can be used to guide estimates of severity.

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Associated Features Supporting Diagnosis

A positive family history of language disorders is often present. Individuals, even children, can be adept at accommodating to their limited language. They may appear to be shy or reticent to talk. Affected individuals may prefer to communicate only with family members or other familiar individuals. Although these social indicators are not diagnostic of a language disorder, if they are notable and persistent, they warrant referral for a full language assessment. Language disorder, particularly expressive deficits, may co-occur with speech sound disorder.

Development and Course

Language acquisition is marked by changes from onset in toddlerhood to the adult level of competency that appears during adolescence. Changes appear across the dimensions of language (sounds, words, grammar, narratives/expository texts, and conversational skills) in age-graded increments and synchronies. Language disorder emerges during the early developmental period; however, there is considerable variation in early vocabulary acquisition and early word combinations, and individual differences are not, as single indicators, highly predictive of later outcomes. By age 4 years, individual differences in language ability are more stable, with better measurement accuracy, and are highly predictive of later outcomes. Language disorder diagnosed from 4 years of age is likely to be stable over time and typically persists into adulthood, although the particular profile of language strengths and deficits is likely to change over the course of development.

Risk and Prognostic Factors

Children with receptive language impairments have a poorer prognosis than those with predominantly expressive impairments. They are more resistant to treatment, and difficulties with reading comprehension are frequently seen. Genetic and physiological. Language disorders are highly heritable, and family members are more likely to have a history of language impairment.

Differential Diagnosis

Normal variations in language. Language disorder needs to be distinguished from normal developmental variations, and this distinction may be difficult to make before 4 years of age. Regional, social, or cultural/ethnic variations of language (e.g., dialects) must be considered when an individual is being assessed for language impairment.

Hearing or other sensory impairment. Hearing impairment needs to be excluded as the primary cause of language difficulties. Language deficits may be associated with a hearing impairment, other sensory deficit, or a speech-motor deficit. When language deficits are in excess of those usually associated with these problems, a diagnosis of language disorder may be made.

Intellectual disability (intellectual developmental disorder). Language delay is often the presenting feature of intellectual disability, and the definitive diagnosis may not be made until the child is able to complete standardized assessments. A separate diagnosis is not given unless the language deficits are clearly in excess of the intellectual limitations.

Neurological disorders. Language disorder can be acquired in association with neurological disorders, including epilepsy (e.g., acquired aphasia or Landau-Kleffner syndrome).

Language regression. Loss of speech and language in a child younger than 3 years may be a sign of autism spectrum disorder (with developmental regression) or a specific neurological condition, such as Landau-Kleffner syndrome. Among children older than 3 years, language loss may be a symptom of seizures, and a diagnostic assessment is necessary to exclude the presence of epilepsy (e.g., routine and sleep electroencephalogram).

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Comorbidity

Language disorder is strongly associated with other neurodevelopmental disorders in terms of specific learning disorder (literacy and numeracy), attention-deficit/hyperactivity disorder, autism spectrum disorder, and developmental coordination disorder. It is also associated with social (pragmatic) communication disorder. A positive family history of speech or language disorders is often present.