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Functional diagnosis of communication skills and needs of girls with ASD*

Abstract: This study is dedicated to recognising the issue of appropriate, accurate and reliable identification of communication needs and skills in the diagnostic process among girls/women with autism spectrum disorders. The present article describes changes in the approach to diagnosing people with ASD, the latest classifications and diagnostic criteria of the disorder in question. It characterises the deficits related to communicative competences in people with autism spectrum disorder and Asperger's syndrome. Consideration is also given here to the specificity of the diagnostic assessment of girls/women with ASD and Asperger's syndrome and the utility of using functional diagnosis and selected diagnostic tools to correctly identify the communication skills and needs of girls with autistic spectrum behaviours.

Keywords: diagnosis of people with ASD, differential diagnosis, functional diagnosis, verbal and non-verbal communication, social communication, communication skills and needs, specificity of diagnostics of girls/women with ASD

Diagnoza funkcjonalna w zakresie umiejętności i potrzeb komunikacyjnych dziewcząt z ASD

Streszczenie: Niniejsze opracowanie zostało poświęcone dostrzeżeniu problematyki właściwej, trafnej i rzetelnej identyfikacji potrzeb i umiejętności komunikacyjnych w procesie diagnostycznym wśród dziewcząt/kobiet ze spektrum zaburzeń autystycznych. W artykule przedstawiono zmiany jakie zaszły w podejściu do diagnozowania osób z ASD, najnowsze klasyfikacje oraz kryteria diagnostyczne omawianego zaburzenia. Scharakteryzowano deficyty związane z kompetencjami komunikacyjnymi u osób ze spektrum autyzmu i zespołu Aspergera. Podjęto rozważania dotyczące specyfiki oceny diagnostycznej dziewcząt/kobiet z ASD i zespołu Aspergera oraz użyteczności stosowania diagnozy funkcjonalnej oraz wybranych narzędzi diagnostycznych do prawidłowej identyfikacji umiejętności i potrzeb komunikacyjnych dziewcząt ze spektrum autystycznych zachowań.

Słowa kluczowe: diagnoza osób z ASD, diagnoza różnicowa, diagnoza funkcjonalna, komunikacja werbalna i pozasłowna, komunikacja społeczna, umiejętności i potrzeby komunikacyjne, specyfika diagnostyki dziewcząt/kobiet z ASD

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Theories and concepts explaining autistic behaviours – such as the theory of mind, salience landscape theory, weak central coherence or mirror neuron deficits – explain problems in social functioning and communication of people with ASD. People on the autism spectrum have difficulties in making sense of other people's minds. Sometimes they simply fail to understand that one person can convey a message to another person; they seem to be unaware of the communication process taking place between two people. Some of them do not send any clear signals at all to communicate their needs. Barriers in social (interpersonal) communication which consist of deficits in verbal and non-verbal communication, and which result from the characteristics of the autistic spectrum disorder, may seriously delay the development of the person, including further development of speech and language. This may result in the inability to create socially satisfactory relations with others, both with adults and peers, to make friends, to establish close and intimate relations, to access education, to get a chosen profession, and to perform social roles. According to the current empirical studies and scientific literature, girls with ASD in areas such as social competencies and non-verbal communication may function better than boys and display fewer autistic behaviours. Therefore, it is worthwhile in the diagnostic process to pay attention to the proper, accurate and reliable identification of the communication skills of girls and their needs in this respect. Particularly given the fact that the diagnosis of girls/women with ASD is often made late, or accidentally, while diagnosing other problems and disorders in their functioning. Using the functional diagnosis with the application of a holistic view to the examined person in the diagnostic process may result in a more adequate understanding of communication needs and shaping skills in this regard among girls diagnosed with ASD.

Autistic spectrum disorder – diagnostic criteria, neurodevelopmental approach, diagnosis of communication disorders/deficits

Autistic spectrum disorder (ASD) is a wide and heterogenous term. Various disorders included therein have a common denominator in the form of characteristic features (therefore the word *spectrum* is of key significance); however, the skills and abilities of particular individuals affected by this disorder are diversified. Until 2013, autism was categorised as a pervasive developmental disorder by international classification systems. According to the diagnostic criteria of ICD – 10 (International Statistical Classification of Diseases and Health Related Problems), autism was listed among mental disorders and in the taxonomy of

diseases it was given the symbol F84.0 (The ICD-10 Classification of Mental and Behavioural Disorders. Research diagnostic criteria, 1998, p. 133). The diagnostic criteria DSM-IV, developed by American Psychiatric Association, located autism as a pervasive developmental disorder, appearing in early childhood or adolescence (DSM-IV – 5th. edition). CFTMEA (The French Classification for Child and Adolescent Mental Disorders), in turn, placed autism in the category of psychoses (Puszczałowska-Lizis and Biała, 2017, p. 70). The *pervasive developmental disorder*, according to ICD-10, is a group of disorders characterized by impaired social functioning and social interaction, in the development of speech and communication skills, as well as in the sphere of activity and entertainment (stereotypical, routine and stimulating behaviours). These abnormalities may refer to behaviours in each situation, although in the case of particular persons their intensity may differ (Wojciechowska, 2011, p. 14). The disorders listed as pervasive developmental disorders include, among others: 1. autistic disorders or autism, 2. childhood disintegrative disorder (CDD) – Heller's syndrome, 3. Asperger's syndrome, 4. Rett syndrome, 5. extensive developmental disorders not listed in any other way (Smith, 2008, pp. 274–275). Changes in international classifications which took place after 2013 (DSM-V classification) and already available classification ICD-11 define autism as a *neurodevelopmental* disorder, in which symptoms exist in the period of early childhood (the provision that they have to appear before the age of 3 was excluded), the disorder is related to the damage or delay of functions strictly related to the process of brain development and refers to various spheres of functioning. In currently applicable classifications, therefore, the term *pervasive disorder* was replaced with the term *autism spectrum*, Rett syndrome and childhood disintegrative disorder were removed from the classification, and two groups of syndromes from the triad of autistic disorders (of interaction and communication) were joined into one group, called social communication and interaction (Śpila, 2017, pp. 120–121; Rynkiewicz and Kulik, 2013).

Autism, or autistic disorders, is understood as: "A developmental disability significantly affecting verbal and non-verbal communication and social interactions, usually discernible before the age of 3, which adversely affects a child's achievements. Other features associated with autism include performing repeatable activities and stereotypical movements, resistance to environmental changes or changes in everyday procedures and untypical reactions to sensory experiences" (Smith, 2008, p. 275). In the case of Asperger's syndrome, in turn, we may refer to qualitative disorders of social interactions, limited, repeated and stereotypical models of behaviours, interests and activities, and to the fact that the disorder leads to significant problems in social, professional, and other areas of functioning. Autistic behaviours occur here, however, there may be no fundamental, general language development delay, and crucial clinical delay in cognitive development or the development of self-service skills, adaptation behaviours and interest in the

environment in childhood adequate for the age do not have to occur. (Attwood, 2015, pp. 52–54; Desk Reference to the Diagnostic Criteria From DSM-V, American Psychiatric Association, 2015, s. 24–28).

Until today, researchers and experts dealing with the issue of autism have not identified the unequivocal cause of this disorder. The current research indicates mainly biological, genetic, and biochemical factors. Scientific investigation regarding the causes of autism and various speculations about this topic continues. Many researchers consider the causes of autism in polyetiological concepts.

Despite the heterogeneity of autism, several characteristics common for people affected by it can be differentiated. These include **communication disorders (of speech and communication), social interaction disorders (social skills, imagination), and specific models of behaviours and interests.** With respect to the disorders of the socialisation process, we may refer to improper contact both with adults and peers (autistic persons full of the reserve are differentiated here – more than 80% of this group are people with a profound degree of mental disability, passive and active persons). In the case of verbal communication disorders, autistic persons are characterised by the disorders of speech and language development, problems with using communication skills, and occurrence of echolalia (e.g., immediate, delayed, mitigated or functional). There are also major differences in expressing and understanding non-verbal messages. Concerning disorders of functioning of senses, they may refer to the sense of hearing, sight, touch, taste, smell, or proprioception; the sense may be excessively increased or decreased, and sensory interference (overlaying of sensory stimuli) may occur. Moreover, among autistic persons, the following may be observed: intellectual disability (approx. 75–80% of people), self-aggression (approx. 40% of people), lack of verbal communication (50% of people), and fits (approx. 33% of people) (Puszczałowska-Lizis and Biała, 2017, pp. 72–73; Przybyla, 2020, pp. 352–353; Smith, 2008, pp. 291–292;. In the period of adolescence and early adulthood, some persons on the spectrum may display or intensify symptoms or mental and/or somatic disorders, such as schizophrenia, depression, sleep disorders, epilepsy, gastrointestinal diseases, and autoimmune diseases. According to Bożena Śpila, psychiatric disorders resulting from the impact of the environment and appearing in the period of adolescence and early adulthood are experienced by less than a half of autistic youth – they include clinically relevant anxiety states, i.e., separation anxiety (9–38%), specific phobias (26–57%), social phobias (13–40%), panic attacks (2–25%), and generalised anxiety (15–35%) (Śpila, 2017, p. 129). It must be emphasised here that the co-existence of psychiatric symptoms with autism in young people with classic autism may differ from their peers with Asperger's syndrome or high-functioning autism, for the very simple reason that the former usually receive help and participate in therapy much earlier and much broader. Among persons with ASD, it is assessed that approx. 74% of them

have concurrent disorders (one or more). Most commonly observed are disorders of behaviour (44%), anxiety disorders (42%), twitches (26%), but also oppositional defiant disorders, depression, eating disorders, and sleep disorders (Śpila, 2017, pp. 131–132). Among girls, the most commonly diagnosed are anxiety disorders, depression, specific disorders of educational abilities, and eating disorders, including anorexia, ADHD, obsessive-compulsive disorders, schizophrenia, as well as bipolar affective disorder (Putko-Stawiecka, 2022, p. 16).

The table below presents characteristic features of the functioning of people with autism, which was elaborated by Jadwiga Kamińska-Reyman based on the typology of autism of Olga Nikolska. The typology is functional, including diagnostic values and may constitute implications for undertaken therapeutic activities. The classification refers to the levels of gravity of intensity of disorders included in the spectrum of autism, described in the classification (DSM-V) and levels of their adequate support (Desk Reference to the Diagnostic Criteria From DSM-V, American Psychiatric Association, 2015, p. 27).

Communication disorders and the "specificity" of the diagnostic assessment of girls/women with ASD

For people on the autism spectrum, one of the basic problems in their functioning is difficulties in communicating with the environment. The first symptoms of the future communication difficulties related to autism may already be visible in the infancy and toddler period, e.g. the child does not make eye contact with the mother, does not smile at the sight of her, there may be no babbling, no reaction to reaching out to close people, no finger pointing, no reaction to the name or no first words (up to approx. 12 months). After the first year of life, you can observe symptoms such as: lack of a common field of attention, no non-verbal reactions to the sight of loved ones, long phases of crying and screaming, no imitation of movement, no attempts to imitate speech, no speech development (Cieszyńska-Rożek, 2013, pp. 268–269). In turn, in the case of early behaviours from the Asperger's syndrome spectrum, in the case of speech development, we can observe, inter alia, rapid development of specific vocabulary, use of adult language, repetition of entire poems, statements of characters in films and commercials (so-called hidden echolalia), fixations on numbers, fixations on the alphabet, global recognition of words. This is an example of Asperger's syndrome with early speech development. In the case of the Asperger's syndrome with delayed speech development, there is often a lack of connecting words at the age of three, pronouncing words that are difficult to articulate, at the same time without naming

Table 1
Observation sheet of behaviours in an autistic person

	Forms of active contact with the environment	Forms of social interaction	Forms of defence	Forms of self-stimulation
I The main adaptation goal: **maintaining calmness**	▪ has no points of active contact with the environment ▪ walks around the room without any purpose ▪ avoids contact with the environment (walks away) ▪ perceives peripherally ▪ lack of top-down attention ▪ lack of selectiveness in actions ▪ is skilful in spatial movement, ▪ problems with basic self-service activities	▪ distinguishes close persons from the environment ▪ retreats seeing strangers ▪ quick oversaturation during interaction ▪ passivity and submissiveness to close persons ▪ treating a close person as an element of the environment ▪ virtual lack of cooperation ▪ lack of own needs and habits ▪ speech is not developing or mutism ▪ no expression of feelings	▪ backs out from the intensive impact of the environment (including physical stimuli) ▪ behaves as if they didn't see, didn't hear, didn't feel	▪ passive drawing from external sensations maintaining the sense of comfort (spinning, jumping, climbing furniture and people, static looking) ▪ directing the body towards the source of stimuli
II The main adaptation goal: **Determining the optimum course of events**	▪ active cooperation with the environment in a few constant situations ▪ preferring the stability of the environment - all changes cause fear ▪ avoiding unpleasant objects ▪ particular selectivity (of food, music, clothes, order of actions, etc.)	▪ selective human relations: likes and dislikes ("primitive" symbiotic emotional bonds) ▪ contact with strangers causes panic ▪ speech not directed to the recipient: echolalia, quotations, lack of proper modulation and intonation, 2nd or 3rd person form ▪ communicates own needs (verbally or by gestures) ▪ knnows what they want and what they don't want to do	▪ excessive selectivity ▪ too rigid control over the environment ▪ changes cause screaming, rebellion, aggression, self-aggression	▪ active and selective self-stimulation utilizing pleasant stimuli (verbal and motor stereotypes, perseverations, obsessive objects) ▪ self-aggression

	Forms of active contact with the environment	Forms of social interaction	Forms of defence	Forms of self-stimulation
III The main adaptation goal: **Guaranteeing success in contact with the environment**	▪ increased tolerance to changes (allows uncertainty, changes in the course of events) ▪ wants to overcome obstacles and achieve success ▪ wants to be sure of executing their action plan ▪ does not check new circumstances due to the fear of risk and failure ▪ performs only known tasks completed with success ▪ more self-reliance (learnt self-service habits) ▪ signs of interest in the environment ▪ increased calmness, decreased tension in contact with the environment	▪ lack of longer cooperation with another person ▪ execution of own, assumed action plan: verbal (monologue), creating collections, etc. ▪ is able to keep eye contact with an interlocutor ▪ many conflicts with adults ▪ problems in cooperation – does not want to be taught, ignores emotions of another person ▪ is more independent and simultaneously less emotional bound	▪ strives to gain an advantage over the environment ▪ obstinacy	▪ stereotypical reconstruction of the situation of fear or discomfort they went through and own rescue (such as fire, funeral, hospital) ▪ fascination with fear and horror ▪ teasing and aggravating caretakers ▪ provoking others to express anger and resentment ▪ the pleasure from ordering and quoting
IV The main adaptation goal: **Maintaining positive emotional relations with the environment**	▪ strives towards interaction with the environment ▪ is able to control their relations with the world through adults ▪ rigid adherence to the system of rules and rituals, mastered sequence of activities and models of behaviour (learnt earlier)	▪ behaviours subject to constant acceptance of people (also strangers) ▪ interested in people ▪ lack of orientation in interpersonal relations ▪ treating messages literally, lack of understanding of irony and joke ▪ seems to be blunt, lost in reality, despite near-standard intelligence ▪ cannot bear surprise	▪ rigid adherence to once learnt action plan ▪ occasional movement stereotypes – in a situation causing emotional tension (e.g., waiting, surprise, pressure)	▪ does not need to apply developed forms of self-stimulation ▪ constant emotional support from close persons and the need for confirmation of proper behaviour

Source: Study: Jadwiga Kamińska-Reyman acc. to O.S. Nikolska's Typology – own resources.

family members, frequent echolalia (repeating one word or phrase), fixations on numbers – often regression in speech development is not observed (Korendo, 2013). Typical for communication of people with ASD are quantitative, qualitative and pragmatic deficits, both in verbal and non-verbal communication. Quantitative deficits refer to the lack of speech (with no or only elementary gestures), speech delays and limitations. Qualitative deficits are manifested in the form of, among others: echolalia (direct or delayed), the appearance of neologisms, inversion of pronouns, the use of stereotypical language, defects in articulation. The manifestations of pragmatic deficits are: lack of communication in relation to peers and adults, inability to symbolically use objects, poor use of prosody, poor use of visual-facial stimuli for metacommunication (Gagat-Matuła and Malik, 2018, pp. 202–214; Przybyla and Wons, 2018, pp. 226–254).

The main features of disturbed verbal communication in people with ASD include:

- no development of active speech,
- inhibition of speech development,
- gradually revealing irregularities in the development of verbal communication, despite the initial norm in development,
- speech regression,
- disturbed understanding of verbal messages,
- disturbances in social/interpersonal communication despite mastering the basics of the language system sufficiently for communication.

In turn, when it comes to non-verbal communication in people with ASD, it is characterized among others by:

- lack of development of non-verbal communication, its inhibition or regression,
- disturbed understanding of non-verbal messages,
- disturbances in expressing non-verbal messages,
- disturbances in social/interpersonal communication despite mastering the basics of the language system sufficiently for communication (Emiluta-Rozya, 2020, pp. 62–66).

The literature on the subject and scientific research indicate that the development of verbal speech in people on the autism spectrum is often at a lower level than non-verbal functions.

The empirical research conducted so far and the experience of clinicians from working with people with ASD indicate that the diagnosis and diagnosis of the autism spectrum in girls is more difficult than in the case of boys. Practising clinicians often indicate that difficulties in the diagnosis of girls result from the fact that girls use the so-called camouflage and coping mechanisms. Through observation, they learn how to behave in a specific social situation. As Tony Attwood (2015, p. 57) points out, girls develop the ability to "disappear" in

a large group. Problems with motor coordination are camouflaged by girls with less behavioural difficulties than those presented by boys with ASD, hence they are less "conspicuous" and less often referred to specialists. According to the researchers, girls may reveal differences in individual spheres of the autism spectrum compared to boys. In terms of social competences, they show greater motivation to establish social relations, use camouflage methods in order to belong to a given group, collect social experiences, are more ready to meet the expectations of others. They are less likely to show rigid, narrow, stereotypical patterns of activity and interests. In terms of communication, they use gestures more spontaneously. They are better at imitating non-verbal messages, especially those from significant people (facial expressions, body postures, intonations) (Putko-Stawiecka, 2021). Agnieszka Rynkiewicz and Izabela Łucka conducted research on a group of adolescents from the autistic spectrum disorder (16 boys and 15 girls were examined) using the ADOS-2 diagnostic tool. The authors' research showed statistically significant differences between the two groups of the studied adolescents in the use of gestures and verbal speech. Girls showed lower intensity or no autistic features in terms of gestures and verbal communication compared with boys. On the other hand, girls obtained a higher score reflecting autistic features in self-assessment questionnaires and clinical interview, which may confirm that they acquire the ability to conceal their deficits and show greater determination in learning the norms of social interactions than boys. In addition, the results of the study showed that girls with ASD in adolescence are at a higher risk of anxiety, depression, suicidal thoughts leading to psychiatric hospitalization, compared to boys with ASD. The researchers' observations showed that both boys and girls with the autism spectrum disorder, compared to neurotypical people, show higher internalization in terms of psychopathology. According to the authors of the study, young girls with ASD are at risk of developing, apart from autism spectrum disorders, also affective disorders, which may additionally burden them in adolescence (Rynkiewicz and Łucka, 2015). In turn, qualitative research conducted by Marta Niemiec (individual cases) with a group of girls diagnosed with ASD in preschool and school age, who were patients of the speech therapy clinic, revealed cases where girls functioned less in terms of non-verbal than verbal communication (non-verbal communication disturbed to a greater extent than verbal one), which implied significant difficulties in the field of social and emotional competences in the surveyed children (e.g. examination with the KOZE tool) and indicated the need to intensify therapeutic and educational interactions in these areas. First of all, this is due to the fact that as girls grow up, these problems may worsen and lead to behavioural and emotional disorders coexisting with autism, unfavourably for the functioning and development (Germany, 2022). It is also not uncommon that the diagnosis of autism spectrum disorders in girls is made later, accidentally, when reporting other problems or difficulties in functioning, such

as: learning difficulties, difficulties in peer relationships, aggressive behaviour, oppositional behaviour, anxiety symptoms, emotional lability, experiencing peer violence (Putko-Stawiecka, 2021, p. 16; Przybyla and Wons, 2018, pp. 226–252).

The causes of "more frequent" diagnoses of ASD in boys than in girls are believed, among others, in theories of gender differences, socio-cultural differences and, finally, the diagnostic criteria themselves. The results of research conducted by Simon Baron-Cohen indicated the possibility of increased testosterone levels in male foetuses, which in boys with the autism spectrum causes that their phenotype includes the so-called increased "systematization" (focus on systems and details) compared to empathic feeling (focus on interpersonal relationships). The theory of gender differences explains, for example, that the female sex "protects" against autistic features due to the higher level of the oxytocin hormone in women, which is responsible for care and belonging (Salomon et all., 2011, pp. 48–59). The diagnostic criteria of the autism spectrum disorder is also largely based on the symptoms of ASD presented by boys. In this form, in 1952, autism was described in the classification of the American Psychiatric Association (DSM). The theory of socio-cultural differences, on the other hand, assumes the differentiation of expectations as to behaviour and social relations, directed towards girls and boys (Putko-Stawiecka, 2021).

Functional diagnosis of communication skills and needs of girls with the spectrum of autistic disorders

In the case of the diagnosis of ASD, as well as one of its axial symptoms – disturbed verbal and non-verbal communication – and thus interpersonal and more broadly social communication – differential diagnoses are developed, mainly by specialists – psychiatrists and psychologists as well as clinicians. More and more often now it is written about the validity of the diagnosis between 18 and 36 months of a child's life. Standardized diagnostic tools are used for this, such as: Q-CHAT, *The Checklistist for Autism in Toddlers* M-CHAT, *Modified Checklist for Autism in Toddlers M-CHAT*, STAT *Screening Tool for Autism in Toddlers and Young Children* (Polish version: Skriningowy Test w Autyzmie dla małych dzieci STAT [STAT – Screening Test for Autism in small children], developed by Agnieszka Rynkiewicz). For an in-depth diagnostics of autism-spectrum disorders, specialists also use ADOS-2, Second Edition, *Autism Diagnostic Observation Schedule* and ADI-R *Autism Diagnostic Interview-Revised*. These tools constitute a "golden diagnostic standard" in the Anglosphere (Rynkiewicz and Kulik, 2013, p. 44).

On the grounds of special pedagogy, including speech therapy, diagnostic and therapeutic work with an individual case/person and its conceptualization, in connection with the development of individual diagnoses, multi-specialist assessments of a person's functioning, educational, therapeutic and pedagogical programs, speech therapy, the use of diagnostic and therapeutic observation, reference is often made to the elements of a functional diagnosis (diagnosis of functional skills). Although the basic essence and goal of the diagnostic process (diagnostic tests) is the description and analysis of facts, events, phenomena and processes leading to their understanding and explanation, as explained by Danuta Skulicz:

> [...] one does not refrain to the identification of the subject of research and its description (genesis, classification, typology). With regard to research, the subject of which is a human being, we want to find an answer not only to the question of who a human is, but also to what they become and who they should be [...] diagnosing (in the sense of understanding and explaining) leads us to another goal, which is human development and complex (observable and unobservable) contexts of his being and functioning in the world. The determinants of human existence and functioning have a cultural, symbolic and social dimension. And these are the dimensions in which we are trying to answer the question of who a human being should be. The multi-faceted and multi-threaded answers have consequences both for building pedagogical theories and for pedagogical practice (Skulicz, 2010, pp. 221–222).

Changes in the approach and way of thinking about people with individual needs (including people with ASD) also resulted in changes in the conduct of diagnostic activities in the area of special education. The transition from the biological model, which was dominated by nosological diagnosis, was replaced by the social (individual) model and the humanistic paradigm, where the need to take into account the needs of a person with disabilities and the possibility of satisfying them in the most effective manner was noticed, which was reflected in the functional diagnosis / diagnosis of functional skills (Niemiec, 2018, p. 48). The basic theoretical assumptions behind the current model of diagnosis understood in this way are, above all, its processual character, holistic view of the human being, immersion in the environmental context, positive dimension of diagnosis, full (developed) diagnosis, diagnosis update, functional diagnosis (Głodkowska, 1999). Functional diagnosis contains information about the stage of development of cognitive functions, communication competences and about social and emotional development (Trochimiak and Gosk, 2012, p. 144). Thus, it covers the entire functioning of a person with individual needs and their immediate environment. Its main task is to determine the level of functioning of a person in the zone of current and immediate development, in accordance with the concept of Lev Vygotsky (1971). The term of functional skills indicates the skills that have a direct impact on a person's independence, self-reliance, resourcefulness. Func-

tional diagnosis focuses not only on "strengths and weaknesses," but above all on human development potential, so it contains a positive diagnosis. The diagnosis of functional skills is a long-term (verification of the diagnosis during therapy, possible modifications of methods and techniques of interaction, observation of changes in individual development spheres, etc.) and interdisciplinary process (mutual cooperation of many people: specialists, people from the closest environment of the examined person). It is also particularly important to include in the diagnosis the functional skills of educational diagnostics related to the perception, understanding and realization of the needs of people with individual needs. These needs may be related to the functioning of the respondent's family, a care or educational institution, they may result from the properties of the organism, or they may be related to the activity of a person with individual needs in the environment (Niemiec, 2018). The basic differences between the nosological diagnosis and the diagnosis of functional skills relate to the purpose of cognition, i.e. the entire functioning of a person in natural situations, and not only the determination of symptoms and the assignment of nosological units; the functional diagnosis is most often developed by all persons participating in the activities of the respondent, not only specialists; observations are most often used as cognition methods, and tools such as observation schedules / sheets or interview questionnaires are more individualized than standardized tools used in nosological diagnosis (where mainly tests are used). In the case of functional diagnosis of people with ASD, useful tools that can be used as an aid in identifying the communication skills and needs of this group of people include: PEP-R Psychoeducational Profile, ADOS-2, Child's Sensory Profile PDS, KORP (Psychomotor Development Evaluation Cards), KOZE (Behaviour and Emotions Assessment Card) and others. These tools take into account the basic features of a functional diagnosis, such as: its dynamic nature (the diagnosis is not constant, it is subject to modifications, it is updated on an ongoing basis and verified with the actual state – in special pedagogy practice, diagnostic verification should take place at least every six months), profiling, including positive diagnostics (we get answers to the questions: what does an individual know, what they can do, what are their features?; what are their interests, talents, what do they like?; what is their family environment, immediate surroundings and their potentials?; what is their local environment – proximity to institutions, a supporting community, the existence of a support network). In the context of the correct identification of the communication skills and needs of girls with ASD, functional diagnostics seems to be extremely necessary and useful, it allows to determine the key elements of therapy, corresponding to the very real needs of a given person. It enables the use of individualized tools to identify needs, e.g. need diagrams. Due to the permanent verification, it allows to introduce therapeutic elements during its duration, e.g. build communication situations conducive to the training of language competences.

Conclusion

In this study, the emphasis was placed on recognizing the role of functional diagnosis in identifying the skills and needs of girls with ASD. Functional diagnostics is a useful (pragmatic) diagnosis in nature, serving practical interactions. It also contains elements of educational diagnostics; hence the key concept is the need, and in the context of this paper, specifically the communication needs of girls with ASD, in whom the diagnosis is often not obvious or delayed, and in whom – as indicated by research and practice – non-verbal communication is more often better developed than the verbal one. The basic diagnostic task should therefore be the correct identification of girls' communication skills, both verbal and non-verbal, because girls – as described earlier – use various mechanisms and camouflages, they "learn" to adapt, adjust to the situations and social interactions they observe. In new, difficult or unexpected situations, however, they very often feel lost, insecure, they often feel internally at odds with themselves, do not "feel" social and interpersonal communication. Proper, accurate and reliable identification of communication needs and skills should, on the one hand, be individualized (taking into account the unique properties of the examined person), and, on the other hand, also take into account the typical difficulties and challenges of the neurodivergent girls, such as: feeling of exhaustion, overstrain, faster fatigue, problems with concentration, anxiety symptoms, problems with understanding social contexts and messages, which may arise, especially in new, unknown social situations, increased risk of using outbursts or "cutting off" as a form of emotional regulation. Functional diagnosis in terms of identifying communication skills and needs in girls with ASD allows the operationalisation of more adequate therapeutic and developmental goals in speech therapy work / therapy with patients: in training language competences (symbolic understanding, metaphorical use of language), developing communication skills aimed at shaping the ability to express one's thoughts, feelings and needs.

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