Should Speech and Language Therapists be working with children with receptive language impairment?

Anna Hetherington

Introduction

Children with receptive language impairment (RLI) have difficulties understanding spoken and written language, understanding vocabulary and grammar and inferring meaning. RLI is one of the most serious manifestations of language disorder in children. Despite evidence that RLI persists over time, carries a greater risk of comorbid behavioural difficulties compared to expressive or phonological delays and is the most likely indicator of poor outcomes, for example educationally and socially, relatively little is known about what can be done to treat these children.

RLI is more resistant to intervention than specific expressive or phonological delays, and intervention studies have, to date, failed to show treatment effects for this group.

The Evidence Base

Meta-analyses and systematic reviews report a consistent pattern of positive impact of speech and language therapy (SLT) on speech and expressive language impairment (ELI) but not RLI. There are only a few published controlled intervention studies for children with RLI. The table below displays the most recent randomised control trials (RCTs) in this field.

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Intervention</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohen et al. (2005)</td>
<td>77 children aged 6-10 years with receptive and expressive language impairment (RELI).</td>
<td>Fast ForWord (FFW) Language programme - acoustically modified speech.</td>
<td>FFW is not effective for children with RELI.</td>
</tr>
<tr>
<td>Gillam et al. (2008)</td>
<td>216 children aged 6-9 years with RELI.</td>
<td>FFW Language programme.</td>
<td>FFW provided no additional benefit than educational support.</td>
</tr>
<tr>
<td>Boyle et al. (2009)</td>
<td>161 children aged 6-12 year with RELI and ELI.</td>
<td>Project therapy; individual or group, direct or indirect.</td>
<td>No significant difference between therapy types. Children with ELI made greater gains than RELI.</td>
</tr>
</tbody>
</table>

Why is the evidence base so poor?

- Issues with measuring RLI – composite scores are often used which do not distinguish between expressive language skills and receptive language skills, making it difficult to track solely receptive language progress. Also criteria for RLI diagnosis varies between studies.
- RCTs may not be a true representation - as they group children and randomly assign interventions, whereas children have individual profiles and SLT needs to be tailored to their needs.

Where should research go from here?

Findings from small scale studies and single case studies have shown certain interventions to be effective. The diagram below illustrates the two complementary directions suggested for future research.

Future Research

- Impairment based interventions e.g. vocabulary development
- Enabling interventions e.g. coping strategies

Current practice

As RLI appears to be resistant to intervention, an important question is: What are Speech and Language Therapists (SLTs) currently implementing for this population?

A recent survey of qualified SLTs in the UK focused on the practice with children aged 5-11 years. The findings regarding RLI were as follows:
- Children with RLI are seen as a priority, they receive extensive services which reflects diverse practice.
- Interventions target specific deficits or are based on published programmes/frameworks.
- Behavioural approaches are used to teach vocabulary and sentence comprehension.
- Skills acquisition and meta-cognitive activities changed systematically with age, see quote below.

"After the age of 7 or 8, I feel we become more engaged in teaching coping strategies to help the child function in school/socially, whereas at a younger age, we may have more impact on the language learning/processing abilities." SLT.

- Underlying theory was not regarded as important for informing therapy - the presentation of the deficit was. However, these findings need to be interpreted with caution as only 56 SLTs took part.

Conclusion and Implications

The lack of evidence base could be used to argue that SLTs should not work with this population. However, as undetected RLI persists, overdue, to possible educational and social exclusion, functional interventions helping children cope with their receptive difficulties are vital. As part of a network of support SLTs do have a role, such as encouraging children to develop self-regulation skills used in planning/monitoring and implement functional communication goals and interventions aimed at increasing participation. Indirect work with teachers and parents for this population is also essential. There needs to be further research in this area, in respect of diagnosis and effective joint interventions.

References