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Investigating Label Use by English Canadian Speech-Language Pathologists

Enquête sur la terminologie employée par les orthophonistes canadiens anglophones

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KEYWORDS

DEVELOPMENTAL LANGUAGE DISORDER

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Abstract

Children with unexplained language problems have been assigned a variety of diagnostic terminology throughout history. This lack of consistency has created barriers for researchers and clinicians. In 2016 and 2017, Bishop et al. conducted the CATALISE studies, which reached a consensus for the use of the diagnostic label "developmental language disorder" to describe children with unexplained language problems. Only 8 of 59 experts included in the CATALISE study were Canadian and information regarding the use of diagnostic labels, like developmental language disorder, in a Canadian context is lacking. The purpose of this study was to examine English Canadian labelling practice. In 2018, English Canadian speech-language pathologists (n = 370) completed a 24-question online survey addressing current use of diagnostic labels in practice, constraints on the use of labels, opinions on assessment purposes, and knowledge/use of the specific diagnostic label developmental language disorder. Label use among Canadian speech-language pathologists was found to be highly inconsistent. Several reasons for assigning/not assigning diagnostic labels were provided. Most participants reported being familiar with the label developmental language disorder, although fewer accurately selected the label's definition. Respondents suggested that the use of the label developmental language disorder would increase if other speech-language pathologists were also adopting this practice. Most participants agreed that having a consistent label for children with language disorders would provide better advocacy for children with developmental language disorder and that children with developmental language disorder would be better off if professionals consistently used the same label.

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Les conclusions orthophoniques (diagnostics) attribuées aux enfants atteints d'un trouble du langage inexpliqué ont fait historiquement l'objet d'un foisonnement terminologique. Ce manque de consistance dans les termes employés constituait un obstacle pour les chercheurs et les cliniciens. En 2016 et 2017, Bishop et al. ont mené les études CATALISE (*Criteria and Terminology Applied to Language Impairments: Synthesising the Evidence* [critère et terminologie utilisés pour les troubles du langage : une synthèse de l'évidence]) afin d'arriver à un consensus quant à la terminologie à privilégier pour décrire les enfants présentant un trouble du langage inexpliqué (c.-à-d. *developmental language disorder* [trouble développemental du langage]). Cependant, seuls 8 des 59 experts inclus dans les études CATALISE étaient de nationalité canadienne et peu d'information existe actuellement sur la terminologie utilisée en contexte canadien. L'objectif de la présente étude était d'examiner les pratiques terminologiques en matière de conclusions orthophoniques au Canada anglais. En 2018, 370 orthophonistes canadiens anglophones ont répondu à un questionnaire en ligne composé de 24 questions portant sur la terminologie utilisée au moment de poser une conclusion orthophonique, sur les contraintes en matière des termes employés, sur leurs points de vue quant aux objectifs de l'évaluation d'un patient et sur la connaissance et l'emploi spécifique du terme *developmental language disorder*. Les résultats de cette étude montrent un haut degré d'inconsistance dans les termes employés par les orthophonistes canadiens. De nombreuses raisons expliquant l'attribution ou non d'un terme lors de l'établissement d'une conclusion orthophonique ont été fournies. Si la plupart des participants de l'étude ont affirmé être familiers avec le terme *developmental language disorder*, seuls quelques-uns d'entre eux ont été en mesure de l'associer à la bonne définition. Les répondants ont par ailleurs indiqué qu'ils seraient plus susceptibles d'utiliser le *developmental language disorder* si d'autres orthophonistes l'intégraient à leur pratique. La plupart des répondants s'entendent sur le fait qu'une consistance dans la terminologie utilisée pour décrire les enfants atteints d'un trouble du langage contribuerait à une meilleure défense de leurs intérêts et que ces derniers seraient mieux servis si un seul et même terme était utilisé par tous les professionnels.

Children whose language abilities fall below the abilities of their peers are at increased risk of a variety of other problems including academic failure (Durkin et al., 2012; Johnson et al., 2010), behavioural problems (Conti-Ramsden et al., 2013), later economic disadvantage (Parsons et al., 2011), and social problems (Clegg et al., 2005). It is estimated that just over 7% of young children have a persistent language disorder that impacts their learning or social interactions (Norbury et al., 2016; Tomblin et al., 1997). These findings indicate that professionals from a variety of disciplines, including speech-language pathologists (S-LPs), need to be concerned about identifying and treating children with language problems. Until recently, there was no agreed upon label for children with unexplained language problems (Bishop, 2014), which resulted in substantial variability in the practice of labelling children with unexplained language problems. Two research studies (i.e., Bishop et al., 2016, 2017) reported a new international consensus regarding the use of the term developmental language disorder (DLD) to describe children with unexplained language problems. For this terminology consensus to have an effective and timely impact, it is important to examine how this research translates into clinical practice. The purpose of the present study was to examine current labelling practice around the time of the publication and new consensus regarding the term DLD.

The Use of Diagnostic Labels

Diagnostic labels are a key tool for advancing understanding of language problems in children and providing appropriate support to these children (Bishop, 2014). There are many potential positive consequences to providing children with diagnostic labels including providing legitimacy to and an explanation for a child's difficulty; removing blame from parents, teachers, and the child; promoting an understanding and awareness of a child's particular difficulty; providing access to resources for a child; and allowing for easier communication among professionals (Bishop, 2014; Lauchlan & Boyle, 2007).

Despite potential advantages, there is also considerable potential for unintended negative consequences of diagnostic labelling. Providing a child with a diagnostic label may emphasize what a child is incapable of doing while ignoring their strengths, allow for parents to take no responsibility for a child's struggles, cause a child to feel that their failure is inevitable, lead to a denial of resources, and lead to stigmatization, among others (Bishop, 2014; Lauchlan & Boyle, 2007). It is important that professionals are aware of the potential advantages and disadvantages of label use so efforts can be made to maximize benefits and minimize potential harm. The label chosen for a child and the process of providing a child with a label must be navigated carefully (Bishop, 2014).

Overall, it is unclear if label provision is a priority for S-LPs when they are conducting language assessments with children. In general, despite the high prevalence and persistent functional impact of DLD, it is largely underdiagnosed (Prelock et al., 2008; Tomblin et al., 1997). For example, Tomblin et al. (1997) found that in a sample of 216 kindergarten children diagnosed with specific language impairment (SLI), only 29% of parents had previously been informed that their child had a speech or language problem. This lack of identification suggests that many children with DLD are not being seen by an S-LP. Furthermore, when these children are referred to speech and language services, how an S-LP prioritizes the various purposes for conducting language assessments is unclear. McGregor et al. (2017) informally surveyed 60 American S-LPs regarding the purpose of a language assessment. These S-LPs were asked to rate the level of importance they would assign to several assessment objectives including establishing goals for intervention, determining if a child meets eligibility criteria for services, providing parents with a diagnostic label for their child, assessing the functional impact of a child's struggles, and identifying a child's strengths and weaknesses. Interestingly, providing parents with a diagnostic label was viewed as the least important assessment objective by respondents. One contributing factor to S-LPs' failure to attribute much value to the use of labels could be the longstanding lack of consensus regarding which diagnostic term to use particularly in child language disorders.

In 2014, Bishop investigated the labels that were in current use to describe children with unexplained language problems and reported finding 132 terms in use. Many of the labels in use were observed to be too general to be useful but, of the terms deemed useful, the term SLI was the most reported. Overall, it was concluded that the varied and inconsistent use of labels for children with unexplained language problems was causing confusion, limiting service availability, hampering advocacy efforts, and impeding research.

The History of Terminology Used for Children with Language Disorders

One of the earliest references to children experiencing difficulty in language, in the absence of any other condition, was by the physician Gall in 1822 (Gall, 1835). In the years following Gall, a plethora of other diagnostic labels were used to describe children with language problems (Reilly et al., 2014). From the 1980s onward, the label SLI was widely used to describe children with language problems occurring

in the absence of other developmental deficits (Reilly et al., 2014). It should be noted that the term SLI was excluded from the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) following a recommendation by the American Speech-Language-Hearing Association in 2012. The term *language disorder* was adopted to describe persistent difficulties in the acquisition and use of language across all modalities due to deficits in comprehension or production (American Psychiatric Association, 2013). The inclusion of the term language disorder was accompanied by the removal of cognitive referencing, the practice of comparing the function of interest to performance on a cognitive measure. Children with any nonverbal IQ score could be given the diagnostic label of language disorder if they did not meet the criteria for intellectual disability.

The Criteria and Terminology Applied to Language Impairments: Synthesizing the Evidence Studies

Following calls for an international and multidisciplinary panel to establish a consensus regarding both diagnostic criteria and the label used for children experiencing unexplained language problems (Bishop, 2014; Reilly et al., 2014), Criteria and Terminology Applied to Language Impairments: Synthesizing the Evidence (the CATALISE project) was created and spearheaded by Drs. Dorothy Bishop, Maggie Snowling, Trish Greenhalgh, and Paul Thompson. The project involved a panel of 59 international experts in children's language impairments and represented 10 disciplines (e.g., education, psychology, speech-language pathology, paediatric medicine, child psychiatry) and six countries (i.e., Australia, Canada, Ireland, New Zealand, United Kingdom, and the United States).

Bishop et al. (2016, 2017) administered two Delphi Surveys involving an iterative process of rating and commenting anonymously on a series of statements such that a 75% consensus be reached and a final list of agreed upon statements produced (Hasson et al., 2000). The first exercise addressed the criteria used to identify children with language disorders requiring intervention (Bishop et al., 2016) and the second considered the terminological issues surrounding these children (Bishop et al., 2017).

Consensus was reached regarding an overarching term of language disorder to be used for children likely to endure language problems into middle childhood and beyond that significantly impact their educational progress and everyday social interactions. Rather than employing exclusionary criteria in the definition of language disorder found to be problematic in the past, it was agreed that distinctions would be drawn between differentiating conditions, risk factors, and co-occurring conditions. Differentiating conditions were defined as biomedical conditions in which a language disorder occurred as part of a more extensive pattern of impairments (e.g., acquired brain injury, certain neurodegenerative conditions, cerebral palsy). The panel recommended that this population of children be labelled as having a "language disorder associated with 'X'" where "X" referred to the differentiating condition. It was also recommended that the term DLD be used to describe cases of language disorder occurring in the absence of any such biomedical condition. Importantly, children with low nonverbal ability, who did not meet criteria for intellectual disability, could be given a diagnosis of DLD—a specific level of nonverbal ability was not included as an exclusionary criterion.

Co-occurring disorders were defined as impairments in cognitive, sensory-motor, or behavioural realms that may co-occur with DLD and may affect that child's impairment and/or response to treatment (e.g., attentional problems, motor problems, reading and spelling problems, emotional disorders). It was also acknowledged that DLD is a large and heterogenous category that will include children with a wide variety of problems and needs. To date, attempts to identify reliable subtypes of DLD have been unsuccessful because language problems can manifest in a wide variety of ways (Conti-Ramsden & Botting, 1999; Lancaster & Camarata, 2019). As such, it has been suggested that clinicians and researchers describe strengths and weaknesses in a child's language profile including in areas such as phonology, grammar (syntax and morphology), semantics, word finding, pragmatics/language use, and verbal learning and memory.

Implementation of the CATALISE Consensus Terminology

The publication of the CATALISE studies (i.e., Bishop et al., 2016, 2017) spurred significant international advocacy efforts to raise awareness of DLD. One goal of those seeking to advocate for the use of the terminology has been early adoption of the research findings by S-LPs in clinical practice. We know, however, that research findings can take many years to impact practice (Olswang & Prelock, 2015). This observation has led to the rise of knowledge translation, a dynamic and iterative process involving the synthesis, dissemination, exchange, and ethically sound application of knowledge to improve health, and social service delivery and systems (Canadian Institutes of Health Research, 2019). Knowledge translation activities vary widely according to the intended audience and the knowledge being translated, but they are a key element in fostering clinical uptake of research findings. One important starting point is identifying current practice, beliefs, and attitudes relevant to the new knowledge to inform necessary steps for achieving change. We considered developing an understanding of how

S-LPs currently use diagnostic labels related to childhood language disorders as a particularly important first knowledge translation activity on the road to adoption of the CATALISE international consensus on terminology.

We were particularly interested in implementation of the CATALISE consensus terminology in the English Canadian context. Only 8 of 59 experts who participated in the CATALISE studies were Canadian, which could have implications for the perceived fit with Canadian clinicians and service agencies. Another important factor relates to current practice in the use of labels, which can be expected to vary across Canada due to legislative restrictions in some provinces. For example, in the province of Ontario, the Regulated Health Professions Act enacted in 1991 lists several controlled acts, that is, activities considered to have potential to cause harm if performed by an unqualified person. One controlled act prohibited for S-LPs is communicating a causal diagnosis, a restriction many professionals view as interfering with their ability to provide labels to children. A 2018 clinical practice advice document published by the College of Audiologists and Speech-Language Pathologists of Ontario specified that, when communicating assessment results, S-LPs may use terms to describe symptoms and dysfunctions falling within their scope of practice. They stated that some of the terms used to describe assessment results may include the term "disorder." This publication indicates that S-LPs may provide children with the label of DLD because the label is used to describe a set of symptoms and does not identify the cause of those symptoms. Despite this clarification, there is still relative uncertainty among many S-LPs practising in restricted jurisdictions like Ontario. How diagnostic labels are being used in other jurisdictions, without any restrictions, and how S-LPs within restricted jurisdictions are navigating label use has not been investigated to date.

The Current Research

The purpose of the study was to understand current practice, beliefs, and attitudes regarding label use in child language disorders to inform our knowledge translation plan for fostering implementation of the international consensus terminology related to DLD. The specific aims of the study were to investigate (a) English Canadian S-LPs' current use of labels in practice; (b) the purposes of assessment and perceived advantages and disadvantages of using labels; (c) the barriers that exist when using diagnostic labels in practice; and (d) knowledge of, and attitudes towards, the specific diagnostic label of DLD. It was hypothesized that current use of specific diagnostic labels among S-LPs in Canada would be highly inconsistent. Additionally, it was expected that barriers to English Canadian S-LPs' use of specific diagnostic labels for children would include a lack of agreement regarding the importance of providing a label, confusion over which label to use, and licensing/legislative restrictions in Canada. It was further hypothesized that, due to the recency of consensus regarding the use of the specific diagnostic label of DLD (Bishop et al., 2017), the label would not be well understood or commonly used by S-LPs in professional practice today but that consistent use of a label would be seen as beneficial.

Method

Participants

A total of 370 English Canadian S-LPs working with children with language disorders agreed to take the online survey, although the number of responses per question varied. Of 355 S-LP respondents, 17.2% (n = 61) worked exclusively with 3–5-year-old children, 3.9% (n = 14) worked with 6–13-year-old children, and 0.3% (n = 1) worked with 14–18-year-old children. Additionally, 19.4% (n = 69) of the S-LPs worked with children in both of the younger age categories and 7.3% (n = 26) worked with children in both of the older age categories. The largest proportion of respondents, 51.8% (n = 184), worked with children from all three age categories.

Of 353 respondents, 44.5% (n = 157) worked exclusively in a school board setting, 10.5% (n = 37) worked in private practice, 4.5% (n = 16) worked in a hospital setting, and 13.3% (n = 47) reported working in "other" locations (e.g., a children's treatment centre, client homes, health units, government funded autism agency, First Nations Reserves). The remaining 27.2% (n = 96) of respondents worked in some combination of the previously listed locations.

Of 367 collected responses, most participants (67.3%, n = 247) reported that, at the time of survey completion, they practised in the province of Ontario. Nine provinces were represented in this sample. The percentages of total participants who reported practising in each province is presented in **Table 1**.

Questionnaire

A 24-item questionnaire, available in English, was developed using the online survey platform Qualtrics. The first three questions addressed the specifics of the participants' work as S-LPs (i.e., population serviced and location of practice). Four questions examined the S-LPs' current use of specific labels to identify children with language disorders. One to three questions (depending on how each question was answered) focused on the constraints placed on the S-LPs' use of labels based on their professional licensing body or legislature. Three

Table 1

The Percentage of Total Participants who Reported Practising in Each Province

Province	Participants practising in province	
	n	%
Ontario	247	67.3
Alberta	42	11.4
New Brunswick	29	7.9
British Columbia	27	7.4
Saskatchewan	12	3.3
Manitoba	6	1.6
Nova Scotia	2	0.5
Newfoundland	1	0.3
Québec	1	0.3

Note. Of the 370 participants, 367 responded to this item.

questions addressed the S-LPs' opinion regarding the purposes of assessment in practice. The final 11 questions specifically addressed each S-LP's knowledge and use of the diagnostic label developmental language disorder or DLD. Questionnaire responses involved either choosing from provided choices, rating using provided scales, or filling in free text (see Appendix).

Procedure

This study was approved by Western University's Non-Medical Research Ethics Board on April 11, 2018 (ethics approval number: 2018-111290-9486). Participants were recruited in person at the 2018 Speech-Language and Audiology Canada conference in Edmonton, Alberta, and online through social media and email invitation. A request for participation was also posted on the Speech-Language and Audiology Canada's website. Additionally, a request was sent via email to all members of the preschool and school-aged interest groups of the Ontario Association of Speech-Language Pathologists and Audiologists. After anonymously agreeing to participate, indicating their involvement with a paediatric population, and indicating employment as a registered S-LP in Canada, participants completed any or all of the remaining 21 survey questions.

Results

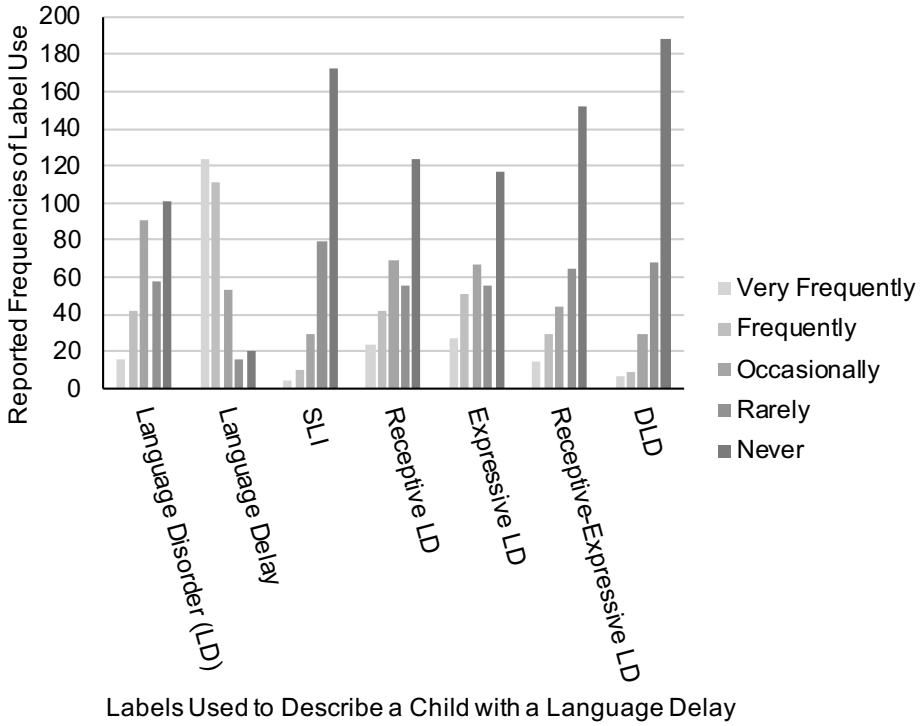
Label Use

When 344 participants chose descriptions of how often they would use a specific label to describe the profile of a child presenting with a significant language delay, 12.5% (*n* = 43) reported that they would do so very frequently, 29.1% (*n* = 100) frequently, 34.6% (*n* = 119) occasionally, 15.4% (*n* = 53) rarely, and 8.4% (*n* = 29) never.

Participants were asked how often they would use various labels when faced with a child presenting with a language delay (see **Figure 1**). Overall, the term language delay was used most frequently, with most respondents reporting that they used the term either frequently (34.3%, *n* = 111) or very frequently (38.3%, *n* = 124). The labels specific language impairment and developmental language disorder were used least frequently. Most respondents reported that they used the term specific language impairment rarely (26.9%, *n* = 79) or never (58.5%, *n* = 172) and the term developmental language disorder rarely (22.6%, *n* = 68) or never (62.5%, *n* = 188). In fact, a considerable proportion of respondents reported never using the labels language disorder (32.8%, *n* = 101), specific language impairment (58.5%, *n* = 172), receptive language disorder (39.5%, *n* = 124), expressive language disorder (36.9%, *n* = 117), receptive-expressive language disorder (50.0%, *n* = 152), and developmental language disorder (62.5%, *n* = 188). Additionally, it was made clear through written comments that some S-LPs preferred the term delay over disorder because it was generally perceived as less overwhelming or severe and was therefore seen as easier to apply in practice. Furthermore, some S-LPs shared, in responses, that their location of practice had prescribed labels associated with their services suggesting that constraints by individual work settings might add to the variation demonstrated in labelling practice.

S-LPs were asked to indicate reasons (from a list of six provided including "other") that would influence their decision when choosing not to provide a child with a specific

Figure 1



Frequency of Canadian speech-language pathologists' use of various labels to describe a child with a language delay. LD = language disorder, SLI = specific language impairment, and DLD = developmental language disorder. The total *N* varied by label. LD total *N* = 308, language delay total *N* = 324, SLI total *N* = 294, receptive LD total *N* = 314, expressive LD total *N* = 317, receptive-expressive LD total *N* = 304, and DLD total *N* = 301.

label. If the respondent chose "other," they were asked to input additional reason(s) in a free text box. Most of the 528 responses indicated that S-LPs felt that parents may not want a label applied to their child (22.9%, *n* = 121), that a label may not provide a child with any benefits or resources (19.7%, *n* = 104), and that a label focuses on what a child cannot do and may ignore their strengths (16.9%, *n* = 89). Of the 135 respondents who provided a written response, 6.7% (*n* = 9) indicated that they would not provide a label for a child who was an English Language Learner. An additional 31.9% (*n* = 43) of S-LPs commented that they would not provide a child with a specific label due to restrictions imposed upon them by their licensing/legislative body regarding their ability to diagnose or provide labels. Several S-LPs also qualified their response regarding no benefits from having a label by sharing that only particular labels were associated with service provision in their location of practice. Overall ratings for the various reasons for not providing children with a specific label are presented in **Table 2**.

Participants also indicated reasons that may influence their decision to provide a specific label to a child with language problems. Of 1109 responses, most participants reported that the following reasons would most influence their decision to give a label: a label promotes understanding and awareness of a particular difficulty (23.3%, *n* = 258), a label provides an explanation and legitimacy for a child's struggles (22.4%, *n* = 248), a label facilitates easier communication among professionals (20.5%, *n* = 227), and a label provides access to resources and intervention (18.5%, *n* = 205). Overall ratings for the various reasons for providing children with a specific label are presented in **Table 3**.

Constraints on Label Use

Overall, 72.6% (*n* = 233) of respondents indicated that their professional licensing/legislative body limits their ability to use diagnostic labels. A subset of participants (*n* = 227) who were limited in their ability to provide diagnostic labels, reported that they would be either extremely likely (29.1%,

Table 2

Reasons Influencing the Decision to not Provide a Child With a Language Problem With a Specific Label

Reason	Responses	
	%	*n*
Other	29.5	156
Parents may not want a label to be applied to their child	22.9	121
A label may not provide a child with any benefits or resources	19.7	104
A label focuses on what a child cannot do and may ignore strengths	16.9	89
A label may lead to stigmatization or other negative consequences for the child	4.7	25
Certain resources may not be available to a child once a label is applied to him/her	4.2	22
A label may cause a child to feel that failure is inevitable	2.1	11

Note. Participants could select multiple responses to this question; therefore, the total number of responses was 528.

Table 3

Reasons Influencing the Decision to Provide a Child With a Language Problem With a Specific Label

Reason	Responses	
	%	*n*
A label promotes understanding and awareness of a particular difficulty	23.3	258
A label provides an explanation and legitimacy for a child's struggles	22.4	248
A label facilitates easier communication among professionals	20.5	227
A label provides access to resources and intervention	18.5	205
A label removes blame from a child	6.9	76
A label removes blame from parents	6.4	71
Other	2.2	24

Note. Participants could select multiple responses to this question; therefore, the total number of responses was 1,109.

n = 66) or likely (40.1%, *n* = 91) to use diagnostic labels if the limitations posed by their professional licensing/legislative body were to change. Another 26.0% (*n* = 59) of participants felt neutral as to whether they would change their labelling practice following a change in legislation. Some participants shared that they provide appropriate labels within the constraints of their licensing/legislative body by carefully choosing acceptable wording (e.g., "symptoms/impairments are consistent with X") or by collaborating with other professionals without such constraints (e.g., a psychologist) to provide the diagnosis.

Assessment Purposes

Participants rated the level of importance that they would assign to various assessment objectives (McGregor et al., 2017) on a scale from 1 (*very unimportant*) to 5 (*very important*). The highest rated assessment objectives included identifying the child's strengths and weaknesses (*M* = 4.76) and establishing goals for intervention (*M* = 4.71). The lowest rated assessment objective was providing parents with a diagnostic label (*M* = 3.12). The average ratings for each assessment objective are presented in **Table 4**.

Of 319 respondents, 27.0% (*n* = 86) reported that they felt that the outcome of their assessment would definitely put them in a position to provide a diagnostic label. Additionally, 39.2% (*n* = 125) reported that they would probably be in the position, 30.1% (*n* = 96) felt uncertain, 2.8% (*n* = 9) felt they would probably not be, and 0.9% (*n* = 3) felt they would definitely not be in the position to provide a diagnostic label following their assessment. Additionally, when invited to provide a comment about which key parts of an assessment were seen as providing diagnostic information, responses included a range of factors such as standardized assessments, language samples,

Table 4

Average Ratings of Importance of Various Assessment Objectives

Assessment objective	*M*	*n*
Identifying strengths and weaknesses	4.76	318
Establishing goals for intervention	4.71	318
Assessing the level of functional impact	4.50	318
Determining if eligibility criteria for services are met	3.73	316
Providing parents with a diagnostic label	3.12	316

Note. Rating scale ranged from 1 = *very unimportant* to 5 = *very important*. Of the 370 participants, between 316 and 318 responded to these items.

behavioural observations, parental reports, reports from other professionals, case histories, patterns of strengths and weaknesses, clinical judgement, and developmental milestones.

The Label: DLD

When 304 S-LPs reported whether they were aware of the specific label DLD, 58.9% (*n* = 179) stated that they were aware, 23.7% (*n* = 72) reported that they were maybe aware, and 17.4% (*n* = 53) reported that they were not aware. Following this response, participants were presented with four potential definitions for the label DLD and asked to choose which description they felt best matched the label. Overall, 46.2% (*n* = 141) chose the correct definition. S-LPs were then presented with the correct definition of DLD and asked if they felt that the label was effective. Of 307 respondents, 55.1% (*n* = 169) felt that the label was effective, 32.6% (*n* = 100) felt that it was maybe effective, and 12.4% (*n* = 38) felt that it was not effective. Several participants (*n* = 51) voiced concerns in the comment section of this question. These concerns included that the term "developmental" implies that a child will outgrow the disorder (12%), that the label does not include information regarding expressive versus receptive language (8%), and that the addition of the criterion "unlikely to resolve by five years of age" makes the label too challenging to use (16%).

Three-hundred and seven S-LPs responded to several questions addressing their likelihood of using the label DLD. They first rated how likely they were to use the label DLD on a 5-point scale from extremely unlikely to extremely likely (see **Figure 2**). The largest proportion of respondents (32.6%, *n* = 100) reported that they were neutral in their likelihood followed by 26.4% (*n* = 81) who reported they were unlikely to use the label and 25.1% (*n* = 77) who reported that they were likely to use the label. When professionals (*n* = 306) were asked how likely they would be to use the label DLD if the label were commonly used by other S-LPs, most reported that they were either likely (46.1%, *n* = 141) or extremely likely (34.6%, *n* = 106) to also use the label (see **Figure 3**). Finally, participants (*n* = 306) were asked if there was an international consensus reached regarding the use of the diagnostic label DLD how likely they would be to use the label (see **Figure 4**). Again, most participants reported that they would be likely (45.1%, *n* = 138) or extremely likely (44.4%, *n* = 136) to use the label DLD if an international consensus were reached regarding its use.

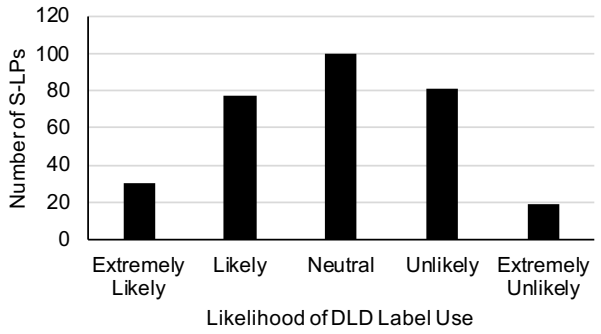
Of 307 respondents, 41.7% (*n* = 128) agreed and 45.9% (*n* = 141) strongly agreed with the statement, "having a consistent diagnostic label for children with language disorders would provide better advocacy for those children." Additionally, of 307 respondents, 35.8% (*n* = 110) agreed and 30.3% (*n* = 93) strongly agreed with the statement, "children with language disorders would be better off if professionals were consistently using the agreed upon label of 'DLD'."

Discussion

The present study examined current practice, beliefs, and attitudes towards diagnostic label provision for children with language disorders in a group of 370 English Canadian S-LPs, 67% of whom practised in Ontario. Results revealed that the majority of S-LPs (76%) at least occasionally apply a specific label to describe children presenting with significant delays in their language. Of all potential labels used to describe these children, the label language delay was reported to be used most frequently while SLI and DLD were used least frequently.

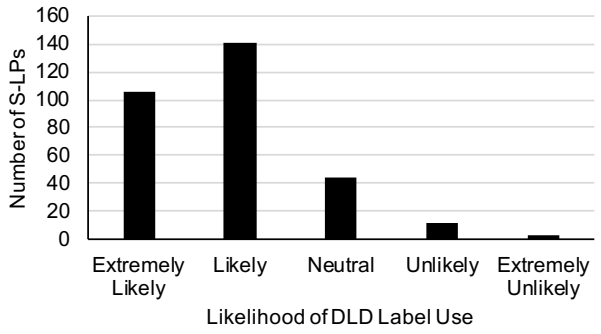
In investigating the perceived advantages and disadvantages of using labels, most Canadian S-LPs felt that disadvantages for label provision included parents not wanting their child to be given a diagnostic label, a label not being beneficial to a child, or a label focusing on what a child is not able to do, while ignoring strengths. Advantages for label provision included that a label promotes understanding of a particular difficulty, provides an explanation for a child's difficulty, facilitates easier

Figure 2



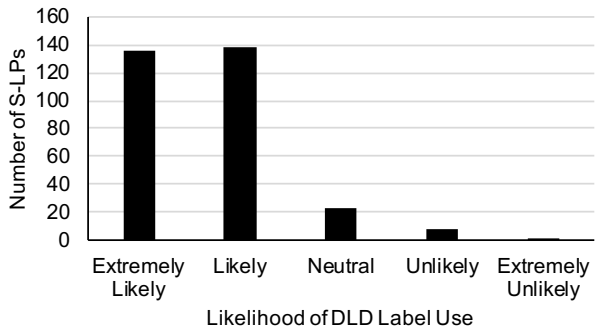
Canadian speech-language pathologists' (n = 307) likelihood of using the diagnostic label developmental language disorder. DLD = developmental language disorder, S-LPs = speech-language pathologists.

Figure 3



Canadian speech-language pathologists' (n = 306) likelihood of using the diagnostic label developmental language disorder if it were commonly used by other speech-language pathologists. DLD = developmental language disorder, S-LPs = speech-language pathologists.

Figure 4



Canadian speech-language pathologists' (n = 306) likelihood of using the diagnostic label developmental language disorder if an international consensus were reached regarding its use. DLD = developmental language disorder, S-LPs = speech-language pathologists.

communication among professionals, and provides access to services. When addressing the barriers to diagnostic label use in current practice, over 70% of participants indicated that their professional licensing/legislative body limits their ability to provide diagnostic labels. Regarding the specific label of DLD, over 80% of participants reported being aware or maybe aware of the label; however, less than half were able to accurately identify the definition of DLD. Nevertheless, very few Canadian S-LPs felt that the label DLD was ineffective. S-LPs indicated they would be more likely to use the label DLD in practice if their colleagues in Canada, and around the world, were also actively using the label. Nearly 90% of participants agreed that having a consistent diagnostic label for children with language disorders would provide better advocacy for these children and two-thirds agreed that children with language disorders would benefit from professionals consistently using the label of DLD.

Current Use of Labels in Canadian Practice

The majority of English Canadian S-LPs use diagnostic labels at least occasionally. Nevertheless, there is considerable diversity in the use of specific labels by English Canadian S-LPs to describe children experiencing a delay in the development of their language (see Figure 1). At the time of the current survey, Canadian S-LPs used a variety of labels with language delay being heavily favoured, followed by language disorder. The terms SLI, receptive language disorder, expressive language disorder, receptive-expressive language disorder, and DLD were reported to never be used by most respondents when labelling children. Interestingly, it was reported that the labels SLI and DLD were used least frequently overall by participants despite SLI being so commonly used throughout the recent literature and DLD being the consensus from Bishop et al.'s (2017) study regarding terminology. It is also important to note that nearly a quarter of English Canadian S-LPs rarely or never applied diagnostic labels to children at the time of the current survey. Overall, the current research provides clear support for the hypothesis that diagnostic labels by S-LPs in Canada is highly inconsistent.

The Perceived Advantages and Disadvantages of Label Use

To investigate potential advantages of label use, S-LPs were asked to indicate their agreement with each of a list of six potential positive consequences of diagnostic labelling (Bishop, 2014; Lauchlan & Boyle, 2007). The greatest number of participants agreed that a label promotes understanding and awareness of a particular difficulty, a label provides an explanation and legitimacy for a child's struggles, and a label provides access to resources and

intervention. In contrast, just under 20% of S-LPs felt that providing a child with a diagnostic label would not provide that child with any additional benefits. The most frequently endorsed reasons for not providing a label included that parents may not want a label to be applied to their child and that a label may not provide a child with any benefits or resources. Label use has previously been reported to be largely helpful and to reduce parental anxiety by providing an explanation for a child's difficulty (Lauchlan & Boyle, 2007). Nevertheless, labels have also been found to be less helpful in special education (Lauchlan & Boyle, 2007) and to have negative consequences such as rejection, exclusion, and stigmatization (Macharey & von Suchodoletz, 2008). Despite the potential benefits of providing labels, these concerns indicate that careful attention must be paid to how labels are communicated. Consistency in using a label and increasing awareness and understanding of that label may be key to reducing negative consequences.

Relatedly, English Canadian S-LPs rated "providing parents with a diagnostic label" as the least important assessment objective of five potential objectives. This finding echoed a similar informal observation made of American S-LPs by McGregor et al. (2017). Recall that 23% of the respondents in the current study indicated that they felt parents may not want a label to be applied to their child. Evidently, S-LPs hold particular beliefs about parental views of diagnostic labels—specifically, that labels will be viewed negatively by parents. Such a belief could have contributed to hesitancy on the part of some S-LPs to provide a particular label. It is also possible that the low importance placed on providing a label is related to available resources or services, a reason given for not providing a label. It is reasonable to assume that if diagnostic labels are not directly tied to access to resources, S-LPs will be less inclined to provide a label. However, this thinking causes a circular problem—if S-LPs are not consistently providing a label when describing children with DLD, then there will be fewer children with DLD seeking resources. As a result, the resources available for these children will be scarce, which may result in S-LPs being less inclined to provide the label. It is important to recognize that DLD must be consistently diagnosed before awareness of the disorder can grow and advocacy efforts can facilitate the development of appropriate resources.

Importantly, only two-thirds of participants reported that they felt the outcome of their assessment would probably or definitely put them in a position to provide a diagnostic label. When invited to provide a comment about what key parts of an assessment S-LPs felt would provide them with diagnostic information, answers were diverse and included standardized assessments, language samples, behavioural observations, parental reports, reports from other professionals, case histories, patterns of strengths and weaknesses, clinical judgement, and developmental milestones. Given that this array of assessment tools represents common practice, further research is needed to understand the circumstances under which S-LPs feel prepared to provide a diagnostic label following their assessment. In particular, research into assessment protocols and methodology for identifying language disorders in children may be required. Greater awareness of the consensus reached regarding how to identify language impairments in children (Bishop et al., 2016) is crucial for those professionals working in the field of childhood language disorders.

Barriers to Diagnostic Label Use in Practice

Most respondents indicated that their professional licensing/legislative body limited their ability to use diagnostic labels. This result was unsurprising considering that most participants in this study were practising in the province of Ontario—a province with particular rules regarding the use of diagnostic labels. Even though the professional legislative body within Ontario has specified that S-LPs can apply the label of DLD, there is still a lack of clarity among S-LPs about these diagnostic regulations. Despite this uncertainty, it is encouraging that of the participants who felt they were not permitted to provide the label, 69% reported that they were either extremely likely or likely to use diagnostic labels if these (perceived) restrictions were to change. With some clarification regarding communicating a diagnosis, it is reasonable to assume that S-LPs will be able to use the label of DLD more actively in the future.

Some of the participants who felt limited in their ability to provide diagnostic labels chose to provide commentary on how they provided labels within the constraints of their licensing or legislative body. Most comments indicated that to communicate the problem a child was experiencing, S-LPs would collaborate with other professionals who were not restricted in their ability to provide a label or, most commonly, they would choose to communicate the problem through carefully worded phrases like, "symptoms/impairments are consistent with X" or "this profile is similar to that of other children presenting with X," where X represents a particular label. Nevertheless, the results of this study support the hypothesis that licensing/legislative bodies in Canada are a major barrier to providing diagnostic labels to children with language disorders.

Anecdotally, some S-LPs shared comments indicating that within specific practices only certain labels were associated with resource allocation—creating a barrier to

their personal provision of the DLD label. Even if an S-LP felt that a diagnostic label was warranted and beneficial for a child, there may be pressures placed on S-LPs from a higher system level to provide or not provide specific labels. This notion indicates that for widespread implementation of the label DLD, and other diagnostic labels, consensus and recognition among various institutions and practices needs to first be achieved.

One additional reason that respondents gave for not providing the label DLD was in the case of children learning English as an additional language. Of course, the challenges of assessing culturally and linguistically diverse children are well recognized (Bedore & Peña, 2008; Espinosa, 2012). English language learners tend to score at low levels on standardized tests of English language for over 3 years (Paradis, 2016). In fact, groups of DLD and culturally and linguistically diverse children have been found to score at comparably low levels on standardized English language tests in many studies (e.g., Paradis, 2005; Windsor & Kohnert, 2004). It follows that for many culturally and linguistically diverse children, their low language test scores can be entirely accounted for by their (developing) English language proficiency. These children are best described as having a language difference rather than a disorder. The CATALISE studies clearly indicated that it is not appropriate to diagnose DLD in cases where low English language proficiency *alone* accounts for low language performance. Crucially, however, this statement does not preclude a diagnosis of DLD in culturally and linguistically diverse children. In cases where assessment results indicate that the observed language learning difficulties go beyond what can be accounted for by low English proficiency alone, it would be appropriate to identify a language disorder. It can be expected that distinguishing language difference and language disorder will be particularly challenging in some cases, which could account for why some respondents considered English language learner status to be a barrier in using the DLD label.

Knowledge of, and Attitudes Towards, the Label DLD

Although just under half of S-LP respondents indicated that they are not likely to use the term DLD, a majority reported they would use it if other S-LPs commonly used it. As well, just over half of participants stated that they were aware of the label DLD, although less than half were able to select the precise definition from the CATALISE studies. Although DLD was rarely used at the time of the survey, most participants agreed that having a consistent diagnostic label for children with language disorders would allow for better advocacy and that these children would benefit from professionals consistently using the agreed upon label of DLD. These results suggest that knowledge translation activities are more likely to be successful if they are aimed broadly at S-LPs across Canada and internationally. The findings also highlight the importance of advocacy efforts aimed at both the criteria for, and application of, the DLD label from the CATALISE studies to properly inform clinical practice. It appears that consistent international practice would encourage clinicians to put aside personal opinions regarding the specifics of the DLD label for the greater benefit of children with language impairment.

Limitations

In the current study, the label language delay was preferred by most participants. The frequency of use of this label may have been influenced, in part, by the wording used in this questionnaire. When S-LPs were asked to choose a label to describe, "a child presenting with a language delay," it may be fair to assume that many were primed to choose the label language delay. It would be useful, in future research, to gather further commentary from S-LPs describing why certain labels were preferred over others. Additionally, most participants in the current study reported practising in Ontario which may have influenced results related to the process of communicating a diagnosis or using diagnostic labels in general. Ontario is particularly diverse in terms of culture and language. Approximately 200 different languages were reported by Ontarians as a mother tongue according to the 2016 Canadian Census (Government of Ontario, 2017). This diversity may present a challenge for clinicians when completing language assessments and may directly influence their likelihood of providing the label DLD. A larger and more diverse sample would provide even clearer evidence of the reality of label use in clinical practice.

Future Directions

An important next step in furthering our understanding of DLD label use among S-LPs is to investigate change in the use of labels in practice as a result of knowledge translation activities. Future work is also needed to understand assessment activities and results that would prompt a practising clinician to apply, or avoid applying, the label DLD. Through use of another online questionnaire, we are interested in investigating clinicians' levels of comfort with the label DLD (when and how it is being applied). We are also interested in expanding the scope of our research to encompass S-LPs from other countries outside of Canada.

Conclusion

Overall, label use was found to be inconsistent in this sample of English Canadian S-LPs with barriers related to perceived disadvantages, practice restrictions, or

challenges of differential diagnosis. Although less than half could select the definition, most participants reported being familiar with DLD, the consensus term for children with a persistent language disorder with a functional impact and no associated biomedical condition. Most participants agreed that having a consistent label for children with language disorders would provide better advocacy for them and that they would be better off if professionals all used the agreed upon label of DLD. Respondents also indicated that they would be more likely to use DLD in situations when other S-LPs were perceived to be using the label as well. These findings set the stage for research, knowledge translation activities, and advocacy aimed at informing clinical practice about consensus terminology related to childhood language disorders.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Speech-Language-Hearing Association. (2012). *ASHA's recommended revisions to the DSM-5*. https://www.asha.org/siteassets/uploadedfiles/dsm-5-final-comments.pdf

Bedore, L. M., & Peña, E. D. (2008). Assessment of bilingual children for identification of language impairment: Current findings and implications for practice. *International Journal of Bilingual Education and Bilingualism*, *11*(1), 1–29. https://doi.org/10.2167/beb392.0

Bishop, D. V. M. (2014). Ten questions about terminology for children with unexplained language problems. *International Journal of Language & Communication Disorders*, 49(4), 381–415. https://doi.org/10.1111/1460-6984.12101

Bishop, D. V. M., Snowling, M. J., Thompson, P. A., Greenhalgh, T., & CATALISE consortium. (2016). CATALISE: A multinational and multidisciplinary Delphi consensus study. Identifying language impairments in children. *Plos One*, *11*(7): e0158753. https://doi.org/10.1371/journal.pone.0158753

Bishop, D. V. M., Snowling, M. J., Thompson, P. A., Greenhalgh, T., & CATALISE-2 consortium. (2017). Phase 2 of CATALISE: A multinational and multidisciplinary Delphi consensus study of problems with language development: Terminology. *The Journal of Child Psychology and Psychiatry*, *58*(10), 1068–1080. https://doi.org/10.1111/jcpp.12721

Canadian Institutes of Health Research. (2019, November 13). *Knowledge translation*. Government of Canada. https://cihr-irsc.gc.ca/e/29529.html

Clegg, J., Hollis, C., Mawhood, L., & Rutter, M. (2005). Developmental language disorders—A follow-up in later adult life. Cognitive, language and psychosocial outcomes. *The Journal of Child Psychology and Psychiatry, 46*(2), 128–149. https://doi.org/10.1111/j.1469-7610.2004.00342.x

Conti-Ramsden, G., & Botting, N. (1999). Classification of children with specific language impairment: Longitudinal considerations. *Journal of Speech, Language, and Hearing Research, 42*(5), 1195–1204. https://doi.org/10.1044/jslhr.4205.1195

Conti-Ramsden, G., Mok, P. L. H., Pickles A., & Durkin, K. (2013). Adolescents with a history of specific language impairment (SLI): Strengths and difficulties in social, emotional and behavioral functioning. *Research in Developmental Disabilities, 34*(11), 4161–4169. https://doi.org/10.1016/j.ridd.2013.08.043

Durkin, K., Conti-Ramsden, G., & Simkin, Z. (2012). Functional outcomes of adolescents with a history of specific language impairment (SLI) with and without autistic symptomatology. *Journal of Autism and Developmental Disorders, 42*(1), 123–138. https://doi.org/10.1007/s10803-011-1224-y

Espinosa, L. (2012). Assessment of young English-language learners. In C. A. Chapelle (Ed.), *The encyclopedia of applied linguistics* (pp. 264–269). John Wiley & Sons, Inc.

Gall, F. J. (1835). *On the functions of the brain and each of its parts: Organology*. Marsh, Capen & Lyon.

Government of Ontario, Ministry of Finance. (2017, October 10). 2016 *Census highlights – mother tongue and language*. https://www.fin.gov.on.ca/en/economy/demographics/census/cenhi16-6.html

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing, 32*(4), 1008–1015. https://doi.org/10.1046/j.1365-2648.2000.t01-1-01567.x

Johnson, C. J., Beitchman, J. H., & Brownlie, E. B. (2010). Twenty-year follow-up of children with and without speech-language impairments: Family, educational, occupational, and quality of life outcomes. *American Journal of Speech–Language Pathology, 19*(1), 51–65. https://doi.org/10.1044/1058-0360(2009/08-0083)

Lancaster, H. S., & Camarata, S. (2019). Reconceptualizing developmental language disorder as a spectrum disorder: Issues and evidence. *International Journal of Language & Communication Disorders, 54*(1), 79–94. https://doi.org/10.1111/1460-6984.12433

Lauchlan, F., & Boyle, C. (2007). Is the use of labels in special education helpful? *Support for Learning, 22*(1), 36–42. https://doi.org/10.1111/j.1467-9604.2007.00443.x

Macharey, G., & von Suchodoletz, W. V. (2008). Perceived stigmatization of children with speech-language impairment and their parents. *Folia Phoniatrica et Logopaedica, 60*(5), 256–263. https://doi.org/10.1159/000151763

McGregor, K. K., Redmond, S., & Oliver, J. (2017, November 9–11). *Why are people with developmental language disorders under-identified and under-researched?* [Paper presentation]. Annual Convention of the American Speech and Hearing Association, Los Angeles, CA, United States.

Norbury, C. F., Gooch, D., Wray, C., Baird, G., Charman, T., Simonoff, E., Vamvakas, G., & Pickles, A. (2016). The impact of nonverbal ability on prevalence and clinical presentation of language disorder: Evidence from a population study. *The Journal of Child Psychology and Psychiatry, 57*(11), 1247–1257. https://doi.org/10.1111/jcpp.12573

Olswang, L. B., & Prelock, P. A. (2015). Bridging the gap between research and practice: Implementation science. *Journal of Speech, Language, and Hearing Research, 58*(6), S1818–1826. https://doi.org/10.1044/2015_JSLHR-L-14-0305

Paradis, J. (2005). Grammatical morphology in children learning English as a second language. *Language, Speech, and Hearing Services in Schools, 36*(3), 172–187. https://doi.org/10.1044/0161-1461(2005/019)

Paradis, J. (2016). The development of English as a second language with and without specific language impairment: Clinical implications. *Journal of Speech, Language, and Hearing Research, 59*(1), 171–182. https://doi.org/10.1044/2015_JSLHR-L-15-0008

Parsons, S., Schoon, I., Rush, R., & Law, J. (2011). Long-term outcomes for children with early language problems: Beating the odds. *Children and Society, 25*(3), 202–214. https://doi.org/10.1111/j.1099-0860.2009.00274.x

Prelock, P. A., Hutchins, T., & Glascoe, F. P. (2008). Speech-language impairment: How to identify the most common and least diagnosed disability of childhood. *The Medscape Journal of Medicine, 10*(6), 136.

Regulated Health Professions Act. (1991). Government of Ontario. https://www.ontario.ca/laws/statute/91r18

Reilly, S., Tomblin, B., Law, J., McKean, C., Mensah, F. K., Morgan, A., Goldfeld, S., Nicholson, J. M., & Wake, M. (2014). Specific language impairment: A convenient label for whom? *International Journal of Language & Communication Disorders, 49*(4), 416–451. https://doi.org/10.1111/1460-6984.12102

Tomblin, J. B., Records, N. L., Buckwalter, P., Zhang, X., Smith, E., & O'Brien, M. (1997). Prevalence of specific language impairment in kindergarten children. *Journal of Speech, Language, and Hearing Research, 40*(6), 1245–1260. https://doi.org/10.1044/jslhr.4006.1245

Windsor, J., & Kohnert, K. (2004). The search for common ground: Part I. Lexical performance by linguistically diverse learners. *Journal of Speech, Language, and Hearing Research, 47*(4), 877–890. https://doi.org/10.1044/1092-4388(2004/065)

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Appendix

1. With which of the following age groups do you work in your practice? Please check all that apply.

- ○ 3–5 years old
- ○ 6–13 years old
- ○ 14–18 years old
- ○ I do not work with individuals in this age range

2. Please indicate the practice settings in which you work (check all that apply):

- ○ School Board
- ○ Hospital
- ○ Residential Health Care
- ○ Nonresidential Health Care
- ○ Private Practice
- ○ Other

3. Please indicate the province or territory in which you practice as a registered/licensed speech-language pathologist.

- ○ British Columbia
- ○ Alberta
- ○ Saskatchewan
- ○ Manitoba
- ○ Ontario
- ○ Québec
- ○ New Brunswick
- ○ Nova Scotia
- ○ Prince Edward Island
- ○ Newfoundland
- ○ Yukon Territory
- ○ Northwest Territories
- ○ Nunavut
- ○ I do not practice in Canada

4. How often would you use a specific label to describe the profile of a child presenting with a significant language delay?

- ○ Very Frequently
- ○ Frequently
- ○ Occasionally
- ○ Rarely
- ○ Never

5. For a child presenting with a language delay, how often do you use the following labels:

Very Frequently	Frequently	Occasionally	Rarely	Never

- ○ Language Disorder
- ○ Language Delay
- ○ Specific Language Impairment
- ○ Receptive Language Disorder
- ○ Expressive Language Disorder
- ○ Receptive-Expressive Language Disorder
- ○ Developmental Language Disorder

6. When you DO NOT provide a child with a specific label, which of the following reasons influence your decision:

- ○ A label focuses on what a child cannot do and may ignore their strengths
- ○ A label may cause a child to feel that failure is inevitable
- ○ A label may lead to stigmatization or other negative social consequences for the child
- ○ Certain resources may not be available to a child once a label is applied to him/her
- ○ A label may not provide a child with any benefits or resources
- ○ Parents may not want a label applied to their child
- ○ Other

7. When you DO provide a child with a specific label, which of the following reasons influence your decision:

- ○ A label provides an explanation and legitimacy for a child's struggles
- ○ A label removes blame from a child
- ○ A label removes blame from parents
- ○ A label promotes understanding and awareness of a particular difficulty
- ○ A label provides access to resources and intervention
- ○ A label facilitates easier communication among professionals
- ○ Other

8. Does your professional licensing/legislative body limit your ability to use diagnostic labels?

- ○ Yes
- ○ No

9. If the limitations posed by your professional licensing/legislative body were to change, how likely would you be to use diagnostic labels?

- ○ Extremely Likely
- ○ Likely
- ○ Neutral
- ○ Unlikely
- ○ Extremely Unlikely

10. Are there ways you can provide appropriate labels within the constraints of your licensing/ legislative body? If so, please describe.

11. What is the level of importance you would assign to the following assessment objectives:

Very Important	Important	Neutral	Unimportant	Very Unimportant

- ○ Establishing goals for intervention
- ○ Determining if eligibility criteria for services are met
- ○ Providing parents with a diagnostic label
- ○ Assessing the level of functional impact
- ○ Identifying strengths and weaknesses

12. Do you feel that the outcome of your assessments puts you in a position to provide a diagnostic label?

- ○ Definitely yes
- ○ Probably yes
- ○ Might or might not
- ○ Probably not
- ○ Definitely not

13. What key parts of an assessment would give you diagnostic information?

14. Are you aware of the label "Developmental Language Disorder"?

- ○ Yes
- ○ Maybe
- ○ No

15. Pick the description that you think matches the label of "Developmental Language Disorder"

- ○ Language that does not develop normally and presents difficulties that cannot be accounted for by generally slow development, physical abnormality of the speech apparatus, Autism Spectrum Disorder, apraxia, acquired brain damage or hearing loss.
- ○ A communication disorder in which both the receptive and expressive areas of communication may be affected in any degree, from mild to severe and involve a difficulty understanding words and sentences.
- ○ Language difficulties that create obstacles to communication or learning in everyday life that are unlikely to resolve by five years of age and are not associated with any known biomedical condition such as brain injury, neurodegenerative conditions, genetic conditions or chromosome disorders such as Down Syndrome, sensorineural hearing loss, Autism Spectrum Disorder or Intellectual Disability.
- ○ Language challenges that present difficulty in expressing language or understanding language, are unlikely to resolve by five years of age, and are unrelated to sensorineural hearing loss, Autism Spectrum Disorder or Intellectual Disability.

16. Developmental Language Disorder is defined as: "language difficulties that create obstacles to communication or learning in everyday life that are unlikely to resolve by five years of age and are not associated with any known biomedical condition such as brain injury, neurodegenerative conditions, genetic conditions or chromosome disorders such as Down Syndrome, sensorineural hearing loss, Autism Spectrum Disorder or Intellectual Disability"

Do you feel that the diagnostic label of "developmental language disorder," as defined above, is an effective label?

- ○ Yes
- ○ Maybe
- ○ No
- ○ Comments

17. How likely are you to use the diagnostic label of "Developmental Language Disorder"?

- ○ Extremely Likely
- ○ Likely
- ○ Neutral
- ○ Unlikely
- ○ Extremely Unlikely

18. Could you use the label of "Developmental Language Disorder" in your current work setting?

- ○ Yes
- ○ Maybe
- ○ No
- ○ Comments

19. How likely would you be to point parents towards resources regarding Developmental Language Disorders?

- ○ Extremely Likely
- ○ Likely
- ○ Neutral
- ○ Unlikely
- ○ Extremely Unlikely

20. If the diagnostic label of "Developmental Language Disorder" were commonly used by speech-language pathologists, how likely would you be to use the label too?

- ○ Extremely Likely
- ○ Likely
- ○ Neutral
- ○ Unlikely
- ○ Extremely Unlikely

21. If there were an international consensus reached regarding the use of the diagnostic label of "Developmental Language Disorder," how likely would you be to use the label?

- ○ Extremely Likely
- ○ Likely
- ○ Neutral
- ○ Unlikely
- ○ Extremely Unlikely

22. How strongly do you agree with the following statement: Having a consistent diagnostic label for children with language disorders would provide better advocacy for those children.

- ○ Strongly Agree
- ○ Agree
- ○ Neutral
- ○ Disagree
- ○ Strongly Disagree

23. How strongly do you agree with the following statement: Children with language disorders would be better off if professionals were consistently using the agreed upon label of "Developmental Language Disorder."

- ○ Strongly Agree
- ○ Agree
- ○ Neutral
- ○ Disagree
- ○ Strongly Disagree

24. Please share anything else that you have heard about the diagnostic label of "Developmental Language Disorder" or any other thoughts you have regarding this label and its use.