Echolalia in children with Asperger's Syndrome: a speech therapy approach

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Dear Editor,

The phenomenon of echolalia in autism and Asperger's syndrome[1] has been well documented. However, few studies have attributed functionality to the structure of echolalia or have investigated the clinical use of this phenomenon in speech therapy for patients fitting this profile.

We have observed that, in children with Asperger's syndrome, some occurrences of echolalia present characteristics of functional communication. As a result, an evaluation and intervention protocol has been developed that departs from the hypotheses that echolalia represents the initial discursive nature in these children.

Each child is observed for 45 minutes, while in a play situation with the speech therapist. The sessions are periodically videotaped. Two blinded observers review the tapes and the production of echolalic speech, within the context of its occurrence, is classified as interactive or noninteractive according to 14 categories.[2]

An initial survey, in which 9 children with Asperger's syndrome were observed, showed that, within the categories considered interactive, certain behaviors occurred more frequently: asking for an object, asking that an action be performed, making social requests, and protesting. In contrast, other interactive behaviors occurred quite rarely: asking permission, expressing gratitude, soliciting information, identifying oneself, and commenting. The last two represent the most complex forms of exchange.

The children frequently exhibited all of the noninteractive behaviors. Among these, it is notable that the categories execution, self-regulation and exclamation suggest behavior regulation through speech, and that the reaction, lack-of-focus, and isolation-tendency categories are characteristic of the pathology itself.

Although the communicative behaviors occurring most frequently are those of the lowest complexity, involving requesting, refusing, seeking attention and becoming involved in simple social routines, we have valued these behaviors and employed them as clinical intervention strategies in the search for social inclusion. Adult interlocutors consider echolalia episodes to have a communicative function. Under this premise, the adult responds to that verbal structure. The use of this presupposition has been extended to other child development contexts, and family members and teachers have begun to use these same procedures.

Using this type of intervention, we have observed that children also begin to use echolalic speech in asking for and giving information, as well as in making some comments. In addition, episodes of immediate echolalia diminish and repetition of speech fragments, modified within contexts (mitigated echolalia), increases. In parallel, there is an increase in spontaneous, nonecholalic speech, due to the contingency management of the speech of these children. In other words, the speech therapist takes great care to maintain the conversation topic, a skill that is fundamental to establishing the dialog dynamic. This contingency management allows the interlocutor to transform echolalic speech into a contextual event.[3]

It is essential to emphasize the importance of participation by the family and the school as partners in this type of clinical intervention. For children with general developmental disorders, which are severe and chronic by definition, the search for strategies to improve the quality of communication and language must involve fundamental processes for guaranteeing social interaction.

References

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