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Exploring the Prevalence and Structure of Language Disorders in Children with Intellectual Disability in Romania

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Abstract

The study presents a quantitative analysis of language disorders in children with intellectual disabilities, based on data obtained through speech–language assessments administered to a sample of 92 participants (21 preschoolers and 71 school-age children). The results highlight a heterogeneous developmental profile, with a predominance of boys and a wide age range among the school-age group. The speech–language diagnoses indicate a high prevalence of pronunciation/articulation disorders and nonverbalism, followed by severe delays in language development. The analysis of affected phonemes reveals that the sounds /r/ and /ʒ/ are most frequently impaired, followed by /ʃ/ and /z/, confirming the articulatory and phonological difficulties of the evaluated children. The typology of articulatory errors reveals phoneme substitution as the dominant pattern, followed by omission and, to a lesser extent, distortion. These findings support the hypothesis of a complex deficit that includes both phonetic–articulatory components and phonological processes, underscoring the need for differentiated speech–language interventions adapted to the child's cognitive level.

Keywords: language disorders; intellectual disability; IQ score; affected phonemes; articulatory errors; pronunciation; phonological profile; speech–language assessment; preschool children; school-age children.

Introduction

Language is one of the central dimensions of cognitive and socio-emotional development, and its impairment is frequent and often severe in children with intellectual disability (ID). Numerous synthesis analyses emphasize that language disorders are not a secondary feature but a defining element of the clinical profile in ID, interfering with academic achievement, social adaptation, and problematic behaviors (Marrus & Hall, 2017; Bourin, 2025). In the context of intellectual disability, language development is delayed, uneven, and often disharmonious, affecting all components of communication: phonetic–articulatory, lexical–semantic, morphosyntactic, and pragmatic (Marrus & Hall, 2017).

In the general child population, epidemiological data indicate considerable variability in estimates of the prevalence of language difficulties, depending on the diagnostic criteria and instruments used. A recent systematic review conducted by Hill and colleagues (2023) reports rates of low language ability ranging from 0.4% to 25.2% in children aged 1 to 16 years, depending on the

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operational definition of the disorder and the severity thresholds applied. In the Romanian context, a large epidemiological study conducted on a sample of 160,622 preschool and school-age children identified an overall prevalence of 14.46% for language and communication disorders, with a higher rate among preschoolers (17.83%) compared to school-age children (11.10%) (Agheana, 2024). Pronunciation/articulation disorders represent the dominant form (79.51%), followed by rhythm and fluency disorders, written language disorders, and developmental language disorders (Agheana, 2024).

In the case of children with intellectual disability, the literature consistently indicates a much higher prevalence of language disorders compared to the typical population. Lesser and Hassip (1986, cited in Memisevic & Hadzic, 2013) estimate that approximately 55% of children with intellectual disability present language disorders. Georgieva and Cholakova (1996) identified various types of disorders—including articulation problems, stuttering, and reading/writing difficulties—in 121 of the 148 children they studied. Memisevic and Hadzic (2013), in a study involving 167 children with mild and moderate intellectual disability from two special education centers in Bosnia and Herzegovina, reported a prevalence of 71.3% for language and communication disorders, with significant differences depending on the level and etiology of the disability. In a recent anthropological study, Borgohain and Barua (2022) reported a prevalence of 60.4% for language disorders in a sample of 250 children with intellectual disability from Assam (India), with a higher frequency among children with moderate ID (94%) compared to those with mild ID (31.3%).

For children with severe, profound, or multiple associated intellectual disabilities, the literature suggests that language and communication disorders are virtually ubiquitous, manifested through an extremely limited verbal repertoire or the absence of oral language, which necessitates the use of alternative and augmentative communication systems (Bourin, 2025). Overall, these findings support the idea that intellectual disability constitutes a major risk factor for the emergence and persistence of language disorders, due both to general cognitive limitations and to the neurobiological and environmental characteristics specific to different etiologies (Marrus & Hall, 2017).

Beyond the mere presence of a language disorder, a qualitative analysis of the phonological and articulatory profile (most frequently affected phonemes, patterns of omission, substitution, and distortion) has direct implications for designing differentiated speech–language interventions adapted to the cognitive level and the sensory and motor characteristics of the child with ID (Memisevic & Hadzic, 2013; Borgohain & Barua, 2022).

The pronunciation disorders associated with intellectual disability present a distinct profile, characterized by increased severity and phonological instability. According to Emil Verza (2003), children with intellectual impairment predominantly exhibit polymorphic dyslalia, which involves the simultaneous impairment of a large number of phonemes, thereby globally disrupting the phonetic system and reducing speech intelligibility. The symptomatology is often accompanied by phonematic perseverations, manifested through the repetition of sounds or syllables, a phenomenon that further accentuates the discontinuity of expression.

Dyslalia in children with intellectual disability is highly unstable and predominantly affects sounds that emerge later in the ontogenesis of language — the rhotic /r/, the affricates /ts/, /dz/, /tʃ/, the sibilants /s/, /z/, and the fricatives /ʃ/, /ʒ/ (Verza, 2003). This phonetic profile suggests converging difficulties at the level of fine articulatory motor skills as well as in the organization and stabilization of phonological representations, thereby justifying the need for intensive, long-term

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speech–language interventions adapted to the cognitive characteristics of the child with intellectual disability.

The present material aims to contribute to filling this gap through a detailed quantitative analysis of language disorders in a sample of children with intellectual disability who received speech–language assessment within a special education setting. The study examines the distribution of participants by age, educational level, and IQ scores, the structure of the speech–language diagnosis, as well as the phonemic/articulatory profile, with a focus on the frequency of affected phonemes and the typology of pronunciation errors. By relating the findings to international epidemiological data and to the Romanian context, the study seeks to provide empirical benchmarks for developing evidence-based speech–language assessment and intervention programs centered on the child with intellectual disability and adapted to the specific characteristics of this target group.

Based on the existing literature and considering the need for a detailed characterization of the linguistic profile in the context of intellectual disability, the present study formulates the following research question:

"What are the structural characteristics of language disorders in children with intellectual disability — in terms of prevalence, the typology of speech–language diagnoses, the affected phonemes, and the types of articulatory errors — and to what extent are these associated with the level of cognitive functioning and with the developmental stage (preschool vs. school-age)?"

Method

Participants and Selection Procedure

The sample was formed through a conventional (non-probabilistic) selection procedure, including all children with intellectual disability who were assessed in the speech–language therapy offices of partner institutions in Bucharest, Romania, during the data collection period. The inclusion criteria were:

(a) the presence of an educational or clinical diagnosis of intellectual disability issued by evaluation committees or a medical specialist;

(b) completion of a full speech–language assessment during the study period;

(c) availability of data regarding the level of cognitive functioning. The selection of participants did not aim for a statistically representative distribution but rather for the exhaustiveness of eligible cases available at the time of the study. No exclusion criteria were applied regarding the severity of the language disorder or the presence of associated comorbidities, as the objective of the research was to analyze the diversity of linguistic profiles within the target population.

Instruments and Assessment Procedure

The assessment integrated both direct and indirect methods in order to obtain the most accurate possible characterization of the children's linguistic and cognitive profiles.

a) Standardized Speech–Language Assessment Tasks

Each child was individually examined in the speech–language therapy setting using assessment instruments recognized in clinical practice. These targeted:

– pronunciation and articulation (identification of affected phonemes; classification of error type: omission, substitution, distortion);

– expressive and receptive language (active/passive vocabulary, basic morphosyntax,

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comprehension);
– speech rhythm and fluency (blocks, repetitions, increased speech rate);
– prosodic features (intonation, stress, speech melody).

The results were recorded in standardized speech–language evaluation forms. For children with severely impaired cognitive functioning, simplified versions with visual support were used in order to avoid distorting the data through verbal overload.

b) Analysis of Educational and Medical Records

The data obtained through direct assessment were supplemented with an analysis of the educational and medical files. Information was extracted regarding:
– primary clinical diagnoses and associated comorbidities;
– previous psychological evaluations;
– prior speech–language interventions and the progress noted in reports.
This stage aimed to triangulate and validate the data, thereby reducing the risk of misinterpretation of the linguistic results.

c) IQ Scores

The level of cognitive functioning was determined based on existing IQ scores reported in psychological assessments conducted by accredited psychologists. The scores were compiled and used to classify participants according to the level of intellectual disability (mild, moderate, severe). The correlation between cognitive indicators and the type and severity of language disorders was performed solely through statistical analysis, without additional clinical interpretation or differential diagnosis.

Research Design

The study adopted a quantitative, non-experimental, descriptive, and cross-sectional design. Data were collected at a single point in time, within the context of routine speech–language therapy activities, without intervention on the variables or manipulation of the educational environment. The descriptive design allowed for the analysis of the distribution of language disorders within the investigated population, while the exploratory aspect enabled the examination of potential relationships between the level of cognitive functioning and the complexity of language disorders.
Ethical compliance included processing the data with the approval of the institutions and, where necessary, of parents or legal guardians. Participant identities were protected through data anonymization.

Findings

This chapter presents the results of the quantitative analysis regarding the characteristics of language disorders in children with intellectual disability, based on data obtained from speech–language assessments. The results are organized across five dimensions: participant distribution, age characteristics, IQ scores, speech–language diagnosis, and the phonemic/articulatory profile.

1. Participant Distribution

Of the total 126 children assessed during the speech–language evaluation, 92 exhibited language disorders, representing 73.02% of the investigated population and thus constituting the sample used in the statistical analysis. This high proportion indicates a significant prevalence of

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communication difficulties among children with intellectual disability and confirms the vulnerability of the linguistic domain within this developmental category.
The children included in the analysis met the criterion of having a formally recorded language disorder in the speech–language assessment form, regardless of its type or severity, allowing for a realistic and heterogeneous representation of clinical profiles. Establishing this inclusion threshold provides the basis for examining interindividual differences associated with age, cognitive level, and phonological/articulatory characteristics, contributing to a detailed description of the evaluated population.

Table 1. Distribution of Participants by Educational Level and Sex

Level	Boys	Girls
Preschool	15	6
School-age	53	18

Note. Percentages are calculated within each educational level (preschool vs. school-age).

Of these, 21 are preschoolers, and 71 are school-age children. Analysis of the sex distribution reveals a clear predominance of boys, approximately 2.5:1 at the preschool level and 3:1 at the school-age level (Table 1). This finding is consistent with international epidemiological data, which indicate that boys are more vulnerable in language development compared to girls.
The numerical predominance of boys suggests a potential interaction between biological, cognitive, and neurodevelopmental factors in the genesis of language disorders in children with intellectual disability, although causal inferences cannot be drawn in the absence of further analyses.

Descriptive Statistics for Age

Descriptive statistics for age indicate distinct characteristics between the two subgroups. Preschoolers have a mean age of 6.38 years (SD = 1.02), corresponding to the critical stage of oral language acquisition, which suggests early access to speech–language assessment and the possible early identification of difficulties. The school-age group is characterized by a mean age of 12.65 years (SD = 3.20), with a wide range (6–25 years). The highest frequency is observed in the primary and middle school cycles, periods associated with increasing academic language demands.

Table 2. Descriptive Statistics for Age

Indicator	Preschoolers	School-age
Count	21	71
Mean	6.38	12.65
SD	1.02	3.20
Min	5	6
Max	8	25

Note. Age is expressed in years. SD = standard deviation.

These data indicate that, for many children, language difficulties persist significantly beyond the preschool stage, requiring sustained, long-term speech–language interventions adapted to the level of cognitive functioning and educational demands.

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IQ Scores

IQ scores were available for 91 of the 92 participants (20 preschoolers and 71 school-age children). The mean values fall within the range characteristic of moderate to severe intellectual disability: 47.30 for preschoolers and 51.13 for school-age children. The higher median for school-age children suggests a slight statistical increase with age; however, the shared range of variation (30–83) indicates considerable interindividual heterogeneity.

Table 3. Descriptive Statistics for IQ Scores

Indicator	Preschoolers	School-age
count	20	71
mean	47.30	51.13
SD	14.33	16.99
min	30	20
percentile 25	36.75	38
percentile 50 (median)	45	49
percentile 75	52.50	67
max	83	83

Note. IQ values are extracted from previously issued psychological assessment reports. SD = standard deviation.

The distribution of scores and the high standard deviation values in both groups suggest that cognitive level, while relevant, is not the sole predictor of language development. It likely interacts with additional factors such as verbal exposure, type of schooling, comorbidities, and the quality of interventions.

Speech–Language Diagnoses

The profile of speech–language diagnoses, calculated for the subgroup of 74 children for whom a clear primary diagnosis could be identified, shows a distribution dominated by pronunciation/articulation disorders (39.19%) and nonverbalism (36.49%), followed by severe delays in language development (20.27%). Rhythm and fluency disorders (2.70%) and voice disorders (1.35%) are significantly less represented.

Table 4. Distribution of Speech–Language Diagnoses

Speech–Language Diagnosis	Number	Percentage (%)
Pronunciation/Articulation disorders	29	39.19
Nonverbalism	27	36.49
Severe language development delay	15	20.27
Rhythm and fluency disorders	2	2.70
Voice disorders	1	1.35
Rhinolalia	0	0
Other disorders	0	0

Note. Percentages refer to the proportion of each diagnostic category within the subgroup of children for whom a single main speech and language diagnosis could be coded (N = 74).

The simultaneous presence of nonverbalism and severe articulatory disorders suggests a complex impairment of language development, involving both the phonetic–articulatory aspects and the phonological and pragmatic mechanisms of communication. The results indicate that, for a

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considerable portion of children, the language disorder does not represent a partially isolated difficulty but rather a global limitation of communicative functioning.

Analysis of Affected Phonemes and Types of Articulatory Errors

The analysis of affected sounds was conducted based on explicit notes in the speech–language assessment forms for children with pronunciation disorders. The affected phonemes were inventoried, and their proportion was calculated relative to the total number of subjects (N = 92), rather than to the total number of errors.

5.1. Distribution of Affected Phonemes

Table 5. Distribution of Affected Sounds in Pronunciation

Affected Sound	Number	Percentage(%)
R	18	19.57
J	18	19.57
Ș	16	17.39
Z	12	13.04
L	10	10.87
Ț	8	8.70
CI	8	8.70
D	8	8.70
CE	7	7.61
S	7	7.61
G	7	7.61
V	7	7.61
GI	6	6.52
H	5	5.43
B	5	5.43
GE	5	5.43
X	5	5.43
C	2	2.17
F	2	2.17
P	1	1.09
T	1	1.09
M	1	1.09
N	1	1.09

Note. Percentages are calculated relative to the entire sample of children with language disorders (N = 92). A single child may present multiple affected phonemes; therefore, percentages do not sum to 100%.

Analysis of the distribution of affected phonemes shows that the most frequently altered sounds are R and J (19.57% each), followed by Ș (17.39%) and Z (13.04%). These phonemes are considered articulatorily complex and frequently occur in the phonetic–phonological disorders associated with intellectual disability. The extended set of affected sounds (including L, Ț, S, G, V, CE, CI, GI) suggests that the impairment is not selective but reflects a broad profile of phonological difficulties, involving plosives, sibilants, and rhotics alike. Percentages were calculated by relating the number of children exhibiting a particular phoneme impairment to the total sample with language disorders (N = 92), meaning that a child may be counted under

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multiple affected phonemes; consequently, the percentage values are not mutually exclusive and do not sum to 100%. This distribution indicates the possibility of motor and phonological instability that exceeds the acquisition of individual phonemes and affects the coherence of the phonological system.

Types of Articulatory Errors

The analysis of types of articulatory errors was based on detailed records in the speech–language assessment forms, with the unit of analysis being the individual error, as a child may present multiple error types across different phonemes simultaneously. In total, 138 distinct articulatory errors were recorded. Their distribution shows a clear predominance of substitutions (55.80%), followed by omissions (36.23%) and, to a much lesser extent, distortions (7.97%). This profile supports the hypothesis of a phonological impairment, characterized by instability of phonemic representations and difficulties in auditory-verbal processing, rather than an isolated articulatory motor deficit.

Table 5b. Distribution of Types of Articulatory Errors

Type of Error	Number	Percentage(%)
Substitution	77	55,80
Omission	50	36,23
Distortion	11	7,97

Note. Percentages are calculated relative to the total number of identified articulatory errors (N = 138). A child may produce multiple errors simultaneously across different phonemes; therefore, the types of errors are not mutually exclusive categories and do not sum to 100% in relation to the number of participants.

Table 6. Distribution of Pronunciation Errors by Phoneme

Sound	Omission	Substitution	Distortion
S	4	13	1
Ș	3	7	2
R	7	3	2
Z	3	6	1
L	6	2	1
J	3	4	1
F	2	5	0
C	2	5	0
V	2	5	0
T	1	4	0
G	1	3	0
Ț	1	1	1
D	1	2	0
H	2	1	0
X	0	1	1
B	0	1	0
N	1	0	0
P	0	1	0

Note. The data represent the total number of errors (phoneme × type of error) recorded in the speech–language assessment forms. A child may produce multiple errors simultaneously across different phonemes and error types; therefore, the values cannot be interpreted as the number of participants.

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The dominant type of error is phoneme substitution, followed by omission; distortions are less frequent. This profile supports the hypothesis of a phonological impairment (auditory processing and discrimination, unstable phonological schemes), rather than merely an articulatory motor deficit. The sound /s/ is the most affected in terms of total errors (18 errors: 4 omissions, 13 substitutions, 1 distortion), suggesting specific difficulties in the production and control of sibilants. The sounds Ș, R, Z and L also exhibit a high number of combined errors (omissions + substitutions + distortions), indicating a high degree of articulatory and phonological instability in children with intellectual disability. For sounds such as F, C, V, substitutions predominate, whereas for R there is a balance between omission and distortion, characteristic of pararotacism and fine motor difficulties.

Table 7. Percentage Distribution of Articulatory Errors by Phoneme

Sound	Number of Errors	Percentage (%)
S	18	15,93%
Ș	12	10,62%
R	12	10,62%
Z	10	8,85%
L	9	7,96%
J	8	7,08%
F	7	6,19%
C	7	6,19%
V	7	6,19%
T	5	4,42%
G	4	3,54%
Ț	3	2,65%
D	3	2,65%
H	3	2,65%
X	2	1,77%
B	1	0,88%
N	1	0,88%
P	1	0,88%

Note. Percentages are calculated relative to the total number of errors (N = 113). A child may produce multiple errors across different phonemes; therefore, the percentages do not represent the distribution of errors across participants.

The distribution of articulatory errors by phoneme reveals a profile of severe phonological impairment, characterized by the predominant involvement of sibilants and the rhotic: /s/ (15.93%), /ʃ/ (10.62%), and /r/ (10.62%). The phonemes /z/, /l/, /j/, and the /f–c–v/ group appear at intermediate frequencies (6–9%), confirming the extension of difficulties to consonants with high articulatory complexity. The lower frequencies for /ț/, /d/, /h/, and the bilabial plosives /b–p/ indicate relatively minor peripheral impairment, supporting the interpretation of a central phonological deficit rather than one limited to articulatory motor skills.

Discussion

The results of this study outline a complex profile of language disorders in children with intellectual disability and can be interpreted both in continuity with and in contrast to data reported in the international literature.

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The finding of a severely affected linguistic profile—with a high prevalence of nonverbalism and severe articulatory disorders—is consistent with literature describing language disorders as a central component of intellectual disability rather than a secondary phenomenon (Georgieva & Cholakova, 1996; Memisevic & Hadzic, 2013).

Our data regarding IQ scores (means falling within the moderate/severe intellectual disability range, with high variability) are congruent with these findings and support the conclusion that the risk of language disorders increases with the severity of intellectual disability. Furthermore, recent studies on large samples of students with intellectual disability in special schools show that language difficulties correlate with indicators of social adaptation and behavior, suggesting an interdependence between cognitive level, linguistic competencies, and social inclusion (Hofmann & Müller, 2021). These results support the interpretive direction of the present study, according to which language disorders in intellectual disability have a systemic impact on both academic and social functioning.

The high proportion of nonverbal children observed in the analyzed sample aligns with the literature on "complex communication needs" in children with intellectual and developmental disabilities. A meta-analysis conducted by Crowe et al. (2022) on augmentative and alternative communication (AAC) interventions in children with intellectual and developmental disabilities indicates that a significant portion of these children have reduced or absent verbalization and benefit from early introduction of AAC systems.

The results of the present study, which indicate a high percentage of nonverbal children or those with extremely limited language, confirm, from the perspective of the Romanian context, the need to extend speech–language interventions beyond pronunciation correction toward the construction of a functional communication system, including AAC strategies and technologies.

The distribution of affected phonemes (predominance of R, J, Ș, Z, and involvement of an extended set of consonants) is consistent with data on pronunciation disorders in populations with atypical development, where phonemes with high articulatory complexity or fine motor demands (e.g., rhotics and sibilants) are frequently affected.

Regarding the typology of errors, our results—with a clear predominance of substitutions, followed by omissions and a smaller proportion of distortions—partially confirm the classical SODA model (substitution, omission, distortion, addition) described in the literature, where substitutions and omissions are the most common forms of impairment in articulatory and phonological disorders. Studies on children with speech sound disorders similarly indicate that substitutions and omissions are dominant, whereas distortions are less frequent but often correlate with a less favorable prognosis for articulation at school age (Preston & Edwards, 2010).

On the other hand, recent epidemiological research on the prevalence of speech sound disorders in preschool children has identified, in some samples, a higher proportion of distortions compared to substitutions, suggesting that the error structure may vary depending on the native language, sample type, and diagnostic criteria (Rey, Sánchez-Delgado, Palmer, Anda & Gallardo, 2022). This difference partially "challenges" the universality of the profile found in the present study and indicates that linguistic specificity (in our case, Romanian), the special educational context, and the combination of language disorder and intellectual disability can influence the manifestation of articulatory errors.

The phonological interpretation of the results is supported by studies showing that many children with speech sound disorders exhibit difficulties in phonological awareness skills and in

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processing phonemic representations, suggesting a deficit at the level of the phonological system rather than merely articulatory motor control (Preston & Edwards, 2010). The fact that, in the present sample, substitution errors are far more numerous than distortions supports the hypothesis of a predominantly phonological profile in children with intellectual disability.
The findings regarding age distribution, particularly the persistence of language disorders into the school-age and adolescent periods, suggest that language disorders in the context of intellectual disability are chronic and are rarely "outgrown" spontaneously. This indicates that the linguistic deficit does not represent a transient delay or a gap recoverable solely through neurocognitive maturation, but reflects a structural limitation in communicative development that continues to manifest even in developmental stages when language would typically be stabilized and functional. The persistence of articulatory and phonological difficulties, often associated with impairments in lexical, morphosyntactic, and pragmatic components, highlights a stagnant developmental pattern in which spontaneous gains are minimal, and the absence of specialized intervention often leads to the consolidation of dysfunctional communicative patterns.
From an educational and psychosocial perspective, this persistence results in a cumulative impact on academic performance, school adaptation, and social participation. Children and adolescents with intellectual disability who continue to experience language disorders face significant difficulties in understanding instructional tasks, expressing needs, negotiating social interactions, and managing behaviors. The lack of significant progress in language development with age suggests that speech–language interventions should be designed not merely as short-term corrective programs but as long-term, dynamic processes systematically anchored in the child's cognitive and educational development. In this regard, the results support the need for continuous, differentiated, and staged intervention models capable of preventing the accumulation of linguistic gaps and supporting the development of functional communication throughout the entire school period.

Conclusions

The results of this study provide a coherent yet complex picture of language disorders in children with intellectual disability and allow for the formulation of conclusions relevant to research, speech–language practice, and special education.
The high prevalence of language and communication disorders among children with intellectual disability confirms that language impairment represents a structural characteristic of development in this population, rather than a secondary or transient phenomenon. The simultaneous presence of severe articulatory disorders, delayed language development, and, in many cases, nonverbalism indicates that the linguistic deficit manifests globally, affecting phonetic–articulatory mechanisms as well as phonological, semantic, and pragmatic processes.
The persistence of language disorders into school-age and adolescence suggests that natural development and exposure to typical educational environments are insufficient to produce significant progress. This finding underscores the importance of early, continuous, and individually tailored therapeutic interventions within a long-term developmental perspective.
Another relevant conclusion concerns the phonemic and articulatory profile: the impairment is not limited to a small set of "difficult" phonemes but involves a broad spectrum, with high frequencies among rhotics, sibilants, and plosives. Furthermore, the predominance of

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substitution errors relative to omissions and distortions confirms that the deficit is primarily phonological rather than purely articulatory motor. This result supports the inclusion of phonological awareness and representation exercises in speech–language programs, alongside the correction of articulatory mechanics.

The high proportion of nonverbal children or those with extremely limited language raises a critical point: for many children with intellectual disability, traditional verbal stimulation is insufficient and must be supplemented from the earliest stages with augmentative and alternative communication (AAC) systems. Functional communication, rather than speech alone, should become the central objective of intervention.

Finally, the results contribute to filling the gap in updated empirical data on language disorders in children with intellectual disability in Romania and support the need for future research directions, such as longitudinal investigation of language development, comparative evaluation of different speech–language intervention models, and analysis of the role of family and educational environments in communicative progress. Thus, the study opens useful perspectives for informing clinical, educational, and public policy decisions dedicated to children with intellectual disability.

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