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Life habits of school-aged children with specific language impairment as perceived by their parents and by school professionals

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ABSTRACT

Purpose: Describe social participation of a group of children with specific language impairment.
Method: 26 parents of children with specific language impairment (SLI) aged from 5 to 13 years and 11 school professionals participated in the study. Data collection was performed with the adapted version for children aged from 5 to 13 years old of the Assessment of Life Habits (Fougeyrollas et al., 2001). The questionnaire encompasses 196 life habits, grouped in 12 dimensions: nutrition, fitness, personal care, communication, housing, mobility, responsibilities, interpersonal relationships, community life, education, work and recreation (Fougeyrollas, 2010).
Results: According to their parents and school professionals, children in this study carried out without difficulty life habits related to housing and mobility. However, they experienced difficulty with life habits related to interpersonal relationships, recreation and responsibilities, in addition to communication and education.
Conclusions: Children with SLI are perceived by their parents and school professionals as having reduced social participation in many aspects of their daily life. Social participation should be considered as a major outcome when offering services in school to these children. This study proposes specific ways to help children with SLI.

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1. Introduction

Specific language impairment (SLI) is defined as a significant limitation in language abilities, not explained by biological factors, such as hearing loss or brain damage (Leonard, 1998). Children with SLI can have problems with language expression alone or with both expression and comprehension (Reed, 2012). Moreover, working memory and language processing speed can be affected in children with SLI, which can compound their language difficulties (Leonard et al., 2007). The prevalence of SLI is estimated around 7% in the general population (Tomblin et al., 1997). The impact of SLI on children's lives is not well understood. Although some aspects of social participation have been studied and are discussed below, a better understanding of SLI children's participation would allow one to more concretely consider it in therapy as an integral part of desired outcomes. The goal of this study was to address the question of social participation in school-aged children with SLI, considering a diversity of activities, social roles, and life environments.

The present study was based on the Human Development Model-Disability Creation Process (HDM-DCP) which describes the relationships between personal and environmental factors, as well as life habits (Fougeyrollas, Cloutier, Bergeron, Côté, & Saint-Michel, 1998). Within this model, life habits refer to common activities and social roles valued by a person or within his/her social and cultural context, according to personal factors, such as age and gender (Fougeyrollas, 2010). They encompass 12 life dimensions, six of which refer to daily life activities—nutrition, fitness, personal care, communication, housing, and mobility—and six to social roles—responsibilities, interpersonal relationships, community life, education, work, and recreation. Although similar to the International Classification of Functioning, Disability and Health (ICF) model (World Health Organization, 2001), the HDM-DCP more clearly represents the interaction between personal factors and environmental factors as the basis of social participation or handicaps situations (Levasseur, Desrosiers, & Tribble, 2007). Within the ICF, the health status of the individual is central to the analysis one makes about his/her participation which may be less pertinent when considering a developmental disorder such as SLI (Levasseur et al., 2007). The HDM-DCP was also chosen because it is largely used in rehabilitation planning and health services delivery in Québec – the second largest province of Canada with a population of over 8 million. Moreover, a complete and validated questionnaire to evaluate the realization of life habits has been developed for use with children (LIFE-H for children 5–13; Fougeyrollas, Noreau, & Lepage, 2001).

These two models are related to the concept quality of life, which is an important health outcome. In a literature review, Feeney, Desha, Ziviani, and Nicholson (2012) pointed out that children and adolescents with SLI have a lower quality of life than their typical developing peers. The social domain – social roles participation, community engagement, interactions with others, friends/family relationships – was the most impacted but the results were mixed regarding the physical domain – exercise, energy/fatigue, self-care, mobility – and the psychological domain – feelings, cognitive functioning, behaviors, attitudes. The authors pointed out the lack of literature regarding quality of life in children and adolescents with SLI.

The present analysis of literature rests upon the available information about different dimensions of life habits in school-aged children with SLI. A non systematic search was performed with quality of life and the different dimensions of the model as key words. Other key words that were included in the dimensions were also searched in databases (Embase, PsycINFO, and Ovid Medline). For example, for the dimension "communication", we looked for "communication", "functional communication", "communication outcomes", "conversation", "computer communication", and "written communication".

1.1. Interpersonal relationships

The available literature suggests that children and teens with SLI are at greater risk for experiencing relationship issues, more so than typically developing peers. This could be due to the language disorder itself, problems with emotional regulation and/or other factors.

Brinton and Fujiki's team showed a relation between SLI and difficulties in interpersonal relationships (Brinton, Fujiki, Spencer, & Robinson, 1997; Brinton, Fujiki, & Higbee, 1998; Brinton, Fujiki, & McKee, 1998; Fujiki, Brinton, & Todd, 1996; Fujiki, Brinton, Hart, & Fitzgerald, 1999; Fujiki, Brinton, Morgan, & Hart, 1999; Fujiki, Brinton, Isaacson, & Summers, 2001; Fujiki, Brinton, & Clarke, 2002; Hart, Fujiki, Brinton, & Hart, 2004). Children with SLI have more difficulty realizing that the expression of an inappropriate emotion can have an impact on the relationship with others (Brinton, Spackman, Fujiki, & Ricks 2007). According to their teachers, they also experience more difficulty in regulating emotions (Fujiki et al., 2002; Fujiki, Spackman, Brinton, & Hall, 2004) and present more withdrawal behaviors than peers with typical development (Fujiki et al., 2004; Hart et al., 2004). Moreover, they do not seem to improve in regulating their emotions as they grow up (Fujiki et al., 2002). In addition, they show less prosocial and friendly behaviors than their peers without SLI (Hart et al., 2004).

Some authors pointed out that factors such as emotion regulation could explain the difficulties children with SLI experience in relationships (Fujiki et al., 2002, 2004). Karasinski (2015) also suggested that internalizing and externalizing behavioral problems of school-aged children with SLI are not directly associated with language difficulties.

St Clair, Pickles, Durkin, and Conti-Ramsden (2011) suggested that behavioral and emotional difficulties decrease as children with SLI get into their teens but that difficulties in relationships with their peers may increase, becoming a central issue. Brinton, Fujiki, and Baldridge (2010) reported that teenagers with SLI had difficulties in regulating emotions and in establishing relationships as well. Similarly, Durkin and Conti-Ramsden (2007) found that almost all typically developing teenagers had good quality friendships at 16 years of age, while 40% of teenagers with SLI still experienced friendship difficulties at the same age.