



Potential Advantages of Introducing Specific Language Impairment to Families

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Children with language delays¹ can be divided broadly into two groups, those with secondary and those with primary language difficulties. Children with secondary language difficulties have language difficulties that are associated with or predicted by sensory, biological, neurological, cognitive, or socio-emotional deficits (e.g., hearing impairment, Down syndrome, autism). In contrast, children with primary language difficulties present with typical development with the exception of language (and in some cases concomitant speech problems). Over the years, children with primary language difficulties have been referred to in the literature and in clinical practice by a number of terms, including speech/language delay, speech/language disorder, speech/language impairment, childhood aphasia, developmental dysphasia, developmental language disorder, language learning disability, and specific language impairment (SLI). Some of these terms have been used for children with secondary language difficulties as well. There has been much discussion from a professional perspective as to the usefulness of these terms and how these terms should be applied in clinical as well as research practices (e.g., Kamhi, 1991, 1998; Lahey, 1990; Plante, 1998). There has been less discussion as to how these terms influence families' understanding of their children's difficulties. The purpose of this article is to

¹In this article, the terms "language delay" and "language difficulty" are employed as generic terms to describe all children who evidence language deficits as compared to their same-age peers, regardless of the etiology.

advocate for the usefulness, primarily from the perspective of families, of SLI as a diagnostic category.

Specific language impairment or SLI is the most prevalent term used in the research literature over the past decade to describe children with primary language difficulties (cf. Leonard, 1998), yet there does not appear to be widespread clinical use of SLI, as a label or as a diagnostic category (cf. Kamhi, 1998). Our clinical interactions led us to question why there was this disparity between research and clinical practice (cf. Wilcox & Ingram, 1998). In the course of evaluating preschool and early-school-age children with primary language difficulties and developing ongoing clinical relationships with families, we found that most families showed little interest in our efforts to describe their children's language difficulties (cf. Aram, 1991). Consistent with Tomblin's (1991) observations, families were far more interested in knowing why their children were having difficulty learning to talk, what they could do about it (beyond simply taking the child to treatment), and what to expect with regard to long-term outcomes. Time and again, families were perplexed that their children seemed quite normal or typical in many respects, yet had such pronounced language difficulties. For families who had accessed services through local school districts, the IDEA eligibility categories of "developmental delay" and "speech/language impaired" often were confusing. The parents reported that these terms did not help them understand what was wrong with their child.

To adequately address families' concerns, we found it necessary to differentiate clearly between groups of children who might have language disorders. That is, we had to clarify that their children's language difficulties were not attributable to autism, hearing impairment, mental retardation, and so on and to establish that there exists a group of children who are typical in all respects with the exception of language. One parent in particular made us realize how important it was to have a label for her child's condition. This mother returned to the clinic with a child development trade book in hand, opened it to the chapter on special needs, and asked "Which one of these does he have?" She wanted a label because she wanted independently to find out more about her child's difficulties. Further, she needed to share this label with family and friends to help them understand her child. Interestingly, broad-based terms such as language delay or language disorder did not suffice, perhaps because these terms can be (and frequently are) applied to all children with language difficulties. As a result

of our interactions with families, we began to use SLI as a clinical diagnosis, frequently saying, “Your child’s profile is consistent with a condition known as *specific language impairment*.” Our use of the term SLI with families and subsequent sharing of what is known about SLI has convinced us of the clinical utility of this label.² In choosing a label for children with primary language difficulties, it seemed imperative that the label meet two conditions: (a) the label needed to differentiate children with primary language difficulties from secondary language difficulties (i.e., provide a differential diagnosis); and (b) the label needed to assist families in accessing information about their children’s difficulties.

Many professionals avoid using diagnostic labels because of the negative connotations associated with the practice of labeling (Meyen, 1995). However, when used judiciously, we believe labels can be quite helpful to families. And indeed, there are problems with not labeling. We have summarized these advantages and disadvantages in Table 1. For one mother, the SLI diagnosis confirmed that indeed her child was different, as she had long suspected. It also helped her to understand the inordinate effort she and her child put forth to get the child to learn language. Before the SLI label was applied, the mother had questioned whether she viewed her daughter as different because she had inappropriate expectations. We found labeling children’s difficulties as SLI and

engaging in an ongoing discussion of the nature of SLI helped families to understand their children’s difficulties.

We believe the SLI diagnosis and label enables families to access the most relevant information on their child’s condition. It confirms their suspicion that their child is different and validates their concerns. In contrast to using the term “language delay,” for example, SLI differentiates the child with primary language difficulties from children that have language difficulties for other reasons. We see the label as integral to understanding the problem, and with the SLI label comes access to a large body of knowledge about a specific group of children. Resources with other labels such as “developmental language disorder” (ASHA, 1998), and “speech and language disorders” (National Information Center for Children and Youth With Disabilities, 1998) do not clearly differentiate this group of children. The label provides a framework from which the family can view their child’s speech/language difficulties. This framework seems to eliminate the parents’ need to continue searching for what is wrong with their child. Further, the SLI label places the child’s difficulties in the context of other children who are quite similar, helping each family to see that their child is not the only one with this behavioral profile. It also allows a family to pull together some disparate observations about their child. For example, it may help the parents see a relationship between their child’s frequent temper tantrums and his difficulties in verbally communicating his wants and needs. The research on SLI provides parents with a

²When we say “use of the label,” we are referring to the provision of a diagnostic label as well as the accompanying explanation. Without the explanation, the label itself is generally meaningless.

TABLE 1. Advantages and disadvantages of labeling.

Diagnostic Labels	
Advantages	Disadvantages
viewing the child’s difficulties as real problems	accurate diagnoses not always possible; several underlying conditions share outward symptomatology
increased understanding of the child’s symptoms and reasons for current symptoms	difficult with young children to identify the limits of normal development (i.e., no clear lines demarcating normal vs. abnormal development)
accessing course of treatment/intervention that is appropriate to current and possible future needs; particular treatment or goals are consistent with certain diagnoses	ignores individual variability of children
independently accessing information about the child’s condition	diagnostic labels do not lead to a clear or absolute prognosis
understanding the long-term implications of the child’s current symptoms	focus on the label rather than on the individual child’s strengths and needs
identification of children in research	labels change over time as the current state of understanding of a condition improves
	biases to expect less from children
	does not give the child the benefit of the doubt

Adapted from Meyen (1995).

diverse set of possible expectations for their child's course of language development and how communication deficits might influence other areas of functioning (e.g., peer interactions). For families with a positive history of SLI, the SLI label helps place the children's current difficulties in the context of what is known of other family members' language and learning problems. Most importantly, with more information about their children's conditions, parents can take a proactive stance in advocating for their children, because they have some knowledge of what the future may hold. A family can then plan with professionals an appropriate intervention program that meets the child's needs, including needs that are evident today and needs that may become more evident in the days ahead.

Some readers might question whether a term other than SLI might be just as useful. The specific utility of the term "SLI" is that it is the term used by scholars in the field. Therefore, familiarity with the term "SLI" enables families to access information. In the course of writing this article, we accessed several online listservs and found many parents looking for information regarding their children's language difficulties. Interestingly, many parents reported that their children had been diagnosed with "developmental dysphasia," yet they had been unable to find any information on the condition. We then did a quick search on Medline and PsycINFO using the terms "language delay," "SLI," and "developmental dysphasia." Specific language impairment or SLI was the only term that led to numerous references and references that were exclusive to children with primary language difficulties. Further, SLI yielded references across professional fields, including speech-language pathology, neurology, linguistics, and developmental psychology. As another illustration, in his recent book, *Late Talking Children*, Sowell (1997) noted an inability to find information on children with primary language difficulties, concluding that there is no research on these children. It seems that his difficulty finding this information may have been in not knowing the right words to use. A search using the term "specific language impairment" would have led him to a number of appropriate resources.

In summary, our clinical interactions with families have led us to believe that what we call children with language deficits and how we characterize those deficits for families makes a lot of difference. Further, it is essential that we differentiate the practice of making a diagnosis from the subsequent determination of eligibility for services (see Ehren, 1993). Terminology may differ across these tasks. In this article, we

argue that parents of children with primary language impairments benefit greatly from having their child's difficulties labeled SLI. Best practice and recent legislation compel us to empower families to be primary decision makers and participants in the assessment and intervention process (Dunst, Trivette, & Deal, 1988). Parental knowledge is essential to reaching this goal (Gowen, Christy, & Sparling, 1993).

In the following discussion, we first provide a brief summary of SLI for those readers less familiar with the term. Next, given that many speech-language pathologists may not use SLI as a clinical diagnosis or category, we address several issues of concern regarding the use of SLI in clinical practice. Finally, we describe how the clinical category of SLI might be shared with families. Our focus is on families and the impact the SLI classification may have on their views. (For a contrasting discussion of the usefulness of the SLI classification for clinicians, see Kamhi, 1998.)

Defining Specific Language Impairment

Specific language impairment refers to a clinical population of children for whom language difficulty is the primary impairment; that is, children with SLI present with language deficits in the face of otherwise typical development (see Leonard, 1998, and Watkins & Rice, 1994, for reviews; see Appendix for an outline of this literature). Stark and Tallal (1981) suggested that children with SLI are those with substantial language limitations who meet several exclusionary criteria: no hearing loss, no significant social or emotional deficits, no frank neurological deficits, no sensory or oral motor deficits, and cognition within normal limits. For research purposes, substantial language limitations typically are operationalized as norm-referenced standard scores one or more standard deviations below the mean or age equivalent scores one year or more below age expectations (e.g., Stark & Tallal, 1981; Tomblin, Records, & Zhang, 1996). Additional descriptive criteria may also be obtained from language sampling (e.g., Rice, Buhr, & Oetting, 1992). Children with SLI are a heterogeneous group, demonstrating problems in receptive and/or expressive modalities as well as different profiles of weakness in syntax, morphology, semantics, and/or pragmatics. It is estimated that 60% of children with SLI present with concomitant speech deficits (e.g., Tallal, Ross, & Curtiss, 1989). Children with SLI are usually late to acquire their first words and word combinations, and as

preschoolers demonstrate pronounced difficulty with the acquisition of grammatical morphology and sentence structure. In some cases, standardized language measures may be insufficient to identify some children with SLI (Schuele, 1998), making an examination of functional language performance essential.

Children with SLI typically are identified in preschool or when they enter elementary school. Longitudinal outcome studies convincingly demonstrate that many children who continue to demonstrate oral language problems throughout the preschool years do not “outgrow” this condition. Language problems will not resolve for 50% to 70% of the preschool children identified with SLI, depending on the age of identification (e.g., Bishop & Edmundson, 1987; Tallal, Curtiss, & Kaplan, 1989). This is in contrast to the fair number of toddlers with early expressive-only language delays, perhaps 50% or more, who catch up to their peers between the ages of 3 and 5 (e.g., Paul, 1996, but see also van Kleeck, Gillam, & Davis, 1997). Importantly, for those children whose language problems persist, early communication difficulties are associated with continued peer interaction difficulties in grade school (e.g., Brinton, Fujiki, & McKee, 1998; Brinton, Fujiki, Spencer, & Robinson, 1997; Craig & Washington, 1993) and academic difficulties, particularly in reading and writing (e.g., Catts, 1993; Magnusson & Naucler, 1990; Menyuk et al., 1991; Stothard, Snowling, Bishop, Chipchase, & Kaplan, 1998; Tallal, Curtiss, & Kaplan, 1989). In many cases, academic problems may lead to a school reclassification of the difficulties as a learning disability without overt acknowledgment of the relationship between oral and written language disorders (Padgett, 1988; Snyder, 1984). Persistent communication difficulties may also present lifelong challenges in future social and vocational settings (e.g., Aram, Ekelman, & Nation, 1984; Bashir & Scavuzzo, 1992; Cordon, 1990; Johnson & Blalock, 1987; but also see Records, Tomblin, & Freese, 1992).

Introducing Specific Language Impairment: A Clinical Conundrum

Telling a family that their child’s language profile is consistent with a diagnosis of specific language impairment may require a change in clinical practice for many speech-language pathologists. Kamhi (1998) recently argued that clinicians are unlikely to use SLI as a diagnostic label because children receive services regardless of its use (see Ehren, 1993 for a discussion of eligibility versus diagnosis). Although we agree that there may be little

professional benefit from use of the SLI label, it is our impression that families benefit from an introduction to this diagnostic term.

In deciding whether the clinical diagnosis of SLI will benefit children and families, it is likely that individual clinicians will find themselves reflecting on several issues. Our discussion highlights four issues that clinicians may contemplate, in addition to the concerns with labeling discussed previously. These include knowledge of SLI, a focus on etiology, social biases about the relation between language and cognition, and the presentation of optimistic versus realistic views. By raising these issues, we hope to foster a discussion that goes beyond the usefulness of the SLI label for determining service eligibility to one that considers our role as parent educators and advocates, and, in turn, encourages clinicians to consider the way in which they present information about primary language impairments to families.

Knowledge of SLI

The first issue addresses the need for speech-language pathologists to have some knowledge of the research literature regarding SLI (see Leonard, 1998) as well as a tolerance for ambiguity when considering a diagnosis of SLI. As Tomblin et al. (1996) noted, there is no gold standard with respect to language performance in the diagnosis of SLI. There are no absolutes as to psychometric criteria or specific descriptive criteria children must meet, although both are recommended for purposes of establishing eligibility for services (Language Learning Disabilities Committee, 1989). Unfortunately, despite general conceptual agreement between researchers and clinicians as to what constitutes SLI, congruity between clinical judgment and measurement tools is lacking somewhat (Aram, Morris, & Hall, 1993; Cole, Mills, & Kelley, 1994). Given the differing goals of research and intervention, this incongruity is not surprising. Research definitions of SLI are rather narrow, and it is likely that a clinical application of SLI may encompass a more broadly defined group of children (cf. Kamhi, 1998). In the end, clinical practice in childhood language impairments requires sound clinical judgment that relies on the speech-language pathologists’ understanding of diagnostic schemes and criteria (Fey, 1986) as well as the speech-language pathologist’s willingness to integrate prior clinical experiences with the empirical literature and to apply relevant research findings to everyday practice-embedded problems (Wilcox, Hadley, & Bacon, 1998). Ultimately, the determination as to whether a child has SLI and will have long-term

difficulties must be viewed from a probabilistic perspective. At present, prediction is far from perfect, but parents are not unfamiliar with risk models. We all encounter probabilistic risks daily. Further, as is true with all research-based clinical practice, as researchers continue to explore, define, and redefine the underlying nature of SLI, application of SLI as a category or diagnosis in clinical practice will likewise be redefined by clinicians.

Emphasis on Causality

Second, speech-language pathologists may shy away from using SLI as a clinical category because it focuses too much on causality or etiology. For many speech-language pathologists, a focus on etiology is not consistent with the models espoused in our graduate education. For many of us, our clinical and academic training suggested that it was far more productive to describe a child's current level of language functioning to identify appropriate language targets for intervention than to be concerned with *why* the child had a communication deficit (Bloom & Lahey, 1978; Lahey, 1990). Certainly, careful description of a child's linguistic system is crucial to understanding the child's linguistic vulnerabilities and planning appropriate intervention. However, despite our focus on description, parents continue to ask *why* (Aram, 1991; Tomblin, 1991). In the absence of any explanation for difficulties, families may seek out unnecessary additional evaluations to find out what is really wrong with their children (cf. parent reports described in Sowell, 1997). This search may result in less appropriate explanations for the children's difficulties, such as attention deficit disorder (ADD or ADHD) or conditions such as central auditory processing disorders (CAPD) that are less well understood than SLI.

Although we may not have complete, definitive answers for parents, our clinical experiences suggest that by providing at least a preliminary answer to the "why" questions, families are better able to cease blaming themselves for their children's language difficulties and to recognize the potential need for viewing the language difficulties from a lifespan perspective. For example, a family's understanding of a child's language difficulties can be enhanced by understanding the likely organic and familial basis of the child's difficulty learning to talk (e.g., Rice, 1996). Regardless of the different theoretical viewpoints held by researchers in the field, there is general consensus that the problem resides in the psychological mechanisms used for learning language, not in the environmental

input (cf. Leonard, 1989). Thus, the clinical application of the SLI label implies that indeed something is wrong with the child's language-learning abilities. The acknowledgment of an organic basis to the problem lessens the possibility that the child's difficulties are attributable to the environment or motivation (e.g., he doesn't want to talk). Similarly, parents begin to understand the implications that follow for long-term intervention planning. If the problem is of an organic nature, they come to acknowledge that the goal of intervention may be most properly focused on minimizing the language disability rather than on ameliorating or "fixing" the problem. Importantly, we have found that the diagnosis of SLI helps families come to understand that their children may simply learn language somewhat differently than other children. For example, they may need greater quantities of input, highlighted targets, additional practice, and feedback compared to the typical language learner.

Social Biases

Third, the SLI label helps families as well as professionals consider their social biases about human development (Rice, Hadley, & Alexander, 1993). It typically is assumed that language and cognitive skills are closely linked, and this social bias often is confirmed by the people we meet. So, when parents as well as professionals encounter a child with average to above average intelligence who is having extraordinary difficulty learning to talk, cognitive dissonance may result for parents as well as professionals. Sowell (1997) reported that many parents struggle with the perceived incongruity between their children's intellect and language skills. How many parents have each of us encountered who make the point at least a half dozen times in the course of an evaluation that "He doesn't talk but he's really smart" with ensuing descriptions of their child's non-language strengths? In the end, this cognitive dissonance may lead to a belief that time alone will assure that the child will catch up because "there really isn't anything wrong." Unfortunately, for many children this is not the case. However, information about the SLI condition can help families view language abilities as distinct from performance on other nonlinguistic tasks (Rice, 1983; Rice & Kemper, 1984) and lead to the understanding that indeed one can have a nonverbal IQ within or above the normal range yet have substantial language deficits (Schuele, 1998). Some researchers (e.g., Johnston, 1994; Kamhi, 1996, 1998) argue that children with SLI have

subtle cognitive deficits; however, for families, what appears most salient is the lack of obvious intellectual impairment as an explanation for the child's language difficulties.

Expectations for Growing Out of the Problem

The final issue to consider is that professional optimism may lead speech-language pathologists to characterize primary language impairments as a speech/language problem or delay, implying that with time, and perhaps some intervention, the child's language abilities will catch up to his or her peers. Certainly, we really do not know what the outcome for any individual child will be, and thus, perhaps an optimistic or at least a neutral view gives the child the benefit of the doubt. Perhaps speech-language pathologists believe that parents want optimism, not the worst-case scenario. For some families, overreliance on an optimistic viewpoint may lull parents into a false sense of security, leading them to believe that there is little real cause for concern. When children continue to have difficulties, parents become frustrated and often blame themselves for not doing more sooner. For other families, the optimistic viewpoint is inconsistent with their parental intuitions. They don't believe that their children have a language delay, if this means that the problem is isolated, transient, easily resolved, not really a disability, or nothing to worry about. What families seem to want is a realistic view of early language impairments that enables them to be informed consumers and advocates for their children and their needs. A realistic view would first inform families of the natural history of oral language impairments. It then would tell what is known from group outcome studies of late talkers and preschool children with SLI (Bishop & Edmundsen, 1987; Paul, 1996; Rescorla, Roberts, & Dahlsgaard, 1997; Stothard et al., 1998; Tallal, Curtiss, & Kaplan, 1989; Thal & Katich, 1996). Providing parents with information also would characterize the enormous variability regarding the outcomes of *individual* children with SLI. Understandably, one might argue that until we have a better understanding of SLI, we should refrain from sharing partial information with families (cf. Kamhi, 1991, 1998). However, there are virtually no clinical conditions that are fully understood, yet professionals across the health fields routinely engage in diagnosis and labeling, realizing that as the state of knowledge evolves, so does the diagnostic process. The existing research on SLI provides much information that can be shared with families now, whether or not researchers fully understand the nature of the condition.

Parent Education: What Do We Tell Parents?

We find in our clinical interactions that many parents come to the diagnostic process with substantial concerns about what communication difficulties mean for their children's future. They ask, "Will my child's speech ever sound okay? Will my child's peers ostracize, reject, or taunt him or her? Should my child go to kindergarten next year? Will my child have to be in special education in school? Will my child have difficulty learning to read? What will my child be like when he grows up?" Before any professional diagnosis of a speech/language difficulty, parents have worried about the subsequent consequences of their child's communication difficulties. Although their children may only be in preschool or kindergarten, the families have thought carefully about the difficulties their children may encounter years from now; that is, they have adopted a lifelong disability perspective.

It is important for us to recognize that many families come to us with far more implicit knowledge of SLI than we perhaps think. Even if families do not have a label for the condition, they frequently have seen other family members cope with the communication difficulties that they suspect their children now have. Indeed, family studies (Tallal, Ross, & Curtiss, 1989; Tomblin, 1989) suggest that half to three-quarters of children with SLI have at least one other family member with similar problems. Thus, families of children with SLI are likely to have more first-hand experience regarding the way in which these communication difficulties manifest themselves over time than do speech-language pathologists who may rely more on the professional literature for this insight. Perhaps half of the families we encounter know of the lifelong challenges that primary language difficulties can present.

If we choose to use SLI as a clinical classification, we must then consider what information we will share with families and how best to share that information. To date, we know of no resources on SLI that have been written specifically for families, and it is truly unfortunate that scholarly discussions on SLI (e.g., Leonard, 1998) do not have a parallel form for nonprofessionals. Interestingly, in two recently published books for parents on speech/language impairments, SLI is not even mentioned (Hamaguchi, 1995; Martin, 1997). Sowell's (1997) book, *Late Talking Children*, written by a parent for parents, also misses the available literature on SLI.

In our clinical interactions, the SLI condition frequently is introduced at the point of initial

contact with a family (i.e., the diagnostic evaluation) if we believe the child's profile to be consistent with SLI. For families of very young children, this label is explained alongside the term "late talker," helping them to see that their children may indeed turn out to be what Thal and her colleagues (e.g., Thal, Tobias, & Morrison, 1991) have called "late bloomers." Clearly, families can easily be overwhelmed by the onslaught of information at a diagnostic evaluation; therefore, we share the information described below and in the Appendix as part of an ongoing process that unfolds over time. A brief overview of SLI might be appropriate at first, and then as the clinical relationship with the family evolves, more detailed information can be provided. More specific information is often shared in response to concerns parents or teachers raise during the course of intervention. For example, information on peer interactions can be shared when families relate the preschool teacher's concerns that the child is not getting along with other children.

In this final section, we turn to an overview of what information we share with parents (cf. Apel & Masterson, 1997; Masterson & Apel, 1997). We have found the information identified below to be helpful to families. This information is organized around four major themes. Additional information and references of interest to professionals and parents are detailed in the Appendix.

1. Introduce the family to the term SLI; describe the child's characteristics that are consistent with a diagnosis of SLI.

In this article, we have suggested that families may benefit from the use of SLI as a clinical category when their children's language profiles are consistent with this diagnosis. When introducing this condition to parents, it is important to help parents understand the distinction between a primary language disorder and language disorders that are secondary to some other developmental condition (e.g., mental retardation, hearing impairment). This will entail providing an explanation of SLI that includes a definition, a description of the language characteristics of SLI, and a summary of the research on children with SLI. In addition, speech-language pathologists might make explicit the assumption underlying the term *delay* in contrast to the term *SLI*. It is also likely that speech-language pathologists will find themselves discussing differences between language and cognition, particularly when helping parents understand why their child may show marked discrepancies on tests of language in comparison to intellectual ability.

Unfortunately, for parents interested in reading materials, resources are limited. Leonard (1998) is a technical professional resource, but some parents may find parts useful. Wang and Bacon (1997) provide a brief explanation (p. 283–284). Dollaghan (1998) provides a clear and concise case study illustration of the diagnosis of SLI. Finally, Rice (1995) provides an overview of SLI that is generally understandable by a lay person but also provides considerable details for those readers more familiar with the topic. Sowell (1997) is written from a lay perspective but it provides no direct discussion of SLI and implies that time alone will resolve children's language difficulties.

2. Discuss the set of possible outcomes for the child, as well as the interface between language abilities, literacy, and peer interactions.

When a family is presented with alternative developmental outcomes, they have a more accurate picture of what the future may hold and can consider SLI from a lifelong disability perspective. They know that there is a possibility that their child indeed will catch up, yet at the same time, they know not to bank on this possibility. We are aware of the argument of a self-fulfilling prophesy. Obviously, we have to balance the costs and benefits of taking a realistic perspective, and we would argue that the benefits outweigh the costs.

Presenting a realistic perspective to parents also makes enormous sense for families with a positive history of speech/language difficulties. In fact, we believe this approach resonates with the life experiences and the concerns many families bring to us. That is, families have specific concerns about their children's current speech/language difficulties, but they are equally, if not more, concerned with the challenges their children may encounter in future social, academic, and vocational situations. Thus, it is important for speech-language pathologists to recognize these concerns about the future, and in turn, to help parents select and set priorities for intervention goals that will address their children's long-term needs. By doing so, it is likely that the services provided will be more compatible with families' perceived needs and expectations. However, to achieve meaningful and relevant outcomes, speech-language pathologists and parents will need to recognize that language abilities are central to, and intricately intertwined with, the development of social competence and academic success (Fey, Catts, & Larrivee, 1995; Gallagher, 1991; Wallach & Butler, 1994; Wallach & Miller, 1988).

3. Help parents to adopt a proactive stance by considering long-term intervention planning

that will minimize disability and handicap.

The distinction made between impairment, disability, and handicap by the World Health Organization (Wood, 1980) can be helpful when introducing SLI within a lifelong perspective. Impairment refers to the abnormality in the structure or functioning of the physical, physiological, or psychological mechanisms. For parents of children with Down syndrome or hearing impairments, chromosomal abnormalities or specific problems with the functioning of the hearing mechanism may be unambiguously identified. In contrast, for parents of children with SLI, identification of the impairment can be more elusive; we know little of the neurological or other causative mechanisms that may underlie SLI (Plante, 1996). The focus of most behavioral interventions is not on “fixing” the impairments; these are recognized as lifelong, persistent conditions. Rather, we can help parents to more appropriately conceptualize our intervention efforts as minimizing the child’s disability (cf. Nelson, 1993; Olswang & Bain, 1991).

Disability, defined as reduced ability to participate in activities of daily living, is a function of impairment but is influenced also by the child’s skills in non-language areas as well as factors outside of the child (e.g., family support, learning environments). In the World Health Organization framework, activities of daily living for the child might include conversations with peers or adults, academic performance, sports, scouting, and so on. To minimize the disability, intervention might teach the child new language skills, help the child develop compensatory strategies to accommodate language deficiencies, and modify the environment to make the child’s limited language ability less of an issue. Modifications might include additional support to help the child succeed or reduced expectations regarding the child’s performance. Intervention may focus on minimizing current disabilities as well as anticipated disabilities. For example, phonological awareness training before first grade would seek to minimize the child’s potential difficulties in learning to read.

Intervention efforts also may be targeted at minimizing a child’s handicap. The World Health Organization defines handicap as the social disadvantage that results from impairment or disability, often reflected in negative societal attitudes or judgments. Parents often provide personal anecdotes about situations in which their children were devalued by peers’ negative comments or teachers’ thoughtless remarks. For example, a kindergartner, although chosen by his classmates for the lead

role in a class play, was told by the teacher, “You can’t be the lead in the play. No one will understand you.” In these instances, education on the nature of SLI may lead to a lessening of social disvalue.

Our direct intervention efforts are aimed at minimizing disability; in other words, increasing the child’s ability to meet the demands of daily communication and language-related tasks (e.g., conversation, reading, writing). Our efforts to educate parents, teachers, other professionals, and even peers are directed additionally towards reducing handicap or the existing social biases individuals with SLI encounter in their interactions with others. Intervention considers the child’s needs today and anticipates the child’s future needs.

4. Consider alternative activities in other areas (sports, art, etc.) that can help to promote the child’s self-esteem.

Because in our society verbal prowess is highly valued, children who lack verbal skill may come to view themselves as less smart and less valuable than their classmates. Parents and clinicians can help children with SLI to see their differences within an appropriate perspective. For example, one might explain in understandable terms that talking is difficult for the child; with time it will get easier, but talking may always be something that is more difficult for this child than other children. Similarly, one may also help the child to appreciate his or her strengths in less linguistically oriented school subjects (e.g., mathematics). Outside of school, parents can assist the child in achieving success in activities that require minimal language participation (Cordoni, 1990). We know a child with SLI who has chosen to excel in sewing. Other children may excel in individualized sports such as swimming or horseback riding or team sports such as baseball that rely less on verbal interactions. For a child, knowing that language is harder for him or her than for other children, while simultaneously recognizing he or she is talented in other areas, may help foster self-esteem.

Conclusion

In sum, we have taken the position that speech-language pathologists should provide parents with a realistic view of the future when their preschooler presents with speech/language impairments in the face of otherwise typical development. A realistic view, in our opinion, provides parents with a label for their child’s slow speech and language development and arms parents with information about this condition. Well-informed parents are empowered

parents, who are then better able to meet their child's current needs and plan for their child's needs in the future.

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Appendix

Specific Language Impairment: Characteristics and Potential Consequences

I. Developmental Language Disorders (Nelson, 1993)

- A. Language disorders secondary to another primary condition (e.g., mental retardation, autism, hearing impairment, brain injury)
- B. Language disorders as the primary disability (e.g., specific language impairment, language-learning disabilities)

II. Specific Language Impairment (SLI; cf. Kamhi, 1991; Watkins & Rice, 1994; Leonard, 1998)

- A. Definition: Extreme difficulty with the acquisition and use of language in the absence of frank neurological problems (e.g., seizure disorders, acquired lesions), mental retardation or general cognitive deficits, hearing impairments, social-emotional impairment (e.g., schizophrenia, autism), motor/neuromotor impairment
- B. Conceptual issues central to understanding SLI
 1. Differentiation of language and cognition (Rice, 1983; Rice & Kemper, 1984)
 2. Differentiation of various facets of intelligence or cognition (Gardner, 1983)
- C. Language characteristics of children with SLI
 1. First words are late to appear; may not appear until 18 to 24 months or later.
 2. Word combinations are late to appear; may not appear until 24 to 30 months or later.
 3. Speech intelligibility may be poor; parents may not understand much of what child says at age 3.
 4. Pronounced difficulty in the acquisition and use of grammatical morphology during the preschool and early school-age years is a characteristic of most children with SLI.
 5. Some children with SLI, but not all, may also show considerable difficulty with conversational regulation and topic maintenance skills.
 6. Utterance formulation problems may appear during the early school-age years, with more difficulty producing coherent and cohesive narratives, descriptions, and explanations.
 7. Lexical limitations and word finding problems may also be observed.

III. Incidence/Prevalence of SLI

- A. Based on a recent epidemiological investigation conducted in the United States, approximately 8% of kindergarten children may be characterized as having SLI (NIDCD, 1991; Tomblin, Records, & Zhang, 1996).
- B. 50% to 70% of children with SLI have at least one other affected family member (Tallal, Ross, & Curtiss, 1989; Tomblin, 1989).

IV. The Natural History of Language Impairments/SLI

- A. Later language problems (cf. Bashir & Scavuzzo, 1992; Bashir & Strominger, 1996; Stothard et al., 1998)
 1. 50% to 80% continue to show later language problems mentioned in II.C.
 2. Language impairments manifest themselves in different ways over time.
- B. Academic consequences
 1. 40% to 75% of these children demonstrate problems learning to read (e.g., Catts, 1993; Magnusson & Naucler, 1990; Menyuk et al., 1991).
 2. 50% to 75% have academic difficulties as reflected by later educational placements (Catts, 1990; Rissman, Curtiss, & Tallal, 1990; Sergeant, 1995).
 3. Well into adulthood, writing is an area of continued difficulty for the majority of children with language-learning disabilities (Johnson, 1987; Scott, 1989).
- C. Social consequences (cf. Windsor, 1995)
 1. Preschool children with SLI have more difficulty interacting with peers in integrated settings than do typical children (cf. Hadley & Schuele, 1995).
 2. Language abilities are important for the formation of friendships throughout the preschool and school-age years (Gallagher, 1993; Gertner, Rice, & Hadley, 1994).
 3. Children with SLI may be judged by teachers and other adults as less socially mature and less intelligent than their typical peers (Rice et al., 1993).
 4. School-age children with SLI may often experience difficulty in their attempts to access peer groups and resolve conflicts (Brinton et al., 1997; Brinton et al., 1998; Craig & Washington, 1993; Stevens & Bliss, 1995).