CHILDREN WITH SPEECH AND LANGUAGE DISORDERS

Dr. Norman Kiogora

International Academic Journal of Arts and Humanities (IAJAH) | ISSN 2520-4688

Received: 20th October 2021

Published: 27th October 2021

Full Length Research

Available Online at: https://iajournals.org/articles/iajah_v1_i2_360_376.pdf

Citation: Kiogora, N. (2021). Children with speech and language disorders. *International Academic Journal of Arts and Humanities, 1*(2), 360-376.

ABSTRACT

Teachers, parents and the society play a major role in supporting children's education, social, and emotional development although they may be unprepared for supporting children with speech and language disorders. Interviews with 157 participants which included parents and teachers in their lives highlighted challenges for these children in school, and challenges for their parents and teachers in meeting these children's developmental and educational needs. These challenges were centered on the need for specific expertise in the school setting, and access to additional classroom and professional services to support these students' engagement in the learning and social environments of school. This research identifies frustrations that impact these families and teachers as they attempt to navigate the bureaucracies to which they are beholden.

Key Words: **Disability, speech disorders, articulation of sounds, special needs, special schools**

INTRODUCTION

Education provided to learners with special needs requiring modified curriculum delivery, methods, education resources, mode of communication as well as modified learning environment to carter for individual differences among these learners (Republic of Kenya, 2009). Children with special needs and disabilities have a right to free and compulsory education as provided for in international conventions to which Kenya is a signatory. However, not all children with disabilities have been fully integrated in the education system in Kenya (Republic of Kenya, 2014).

Providing education for children with special needs is therefore one way of ensuring that their right to basic education is protected. This will in turn promote national development by providing a secure environment that enhances good health to allow people with special needs participate in social and political activities (Republic of Kenya, 2009a). However, without special measures put in place to support these children, their right to basic education may not be realized to facilitate their full potential. Mwoma and Pillay (2015) in their study focusing on orphans and vulnerable children in public primary schools in Soweto South Africa noted that children from disadvantaged background encountered various challenges related to psychosocial support due to lack of trained personnel who could understand them. According to them, without proper attention to these children, their right to compulsory basic education will be affected.

Speech and Language Disorders in Children

Children are born ready to learn a language, but they need to learn the language or languages that their family and environment use. Learning a language takes time, and children vary in how quickly they master milestones in language and speech development. Typically developing children may have trouble with some sounds, words, and sentences while they are learning. However, most children can use language easily around 5 years of age.

Speech and language disorders refer to problems in communication and related areas such as oral motor function. These delays and disorders range from simple sound substitutions to the inability to understand or use language or use the oral-motor mechanism for functional speech and feeding. Some causes of speech and language disorders include hearing loss, neurological disorders, brain injury, mental retardation, drug abuse, physical impairments such as cleft lip or palate, and vocal abuse or misuse. Frequently, however, the cause is unknown.

One quarter of the students served in the public schools' special education programs (almost 1 million children in the 1993-94 school year) were categorized as having a speech or language impairment. This estimate does not include children who have speech/language problems secondary to other conditions such as deafness. Language disorders may be related to other disabilities such as mental retardation, autism or cerebral palsy. It is estimated that communication disorders (including speech, language and hearing disorders) affect one of every 10 people in the United States.

A child's communication is considered delayed when the child is noticeably behind his or her peers in the acquisition of speech and/or language skills. Sometimes a child will have greater receptive (understanding) than expressive (speaking) language skills, but this is not always the case. Speech disorders refer to difficulties producing speech and language disorders or problems with voice quality. They might be characterized by an interruption in the flow or rhythm of speech, such as stuttering, which is called dysfluency. Speech disorders may be problems with the way sounds are formed, called articulation or phonological disorders, or they may be difficulties with the pitch, volume or quality of the voice. There may be a combination of several problems. People with speech disorders have trouble using some speech and language disorders, which can also be a symptom of a delay. They may say "see" when they mean "ski" or they may have trouble using other sounds like "l" or "r". Listeners may have trouble understanding what someone with a speech disorder is trying to say. People with voice disorders may have trouble with the way their voices sound.

A language disorder is an impairment in the ability to understand and/or use words in context, both verbally and nonverbally. Some characteristics of language disorders include improper use of words and their meanings, inability to express ideas, inappropriate grammatical patterns, reduced vocabulary and inability to follow directions. One or a combination of these characteristics may occur in children who are affected by language learning disabilities or

developmental language delay. Children may hear or see a word but not be able to understand its meaning. They may have trouble getting others to understand what they are trying to communicate.

There are three main types of language disorder:

Expressive language disorder: People have trouble getting their message across when they talk. They often struggle to put words together into sentences that make sense.

Receptive language disorder: People struggle to get the meaning of what others are saying. Because of this, they often respond in ways that don't make sense.

Mixed receptive-expressive language issues: Some people struggle with both using and understanding language.

The first thing to do when diagnosing a speech disorder is rule out hearing issues that could have an impact on language. But the only way to diagnose language disorders is through an evaluation. The specialists who do these evaluations are called speech-language pathologists. Schools provide evaluations for free. (Very young kids can get free evaluations through their state's early intervention system) Adults need to do them privately.

A diagnosis is the first step toward getting help. Adults may be able to get support at work. And kids may get free speech-language therapy at school. The earlier treatment begins, the better.

Gaps and challenges facing education for children with special needs

Although progress has been made by government and other players to provide educational services for persons with disabilities and special needs, various challenges have been experienced while supporting these individuals. The challenges include; inappropriate infrastructure; inadequate facilities; and inadequate capacity of teachers to manage learners with special educational needs in regular schools. Other challenges include; inadequate and inexpensive learning materials; societal negative attitude; and inadequate supervision and monitoring of schools implementing inclusive education (Ruteere et al, 2015; Republic of Kenya, 2009a). Mwoma and Pillay (2016) in their study among orphans and vulnerable children in Soweto South Africa noted similar circumstances where learners in full service schools experienced inadequate supervision in implementing inclusive education.

Effective special education service delivery is also hampered by absence of reliable data on children with special needs across all levels of education coupled with inadequate funding (Republic of Kenya, 2013b). Absence of operational guidelines for implementation of the special needs education policy; unreliable and inaccurate data on SNE initiatives across all levels of education; negative attitudes and beliefs with regard to causes and consequences of special needs and disabilities in many communities leading to stigma and discrimination. There is also inadequate skilled and specialized staff for assessment, placement and management of children with disabilities; inadequate funding of the sub-sector, capitation grants are insufficient to address the needs of children with disabilities; limited funding for

environmental adaptation; and inappropriate communication modes (Republic of Kenya, 2014 p.51).

Socio-cultural and economic prejudices, stigmatization and neglect have also been cited as challenges experienced by people with disabilities (Oriedo, 2003; Ngaruiya, 2002). High teacher child ratio make individualized instruction for learners with disabilities difficult (Muchiri & Robertson, 2000; Kemble-Sure, 2003). School buildings not being accessible to physically handicapped children are other challenges that require attention to enhance easy mobility of physically handicapped children (Gichura, 1999; Kochung, 2003; Mukuria & Korir, 2006). Lack of policy guidelines on identifying and placing children who are gifted and talented is another challenge. Children who could be talented and gifted but are not able to continue studying until they sit for their national examinations may go unnoticed by organizations and institutions supporting these groups of children. In the event that these challenges are not adequately attended to, then children with special needs and disabilities will continue to be marginalized.

Language disorders can have many possible causes. A child's language disorder is often linked to a health problem or disability such as:

- A brain disorder such as autism
- A brain injury or a brain tumor
- Birth defects such as Down syndrome, fragile X syndrome, or cerebral palsy
- Problems in pregnancy or birth, such as poor nutrition, fetal alcohol syndrome, early (premature) birth, or low birth weight

Sometimes language disorders have a family history. In many cases, the cause is not known. It's important to know that learning more than one language does not cause language disorders in children. But a child with language disorder will have the same problems in all languages.

LITERATURE REVIEW

Autism

Autism spectrum disorder (ASD) is a broad term used to describe a group of neurodevelopmental disorders. These disorders are characterized by problems with communication and social interaction. People with ASD often demonstrate restricted, repetitive, and stereotyped interests or patterns of behavior. ASD is found in individuals around the world, regardless of race, culture, or economic background. According to the Centers for Disease Control and Prevention (CDC) Trusted Source, autism does occur more often in boys than in girls, with a 4 to 1 male-to-female ratio. The CDC estimated in 2014 that nearly 1 in 59 children have been identified with ASD. There are indications that instances of ASD are on the rise. Some attribute this increase to environmental factors. However, experts debate whether there's an actual increase in cases or just more frequent diagnoses. Compare autism rates in different states throughout the country.

Types of Autism

The DSM (Diagnostic and Statistical Manual of Mental Disorders) is published by the American Psychiatric Association (APA) and is used by clinicians to diagnose a variety of psychiatric disorders. The fifth and most recent edition of the DSM was released in 2013. The DSM-5 currently recognizes five different ASD subtypes, or specifies. They are:

- with or without accompanying intellectual impairment
- with or without accompanying language impairment
- associated with a known medical or genetic condition or environmental factor
- associated with another neurodevelopmental, mental, or behavioral disorder
- with catatonia

Someone can be diagnosed with one or more specifiers.

Prior to the DSM-5, people on the autism spectrum may have been diagnosed with one of the following disorders:

- autistic disorder
- Asperger's syndrome
- pervasive development disorder-not otherwise specified (PDD-NOS)
- childhood disintegrative disorder

It's important to note that a person who received one of these earlier diagnoses hasn't lost their diagnosis and won't need to be reevaluated. According to the DSM-5, the broader diagnosis of ASD encompasses disorders such as Asperger's syndrome.

Language disorders

Due to the fact that virtually all children with autism show severe language impairments, many researchers have studied language disorders in autism (Rutter, 1978d). When Kanner (1943) first wrote about the 11 children with autism seen at his clinic, he described the various language abnormalities he had observed. Later, in 1946, when he had seen 23 children with autism, he wrote "the peculiarities of language present an important and promising basis for investigation." Later research has confirmed that all children with autism show a retarded development of spoken language (either delayed or by regression); about half do not acquire speech; and of those who do acquire speech, over 75% show abnormal speech features, such as echolalia or pronominal reversal (Baltaxe & Simmons, 1981; DeMyer et al., 1974; DeMyer, Hingtgen & Jackson, 1981; Kanner, 1943; Ornitz, 1973; Rutter, 1965, 1970, 1977; Rutter & Lockyer, 1967; Wing, 1971). Only about 30% of those who are able to speak develop somewhat useful language (DeMyer et al., 1981).

Learning how to communicate with others is a process that begins during infancy. Communicative behaviors are learned from the social environment and become increasingly efficient, sophisticated, and conventional over time (Alpert & Rogers-Warren, 1985). Communicative competence is built upon the acquisition of several prerequisite skills,

including being able to: (1) attend to and interact with the physical environment; (2) actively participate in social interactions with other individuals; and (3) understand and use expression forms (Fay & Schuler, 1980; McLean & Snyder-McLean, 1978). Different types of prerequisite skills may be involved in the development of the various components of the communication system. The components that deal with form (i.e., syntax, phonology, and morphology) are believed to involve the prerequisite skills of auditory discrimination and imitative ability. In comparison, the semantic and pragmatic components are believed to involve the prerequisite skills of being able to attend to the physical environment and to participate in social interactions (Blank, Gessner & Esposito, 1979; Curtiss, 1981). The components of semantics and pragmatics are particularly impoverished in 24 individuals with autism compared to the syntax and phonology components (Tager-Fulsberg, 1981).

Language skills may be divided according to whether they measure expressive (language use) or receptive (language understanding) abilities. Although individuals with autism spectrum disorders often have impairments and delays in both, expressive language skills have been the most studied (e.g., DeMyer et al., 1974; Freeman, Ritvo, Needleman &Yokota, 1985; Rutter et al., 1967). For example, DeMyer et al. (1973), in a follow-up study, found that at initial evaluation (mean age 65.6 months), no children had normal speech, 35% had some useful communicative speech (2% could express ideas and converse, but below age level; 4% could converse at a level above immediate needs, but communication was often bizarre or repetitious; 1% could only communicate immediate needs; 20% had both echolalia and only a few words to communicate immediate needs; and 8% had only a few communicative words), 20% had only echolalia and no communicative speech, and 45% had no speech.

At follow-up approximately six years later (mean age was 12 years), most of the children in this study had improved language skills. Four percent had normal speech, 50% had some useful communicative speech (13% could express ideas and converse, but below age level; 13% could converse at a level above immediate needs, but communication was often bizarre or repetitious; 4% could only communicate immediate needs; 12% had both echolalia and only a few words to communicate immediate needs; and 8% had only a few communicative words), 7% had only echolalia and no communicative speech, and 39% had no speech. Eleven percent of the children developed useful speech after age 5 years and an additional 4%, who were mute at initial evaluation, developed echolalia or a few communicative words after age 5. Presence of communicative words at initial evaluation was a more favorable prognostic sign for the later development of useful speech than were only echolalia without communicative speech or muteness.

Children with non-communicative echolalia were more likely to later gain conversational speech than were mute children. Indeed, 65% of the mute children remained mute at follow-up. Eleven percent of the children in this study showed a worsening of speech. The figures in this study are similar to those found in other studies (e.g., DeMyer et al., 1974; Freeman et al., 1985; Rutter et al., 1967). The proportion of children without functional speech at age 5 who later develop speech has been estimated between 17% (DeMyer et al., 1973) and 22%

(Rutter et al., 1967). Among the children with autism who do learn to speak, most children, both with and without mental retardation, show severe speech delays. Bartak and Rutter (1976) compared children with autism with IQs above and below 70. The mean age of the first use of single words was 4 years and 7 months in the group with mental retardation and 2 years and 6 months in the normal IQ group. Ornitz, Guthrie and Farley (1977) found that language comprehension is somewhat less delayed. Parents of children with autism recalled that their child's understanding of simple nouns occurred at a median age of 24 months.

This is 12 months later than the age reported by parents of normal children. Rutter et al. (1967) and DeMyer et al. (1973) found that even in those children whose speech had 25 improved considerably, there still remained difficulties with abstract concepts, repetitive questioning, odd conversations with an obsessiveness over details or one subject, and/or disorders in speech intonation, rhythm, and inflection. Language skills also predict outcome. Those individuals who are mute after age 5 years have a poor prognosis, both for speech acquisition and for general functioning level (Baltaxe & Simmons, 1983). Eisenberg (1956) found poor outcome for all but 1 of 30 children without speech at age 5 years. Rutter et al. (1967) found that higher IQ, lack of response to sounds during the preschool years, and acquisition of useful speech by 5 years were powerful predictors of later good social adjustment.

Lotter (1974) found similar results; IQ and speech were the strongest predictors of later outcome. The existence of some functional, communicative speech is indicative of a better prognosis than is non-communicative echolalia alone (Paul, 1987a). Although echolalia is viewed as an intermediate stage towards more functional language, it continues into adulthood in many individuals with autism (Paul, 1987a). Paul, Cohen and Caparulo (1983) performed a longitudinal study of children with autism and children with aphasia. They found that language comprehension ability at early ages was associated to the degree of improvement in social relations in late adolescence and adulthood. Although children with autism who fail to gain useful speech tend to have a poor social prognosis (Lotter, 1974; Rutter, 1978a; Rutter et al., 1967), the lack of speech in itself is not a sufficient explanation for this poor prognosis. Many aphasic and deaf mutes become well-functioning adults, even though they are unable to speak. Nonspeaking adults with autism lack more than speech. These adults manifest a global problem in communication and cognitive processes, as well as a variety of social and behavioral problems (Rutter, 1978a).

Mutism

The incidence of mutism in individuals with autism has been found to range from 28% (Wolff & Chess, 1965) to 61% (Fish, Shapiro & Campbell, 1966). Other studies have found incidences between these two figures (Eisenberg, 1956; Kanner, Rodriguez & Ashenden, 1972; Lotter, 1967; Mittler, Gillies & Jukes, 1966; Ritvo et al., 1989; Rutter et al., 1967; Volkmar & Cohen, 1989). Occasional bursts of speech in stressful situations, never to be repeated again, have been reported in this group (Paul, 1987a). When first diagnosed during

childhood, about 80% of children with autism are mute (Ornitz, Guthrie & Farley, 1977). About 50% remain mute for life without intensive treatment (Newsom et al., 1988; Rutter et al., 1967). Most of these individuals are functionally mute rather than totally silent. That is, they are able to produce some sounds and perhaps even word-approximations, but are not able to articulate words or phrases (Newsom et al., 1988).

Schuler (1976; cited in Alpert & Rogers-Warren, 1985; Fay, 1980c) has specified three levels of muteness and applied the term to individuals who: 1) produce no vocalizations, neither communicative nor non-communicative ("totally mute"); 2) produce only meaningless vocalizations that are used for self-stimulation ("functionally mute"); and 3) use a limited number of words or word approximations in a functional manner to express immediate desires ("semimute"). The condition "semi-mute" is more common in other childhood language disorders than in autism (Fay, 1980c). In this dissertation, the term "mute" is used for individuals who are "totally mute" and "functionally mute." In addition, Schuler suggests a parallel ordering of deficient receptive skills, ranging from "probably minimal" in regard to total muteness, to "probably poor" in functional muteness, to "somewhat better developed" in regard to semi-muteness.

It is not uncommon for children with autism to begin to speak and then suddenly lose their acquired speech (often between 18-30 months of age), and thereafter fail to progress linguistically (Schreibman, 1988). Reported estimates range from 20% (Rutter & Lord, 1987) to 34-37% (Kurita, 1985; Wolf & Goldberg, 1986). Rutter et al. (1967) performed a follow-up study of 62 patients with "childhood psychosis" seen at Maudsley Hospital between 1950 and 1958. Fifty percent of these children were mute at first examination (average age 6 years) and 40% were still without speech at follow-up (average age 15½ years). An additional 11% lost all speech in adolescence (4 after they developed epilepsy). Thus, half the children were without speech at follow-up.

Ricks and Wing (1976) found that even after an initially mute child acquires some communicative speech, problems still persist with abstract concepts, spontaneity, humor, feelings, idiomatic expressions, pronouns, and prepositions. The introduction of early intensive behavioral intervention (e.g., Anderson, Avery, DiPietro, Edwards, & Christian, 1987; Birnbrauer & Leach, 1993; Lovaas, 1987; Maurice, 1993; Smith, Eikeseth, Klevstrand & Lovaas, 1997) has changed the proportion of individuals who remain mute as adults. For example, in a 12-year prospective follow-up study of 53 children with autism, Freeman et al. (1991) found that only 17% remained completely nonverbal. This was a much lower percentage than the 50% rate usually reported (Eisenberg, 1956; Kanner et al., 1972; Lotter, 1967; Mittler et al., 1966; Ritvo et al., 1989; Rutter et al., 1967; Volkmar & Cohen, 1989). The authors noted that this low figure may be due to the fact that all of these children received early intensive intervention.

Echolalia

Language, when and if it develops, is abnormal in many ways. Echolalia and pronominal reversal are very common, as are deficits in understanding spoken language, and neologisms or metaphorical use of language (Cunningham, 1968; Cunningham & Dixon, 1961; DeMyer et al., 1981; Kanner, 1946; Rutter, 1966a; Shapiro, Fish, & Ginsberg, 1972; Shapiro, Roberts, & Fish, 1970; Tubbs, 1966; Wing, 1971; Wolff & Chess, 1965). The prevalence of echolalia among verbal children with autism has been estimated to be about 75% (Baltaxe & Simmons, 1981; Rutter, 1965; Rutter & Lockyer, 1967). Two types of echolalia have been described. Immediate echolalia is the most common language abnormality in autism (Hingtgen & Bryson, 1972; Prizant & Duchan, 1981). It was previously viewed as nonfunctional and to occur when the child did not understand the speech of others, but attempted to maintain social contact (Carr, Schreibman, & Lovaas, 1975; Coleman & Stedman, 1974; Fay, 1969, 1971, 1980a, 1983; Paccia & Curcio, 1982; Shapiro & Lucy, 1978).

Little research has been performed on delayed echolalia (the repetition of speech after a time lapse), due to the difficulty of identifying the original occurrence of the modeled utterance, which is needed if one is to separate delayed echolalia from the child's spontaneous utterances (Prizant, 1983). Prizant (1982), citing clinical observation, has suggested that delayed echolalia may be a repetition of conversations with the child alternating conversational turns, and that contextual factors (e.g., situation, setting, objects, persons) that are associated with the original utterance may be discriminative stimuli for its occurrence. Although echolalia was previously viewed as nonfunctional, later research has investigated the functional uses of immediate and delayed echolalia and the possible role of echolalia in language acquisition in children with autism.

Rutter (1966b) suggested that children with autism who later acquire more adequate language functioning appear to go through a prerequisite echolalia stage. Similarly, Baltaxe and Simmons (1977) and Prizant (1982) concluded that echolalia is probably necessary for continued language growth. These authors proposed that, unlike normal language development, in which grammar and the functional use of language are viewed as a "build-up" process, language development in children with autism may be viewed as a "breakdown" process, in which language is learned by analyzing larger chunks of repeated language.

Prizant and Duchan (1981) found that many echolalic responses were interactive, produced with evidence of comprehension, and served six communicative functions: assertions, turn-taking, requests, affirmative answers, self-regulation, and rehearsal to aid processing. Even though echolalia is seen as one of the most typical autistic symptoms, not all individuals with autism echo, nor is it unique to autism. It also occurs in blind children, in some forms of dementia, and is seen in the development of normal children as well (Paul, 1987a). Echolalia is found in normal children, beginning at about age 9 months and continuing until age 2 or 3 years. As children's language skills gain complexity, echolalia frequency decreases (Menyuk, 1977; Prutting & Connolly, 1976).

If echolalia is found past a certain point in development, it is associated with language impairment (e.g., autism, mental retardation, aphasia, dysphasia; Baltaxe & Simmons, 1975; Fay, 1980a; Schuler, 1979). Howlin (1982) found that echolalia in children with autism also decreases in frequency as their language skills become more complex. Rutter (1965) reported the incidence of pronominal reversal (e.g., use of "you" instead of "I" when referring to self) to be 25% in speaking individuals 28 with autism. Disorders in pronominal reversal are likely due to echolalia. That is, the pronouns are inverted in the echolalic utterances the individual produces (Fay, 1971).

Spontaneous Communication

The lack of spontaneity of speech in autism is a well-known phenomenon. Studies have found that speaking individuals with autism show a sparse use of verbal expression and a lack of spontaneity and clear communicative intent as compared to groups with other language disorders (Bartak, Rutter & Cox, 1975; Prior, 1977). Prior (1977) compared the language abilities of 20 children with autism and 20 with mental retardation. The author found that expressive verbal and gestural performance was particularly impoverished in the autism group, indicating a severe deficit in spontaneous communicative ability. In addition, the author noted an absence of spontaneous proto-declarative gestures in the 12 mute children with autism, which are a preverbal form of intentional communication that normally occurs around the first year of life.

This result suggested a qualitatively distinct pattern of prelinguistic development (Curcio, 1978). The absence or severe deficiency in gestural usage by children with autism has also been observed by others (Bartak et al., 1975; Wing, 1971). In summary, a considerable number of studies have been performed over the past 35 years to examine the nature of language impairment in autism, and several reviews summarize this work (e.g., Fay & Mermelstein, 1982; Paul, 1987a; Swisher & Demetras, 1985; Tager-Flusberg, 1989). Early descriptive studies (e.g., Pronovost, Wakstein, & Wakstein, 1966; Wolff & Chess, 1965) described the main clinical features of language in autism. These features included immediate and delayed echolalia, abnormal use of prosody, pronominal reversals, non-communicative speech, a lack of spontaneous speech, and mutism.

Later empirical studies, performed within a psycholinguistic framework, have focused on identifying which aspects of language impairment are central to the deficit in autism (e.g., Tager-Flusberg et al., 1990). Based on these studies, it is now agreed that individuals with autism have major deficits in the pragmatic aspects of language use, both in the range of functions that these individuals express (e.g., Wetherby & Prutting, 1984) and in their ability to communicate in a discourse setting (e.g., Curcio & Paccia, 1987). Degree of language impairment is an important prognostic factor (Eisenberg, 1956; Rutter et al., 1967; Wing, 1971). Language abnormalities have been extensively studied in autism spectrum disorders and were considered by Kanner (1943) to be of primary importance in defining the disorder. Because approximately 50 % of individuals with autism never acquire functional speech

(Rutter, 1978b, 1978c), one manner to subgroup persons with autism is according to whether they are able to speak or are mute.

Speech development appears to be associated to IQ, and few children with IQs less than 50 develop speech after age 5 years (Paul, 1987b; Rutter, 1970, 1978a; Rutter et al., 1967), unless they receive early, intensive behavioral intervention (e.g., Lovaas, 1987; Smith et al., 1997). However, the issue may be more complicated. Clinical experience and research have shown many instances of individuals with the same low IQ, and some acquire speech, while others remain mute. Conversely, some intellectually able individuals with nonverbal IQs in the normal range never learn to speak (Rutter, 1978a). As Rutter points out, it is important to study what differentiates the "failure to develop spoken language" subgroup, and how we can identify such children at an early age. Systematic research findings are lacking, but greatly needed. The qualities of a child's play, imitation abilities, language comprehension, and babble are factors that have been suggested as possible prognostic indicators of the child's chances of acquiring useful language skills (Rutter, 1978a). To my knowledge, no studies have been performed comparing large groups of verbal and nonverbal individuals with autism spectrum disorders on symptoms and behavior. Study I is an attempt to compare these two groups on type and degree of symptoms and behavior as measured by the Autism Behavior Checklist, a commonly used diagnostic and screening instrument.

Methodology

The study adopted a descriptive research design. It targeted 121 parents who had visited The Kenya Institute of Special Education in 2019 and 2020 for speech and language therapy and 33 teachers who handled children with speech and language disorders. Secondary data was collected for this study.

The parents revealed that poverty indeed is seriously deterring the children with speech and language disorders from pursuing education. The researcher noted that poverty does not only affect access to education for children with speech and language disorders only but also for other children too that is why concepts like the Education for All (EFA) and its offspring, FPE (free primary education) came into existence. But the researcher agrees with the respondents that because of the perceived added costs of health related problems, the problem is relatively deeper when the children with speech and language disorders are involved. And there does not seem to be any poverty reduction strategies being mainstreamed in all development initiatives through affirmative action to the children with speech and language disorders. Eighty five percent of the families with children with speech and language disorders live in destitution and deprivation, in rural areas where they are detached from much of the benefits and amenities such transportation and certain advanced technological facilities.

All the teachers and parents indicated that the children with speech and language disorders experienced reduced self-confidence in the school context in general, or in particular learning

activities within the classroom. This was mostly reported by parents, although one of the teachers also identified that she was working "to build the children's self-confidence". One of the parents noted that his child was less confident when speaking with others, stating that compared to his friends, he spoke: "A lot less. And [with] a lot less confidence in what he's actually saying". Another child's parents' identified the effect of his lowered self-confidence on his self-esteem as being the biggest impact of having a speech and language disorders disorder on his life. When asked about their aims for their children, the parents identified that their hope was to increase the child's self-confidence.

The parents also indicated that supporting their children's progress in the schooling environment was a challenge for most of these parents. The perceived lack of targeted resources in schools to support their children, and the need to identify and fund additional support outside the school was problematic for these families. The children's resistance to fully participate in activities in school, such as in class presentations, also caused concern for parents.

The teachers also indicated that promoting and supporting the educational development of children with speech and language disorders in schools also presented challenges for schools and teachers. In addition to meeting the learning needs of the children, and difficulties in accessing classroom and professional resources to support the children, teachers reported additional challenges in working with children with speech and language disorders, and in supporting their parents.

Discussion

This research indicates that children with speech and language disorders face a number of challenges in the school environment that impact on their development and education. While there were many examples of parents' and teachers' agency and advocacy, their attempts were not always successful and did not facilitate long-term benefits for (their own or other) children with speech and language disorders. These findings present a challenge in meeting the United Nations Article 29 Aims of Education in society to "empower the child" through the development of children's skills, supporting their learning, and promoting their dignity, self-esteem and confidence (UN, 2001). These results indicate that rather than supporting these children's learning needs, schools, and the families of these children, experienced frustration in their endeavors to access and provide "equitable quality educational" experiences in pursuing these goals (UN, 2001).

These findings have implications for policy, pedagogy and teacher preparation, and identify a need for coordinated advocacy on behalf of children with speech and language disorders, and their families, in the current educational context. By providing current and future teachers with the knowledge of the particular needs of children with speech and language disorders, teachers can be better prepared to meet their educational needs, understand the needs of

families, and advocate for the necessary resources to support the achievement of more equitable outcomes.

Conclusion

Children with speech and language disorders face challenges to their learning in the early years of schooling. The role of spoken language in the contemporary learning environment, and difficulties in accessing speech-language pathology and learning support as part of their school program, means that school presents challenges for these children, and parents and teachers experience challenges in meeting their needs. This research has shown not only that the children felt isolated, parents disempowered, and teachers frustrated, but it provides poignant illustrations of how whole families are impacted and how much of their frustration results from their inability to comprehend the bureaucracy to which they are beholden. Increased awareness of the specific needs of children with speech and language disorders and of the challenges their parents face is needed to enable the provision of greater support as children and their families engage with school curriculum and learning experiences. There is therefore a need for current and pre-service teachers to develop their awareness of the needs of children with speech and language disorders, and of strategies that might better meet these needs in the educational environment.

Recommendations

In this we advocate a multidisciplinary approach that positions speech and language disorders as both a health and educational responsibility, recognizing the educational implications of speech and language disorders and the need for additional school-based learning support including the provision of speech services as part of a holistic development program. Without professional awareness, skills development and speech and learning support services, schools, and society are not able to fully promote the development of children with speech and language disorders towards their potential. In meeting their needs, educators, and society, move towards achieving the aim of education to "empower the child by developing his or her skills, learning and other capacities, human dignity, self-esteem and self-confidence" (UN, 2001).

REFERENCES

Autism Society of Kenya. (2013). Autism Society of Kenya (ASK) – Our history. Retrieved from *http://autismkenya.org/ history.html*

Bogonko, S. (1992). *Reflections on education in East Africa*. Nairobi, Kenya: Oxford University Press.

Bruce, S., & Venkatesh, K. (2014). Special education disproportionality in the United States, Germany, Kenya, and India. *Disability & Society, 29(6), 908–921. doi:10.1080/0968759 9.2014.880330*

Buchmann, C. (2001). The state and schooling in Kenya: Historical developments and current challenges. *Africa Today, 46(1), 95–116.*

Chomba, M., Mukuria, S., Kariuki, P., Tumuti, S., & Bunyasi, B. (2014). Education for students with intellectual disabilities in Kenya: Challenges and prospects. *Disability Studies Quarterly, 34(4). Retrieved from http://dsq-sds.org/article/ view/3846/3793*

Elder, B. (2015). Right to inclusive education for students with disabilities in Kenya. *Journal of International Special Needs Education, 18(1),* 18–28.

Elder, B., Damiani, M., & Oswago, B. (2016). From attitudes to practice: Utilising inclusive teaching strategies in Kenyan primary schools. *International Journal of Inclusive Education, 20(4), 413–434. doi:10.1080/13603116.2015.1082648*

Flower, A. (2016). *Accessing inclusive education for children with disabilities in Kenya*. Retrieved from the Leonard Chesire website: https://www.leonardcheshire.org/sites/default/files/ Accessing-inclusive-education-children-disabilities-kenyagce-appg-report-february-2016.pdf

Gakuru, N., Riak, F., Ogula, H., Mugo, R., & Njenga, A. (1987). *Evaluation of NACECE-DICECE Programme—Part One: Research findings and recommendations*. Nairobi: Kenya Institute of Education.

Gathumbi, A., Ayot, H., Kimemia, J., & Ondigi, S. (2015). Teachers' and school administrators' preparedness in handling students with special needs in inclusive education in Kenya. *Journal of Education and Practice, 6(24), 129–138.*

Kajilwa, G. (2016, August). Kenya to spend Sh900 million on special education. *Standard Digital. Retrieved from https://* www.standardmedia.co.ke/article/2000213844/kenya-tospend-sh900-million-on-special-education

Kamau, J. (2017). Parental roles of mobility and educational resources for children with physical challenges a case of Joytown Special School, Kiambu County, Kenya. Journal of Education and Practice, 8(8), 130–135.

Kenya Bureau of Statistics. (2017). *Economic survey 2017*. Retrieved from https://www.knbs.or.ke/

Kenya Institute of Education. (2005). *The background report of Kenya*. Kenya: Author.

Kenya Institute of Special Education. (2016). Our core functions. *Retrieved from http://kise.ac.ke/*

Kenya National Commission on Human Rights (KNCHR). (2014). *from norm to practice: A status report on the implementation of the Rights of Persons with Disabilities*. Nairobi: Kenya.

Kenya National Survey for Persons with Disabilities. (2008). Preliminary Report. Retrieved from http://afri-can.org/ CBR%20Information/KNSPWD%20Prelim%20Report%20 - %20Revised.pdf

Kinuthia, W. (2009, April 1). Educational development in Kenya and the role of information and communication technology. *International Journal of Education and Development Using ICT*, 5(2). Retrieved from http://ijedict.dec.uwi.edu/viewarticle.php?id1/4740&layout1/4html

Maiwa, J., & Ngeno, G. (2017). Assessment of teacher competencies in handling physically challenged pupils in public primary schools in Kericho County. *Journal of Education and Practice*, 8(2), 114–121.

Mbugua, T. (2009). Teacher training for early childhood development and education in Kenya. *Journal of Early Childhood Teacher Education*, 30(3), 220–229.

Ministry of Education. (2008). *The development of education: National report of Kenya*. Retrieved from http://www.ibe. Unesco.org/National Reports/ICE_2008/kenya_NR08.pdf

Ministry of Education. (2017). Social scene. In Kenya National Bureau of Statistics. *Economic Survey*. Nairobi: Kenya.

Mukudi, E. (2004). Education for all: A framework for addressing the persisting illusion for the Kenyan context. *International Journal of Educational Development*, 24, 231–240

Opini, B. (2010). A review of the participation of disabled persons in the labour force: The Kenyan context. *Disability & Society, 25(3), 271–287*. doi:10.1080/09687591003701181

Persons with Disabilities. (2003). *Disability rights are human rights*. Retrieved from http://www.ncpwd.go.ke/

Powell, J. (2014). Comparative and international perspectives on special education. In L. Florian (Ed.), *The SAGE handbook of special education* (2nd ed., pp. 335–349). Thousand Oaks, CA: SAGE.

Republic of Kenya. (2007). *Kenya vision 2030*. Retrieved from http://www.vision2030.go.ke/

Republic of Kenya. (2009). *The national special needs education policy framework. Nairobi, Kenya*: MOE.

Republic of Kenya. (2010). *The Constitution of Kenya*. Retrieved from http://www.kenya-information-guide.com/support-files/ the_constitution_of_kenya.pdf

Republic of Kenya. (2012). *A policy framework for education and training. Reforming education and training in Kenya. Nairobi, Kenya:* Ministry of Education and Ministry of Higher Education, Science Technology.

Teachers Service Commission. (2017). Social scene. In Kenya National Bureau of Statistics. *Economic Survey*. Nairobi: Kenya.

UNESCO. (1994). *The Salamanca statement and framework for action on special needs education*. Paris, France: Author.

UNESCO. (2000). *Education for all*. Retrieved from http://www.unesco.org/new/en/education/themes/leading-the-international-agenda/education-for-all/

Wafula, R., Poipoi, M., Wanyama, R., & Begi, S. (2012). Early identification of learning disabilities among standard three pupils of public primary schools in Butere district, Kenya. *Journal of Emerging Trends in Educational Research and Policy Studies*, 3(5), 695–700.

World Bank. (2015). *World Bank open data*. Retrieved from http://data.worldbank.org