Amanda Brait Zerbeto[1] (ID)
Regina Yu Shon Chun[1] (ID)
Maria de Lurdes Zanolli[1] (ID)

Contributions of ICF to an integral approach in the Health Care for Children and Adolescents

Contribuições da CIF para uma abordagem integral na atenção à Saúde de Crianças e Adolescentes

ABSTRACT

Purpose: To investigate participation, and functionality of children and adolescents with speech disorders using the International Classification of Functioning, Disability and Health (ICF). **Method:** Descriptive and analytical research of qualitative and quantitative approach. The sample was composed of 30 participants with speech disorders and 30 with typical speech development. For data collection, it was conducted semi-structured interviews with the participants, medical record review, observation of speech aspects' participants, and analyzed study of medical records. The collected data were used to qualify the framework codes. The Mann-Whitney Test was used for comparison between groups, and thematic content analysis for the interviews. **Results:** Participants with speech disorders reported more difficulties than the participants with typical speech development. Speech disorders significantly impacted on the Body Functions (articulation and fluency), Activities and Participation (conversation, relationships, carrying out the routine and handling of stress) and Environmental Factors (attitudes of family, friends and acquaintances). **Conclusion**: The results show the impact of speech disorders and their social consequences for these children and adolescents. The ICF allowed us to comprehend health in all its complexity and integrality, making possible to plan strategies to soften the disorders impact in an individual and collective perspective. Then, ICF can be used, in the future, for elaboration of public policies and actions that will improve the quality of life and promote the health of this population.

RESUMO

Objetivo: Investigar a participação e funcionalidade de crianças e adolescentes com alterações de fala utilizando a Classificação Internacional de Funcionalidade, Incapacidade e Saúde. **Método**: Pesquisa descritiva-analítica de abordagem qualitativa-quantitativa com 30 participantes com alteração de fala (CAF) e 30 com desenvolvimento típico de fala (DTF). Para a coleta de dados, realizaram-se entrevistas semiestruturadas com os participantes, estudo de prontuário, observação dos participantes quanto aos aspectos de fala e aplicação de questionário estruturado com os responsáveis. Os dados coletados foram utilizados para seleção de qualificadores das categorias da Classificação Internacional de Funcionalidade, Incapacidade e Saúde. Para comparação dos qualificadores entre grupos, utilizou-se o Teste Mann-Whitney, e a análise de conteúdo temática, para as entrevistas. **Resultados:** Os participantes do grupo CAF relataram maior grau de dificuldade do que o grupo DTF. As alterações de fala repercutiram significativamente em Funções do Corpo (articulação e fluência), Atividades e Participação (conversa, relacionamentos, realização de rotinas e lidar com estresse) e Fatores Ambientais (atitudes de familiares, amigos e conhecidos). **Conclusão:** Os resultados evidenciam o impacto das alterações de fala e suas implicações sociais para estas crianças e adolescentes. A CIF permitiu compreender a saúde em complexidade e integralidade, possibilitando assim o planejamento de estratégias para amenizar o impacto dessas alterações individual e coletivamente. Podendo ser base, futuramente, para a criação de políticas públicas e ações que poderão melhorar a qualidade de vida e promover a saúde dessa população.

Correspondence address:
Amanda Brait Zerbeto
Av Princesa Isabel, 2808. Barra Velha.
Ilhabela (SP), Brasil. CEP: 11630-000.
E-mail: amandabrait@gmail.com

INTRODUCTION

In the care of children and adolescents with speech disorders, it is important that health professionals are aware of the implications that these difficulties can cause. People with these disorders can suffer vulnerability in several contextual aspects of their physical and social environments, such as difficulties in talking and communicative partners with attitudes that can constitute themselves as *bullying*[1-4]. Thus, it is important to pay attention to what these children and adolescents feel about their speech disorders, by investigating beyond organic speech aspects and using conceptual bases that may understand health in its entirety, adding concepts such as functionality and applying the principles and guidelines of the Unified System of Health (in Portuguese *Sistema Único de Saúde* - SUS). People with these disorders can suffer vulnerability in several contextual aspects of the physical and social environment, such as difficulty in talking and communicative partners with attitudes that can constitute themselves as International Classification of Functioning, Disability and Health (ICF)[5] prepared by the World Health Organization (WHO) and still little known and used in Brazil.

The ICF is a conceptual basis that allows professionals to deal with speech disorders in a biopsychosocial perspective on health[5-7]. Its main objective is to serve as a reference and establish a common language for the description of health, communication between professionals and the formation of database[5-6]. Its relevance is due especially to address functionality and disability as a dynamic interaction between health states and contextual factors, covering the relationship between the organic (Functions and Structure of the Body) and environmental dimensions of Health (Activities and Participation and Environmental and Personal Factors)[5]. Despite its importance, the ICF has been used more in the scientific community to carry out research, mainly in the form of 'core-sets', with items corresponding to the organic dimension being the most used.

Traditionally, the training of health professionals and the approach to speech disorders have been based on the biomedical model [8], focusing on organic functions and little considering the social implications arising from these difficulties. A classification that can enable an individual's biopsychosocial approach, depending on the user's theoretical framework, is the ICF[9].

Despite having demonstrated advantages when used in international research, the use of this tool is still a challenge[10], due to its extension and complexity. This is a topic that is still little explored in Brazilian Speech Therapy, but with great potential due to the growth of the profession in Public Health and the relevance of the debate on the use in practice of an expanded concept of health and promotion of quality of life. The use of a classification that identifies the social repercussions of health problems, and specifically in this research, speech difficulties and can serve for communication between health professionals is of significant relevance. Therefore, the aim of the present study was to investigate the participation and functionality of children and adolescents with speech disorders using the ICF as a conceptual basis.

METHOD

Research with descriptive-analytical design with a qualitative and quantitative approach was performed. Sixty children and adolescents aged 4-16 years were included in the research, who had authorized participation: 30 with speech disorders (in Portuguese *Com Alterações de Fala* (CAF)) and 30 with typical speech development (in Portuguese com *Desenvolvimento Típico da Fala* (DTF)). The CAF group was formed by all children and adolescents with speech disorders being monitored at the speech therapy school-clinic during the research period (15 with a diagnosis of stuttering and 15 with phonological disorders). The DTF group was formed by participants with typical speech development and selected by lot at two public schools in a city in the interior of the State of São Paulo with an age range and socioeconomic conditions similar to those of the CAF group.

Research approved by the Research Ethics Committee under CAAE #14110313.9.0000.5404. Those responsible for the participants signed the 'Free and Informed Consent Form' for consent. Participants were included who were able to understand and answer the guiding questions, and who did not have hearing loss or neurological problems, according to the medical records.

For the application of the guiding questions, semi-structured interviews (Appendix 1) were conducted with the participants. Part of the interview questions was culturally adapted to Portuguese from McLeod's study[8], because it is a reference in the area and uses the same conceptual basis as the present study. Questions were adapted and created, as in question 1, with the purpose of making the participant more comfortable, encouraging them to talk more about their perceptions, as in the questions with "why?" or "give examples" and qualify the pre-selected categories that were not included in the Speech Participation and Activity of Children (SPAA-C) questions, as in question 15[8].

The interviews were conducted by one of the authors (Speech-language pathologist), individually. In the CAF group, the interviews were recorded on video, in the DTF group, they were recorded on audio, due to the requirement of the schools, and later transcribed.

In both groups, legal guardians completed a structured questionnaire about child information, Per-Capita Income (PCI), maternal education and profession, type of parental union, history of communication problems in the family and information about 'Health Services, Systems and Policies' and 'Education'.

From the data obtained, the ICF categories to be used in the 'Body Functions', 'Activities' and 'Participation' and 'Environmental Factors' components were selected.

For the selection of qualifiers, the orthographic transcripts of the interviews, information from the questionnaires answered by the guardians, data from the medical records (CAF group) and observation of aspects related to the speech functions during the interviews were considered. Qualifiers were selected individually for each participant, considering all the information collected. Three judges with experience in CIF agreed on the qualifiers used, each made his classification and was considered

the qualifier in which there was agreement between at least two judges.

In the 'Body Functions', observations and medical records were the main instruments for qualifying the categories, as they contained results of exams and reports to qualify from intellectual functions (b117) to articulation functions (b320).

The interviews were the main data collection instruments for the qualification of the categories of 'Activities and Participation and Environmental Factors', as the objective was to know the participants' perception of their difficulties and in the interview they were able to report their experiences and be observed by the interviewer.

For the quantitative analysis of the data, the statistical analysis program Statistical Package for the Social Sciences (SPSS) for Windows (version 16.0) was used. To compare the ICF qualifiers between the groups, the Mann-Whitney test was used. To compare and verify associations between groups and socioeconomic data, the Chi-square and Fisher's exact tests were used. The level of significance adopted in the statistical tests was 5% ($p \leq 0.05$).

For qualitative analysis, the interviews were read, analyzed, submitted to thematic content analysis, categorizing the themes according to the ICF categories[11]. Participants will be identified by the letter "P", followed by their group's acronym ("P11-CAF": statement from participant 11 of the CAF group).

RESULTS

The characterization of the participants is shown in Table 1.

It is observed that the majority (80%) of the participants in the CAF group were male. In both groups, most fathers lived together, mothers attended high school and had professions that generated income. In the DTF group, seven responsible for the participants did not inform the family income, which prejudiced the statistical analysis of this variable.

No association was found between groups and socioeconomic data: maternal education (p-value = 0.204), maternal profession (p-value = 0.671) and type of parental union (p-value = 0.117).

Below are the results for 'Body Functions' (Table 2), 'Activities and Participation' (Table 3) and 'Environmental Factors' (Table 4) and qualitative data for both groups. The most affected categories in the CAF group were 'Articulation Functions' (b320) in 'Body Functions'; 'Speaking' (d330), 'Conversation' (d350) and 'Family Relationships' (d760) in 'Activities and Participation'; Individual attitudes of close family members (e410) and individual attitudes of acquaintances, peers, colleagues and community members (e425) in 'Environmental Factors'.

In the analysis of 'Body Functions', in the articulation (b320), CAF participants presented difficulties that varied from mild to severe, stating that people had difficulty understanding what they were talking about. In fluency (b330), most of the CAF participants had mild or moderate difficulty. The younger children mentioned that other people said that there was something wrong with their speech, but not all named their speech difficulties. Participants who had been in therapy for a longer time addressed

fluency issues and their repercussions more openly, such as "*my speech is bad because I stutter*" (P11-CAF).

In 'Activities and Participation', the difficulties in the functions of articulation and fluency had repercussions in speaking (d330) and conversation (d350). Most of the CAF group reported preferring to talk to family members. While DTF participants claimed to prefer this activity with school friends and neighbors. The CAF participants also reported that they did not like to talk with those who have difficulty in understanding their speech, with colleagues who imitate their way of speaking, use nicknames or make jokes related to their speech difficulties.

The CAF participants cited different reactions to situations in which they were not understood or someone said something malicious in their speech (d240) (Table 3). Faced with these situations, the majority reported leaving these people and avoiding approaching them "*because like this ... they annoy me, they piss me off and I can't sleep*" (P3-CAF), "*I just try to avoid these people ... when I see someone saying my name, I go out*" (P18-CAF).

As for the relationship with family members (d760), participants from both groups said it was good, claiming that the parents were references, helped and supported whenever they needed (Table 3). However, some CAF participants classified the relationship as a "sad" feeling due to the attitudes that family members had in the face of speech difficulties (e410) (Table 4).

In 'Environmental Factors' (Table 4), the individual attitudes of family, friends and acquaintances (e410, e420, e425) were mostly classified as barriers in CAF group and as facilitators or neutral in DTF group.

Regarding the attitudes of family members (e410), in CAF group, barrier attitudes were reported, such as little conversation between parents and children; parents and relatives correcting the statements of the participants and saying that they are speaking the words in a wrong way; and asking them to repeat until they speak the right way. In the case of stuttering, the members of the immediate family tell the participants to stop talking, to breathe and to continue, to become calmer, attitudes that can be barriers for the child to speak.

The individual attitudes of friends (e420) showed the best qualifiers for facilitators among the categories related to attitudes. At CAF group, there were facilitating attitudes such as: waiting for the child / adolescent to speak, being a play company and being able to tell everything that happens in daily life. However, barrier attitudes have also been reported, such as interruptions when they are in a time of disfluency. Such attitudes from friends considered barriers also appeared in the attitudes of acquaintances and peers (e425), who asked the child / adolescent to speak more slowly, corrected their lines, put nicknames related to speech difficulties and imitated the way of speaking "*they make fun of me ... they keep repeating what I say*" (P16-CAF).

'Services, Systems and Policies' for health (e580) and education (e585) were classified by the majority of those responsible for the participants of both groups as facilitators in 'Environmental Factors'.

Table 1. Characterization of participants in the CAF and DTF groups

Variables		CAF N(%)	DTF N(%)	p-value *
Gender	Female	6 (20)	16 (53.3)	0.007
	Male	24 (80)	14 (46.7)	
Age	Child	20 (66.7)	25 (83.3)	0.136
	Teenager	10 (33.3)	5 (16.7)	
Per-Capita Income (PIC)	No information	0 (0)	7 (23.3)	0.005**
	≤ 1 YES	21 (70)	12 (40)	
	>1 YES	9 (30)	11 (36.7)	
Maternal Education	≤ 9 years of study	11 (36.7)	5 (16.7)	0.204
	10-12 years of study	12 (40)	17 (56.7)	
	> 12 years of study	7 (23.3)	8 (26.7)	
Maternal Profession	Without income, housemaid	4 (13.3)	2 (6.7)	0.670
	With income (work with or without employment bond)	26 (86.7)	28 (93.3)	
Type of parent union	They live together	26 (86.7)	20 (66.7)	0.117
	Separated	4 (13.3)	10 (33.3)	
History of speech problems in the family	With history	11 (36.7)	8 (26.7)	0.405
	No history	19 (63.3)	22 (73.3)	

N (number of cases); % (percentage); SM (minimum wage); CAF (with speech disorders); DTF (with typical speech development); * Chi-square or Fisher's exact test (p≤0.05); ** Analysis compromised by the lack of response from those responsible for the DTF group

Table 2. CIF Classification of Body Functions in the CAF and DTF groups

Body Functions/Qualifiers*		0	1	2	3	4	8	9	p-value**
b117- Intellectual functions	CAF(n)	30							1.000
	DTF (n)	30							
b167- Mental functions of language	CAF(n)	30							1.000
	DTF (n)	30							
b230- Auditory functions	CAF(n)	30							1.000
	DTF (n)	30							
b320- Articulation functions	CAF(n)	12	9	4	5				0.001
	DTF (n)	30							
b330- Speech fluency and rhythm functions	CAF(n)	14	6	8	2				0.001
	DTF (n)	30							

CAF(with speech disorders); DTF (with typical speech development); * 0 (no difficulty), 1 (mild difficulty), 2 (moderate difficulty), 3 (severe difficulty), 4 (complete difficulty), 8 (unspecified), 9 (not applicable); ** Mann-Whitney test (p≤0.05)

Table 3. CIF Classification of Implications in Activities and Participation in the CAF and DTF groups

Activity and Participation / Qualifiers *		0	1	2	3	4	8	9	p-value**
d230- To Perform the daily routine	CAF (n)		13	8	8	1			0.001
	DTF (n)		30						
d240- To deal with stress and other psychological demands	CAF(n)		2	15	11	2			0.001
	DTF (n)		30						
d3101- To understand simple spoken messages	CAF(n)		30						1.000
	DTF (n)		30						
d330- To speak	CAF(n)			11	15	4			0.001
	DTF (n)		30						
d350- Conversation	CAF(n)		5	11	10	4			0.001
	DTF (n)		30						
d710- Basic interpersonal interactions	CAF(n)		4	15	8	3			0.001
	DTF (n)		24	6					
d730- Relationship with strangers	CAF(n)		1	10	17	2			0.057
	DTF (n)		4	13	13				
d750- Informal social relationships	CAF(n)		3	16	8	3			0.001
	DTF (n)		27	3					
d760- Family relationships	CAF(n)		5	11	10	4			0.001
	DTF (n)		24	6					
d880- Involvement in games or play	CAF(n)		16	10	3	1			0.001
	DTF (n)		27	3					

CAF (with speech disorders); DTF (with typical speech development); * 0 (no difficulty), 1 (mild difficulty), 2 (moderate difficulty), 3 (severe difficulty), 4 (complete difficulty), 8 (unspecified), 9 (not applicable); ** Mann-Whitney test (p≤0.05)

Table 4. CIF Classification of Environmental Factors in the CAF and DTF groups

Environmental Factors / Qualifiers *		.4	.3	.2	.1	0	+1	+2	+3	+4	8	9	p-value**
e410- Individual attitudes of close family members	CAF (n)			4	13	7	2	3	1				0.001
	DTF (n)						3	2	8	10	7		
e420- Individual attitudes of friends	CAF (n)			1	6	10	9	3	1				0.001
	DTF (n)					2		1	7	13	7		
e425- Individual attitudes of acquaintances, peers, colleagues and community members	CAF (n)			4	4	16	6						0.001
	DTF (n)				1		29						
e580- Health-related Services, Systems and Policies	CAF (n)				1		4	8	5	11		1	0.277
	DTF (n)			1			4	12		6	1	6	
e585- Education-related Services, Systems and Policies	CAF (n)			2			1	8	7	10		2	0.248
	DTF (n)	1					7	6	1	7	1	7	

CAF (with speech disorders); DTF (with typical speech development); * .4 (complete barrier), .3 (severe barrier), .2 (moderate barrier), .1 (light barrier), 0 (no facilitator), +1 (light facilitator), +2 (moderate facilitator), + 3 (considerable facilitator), +4 (complete facilitator), 8 (not specified), 9 (not applicable); ** Mann-Whitney test (p≤0.05)

DISCUSSION

The use of the ICF conceptual base in children and adolescents enabled the characterization of speech aspects and the social repercussions of speech disorders, with participants being seen as individuals who have difficulties in their functionality, not limiting the professional's view only to organic issues. The ICF enable an understanding of health in all its complexity and completeness, thus making it possible to plan strategies to mitigate the impact of these changes at the individual and collective levels.

When comparing the CAF and DTF groups, it was observed that CAF participants had a higher degree of difficulty in 'Body Functions', 'Activities' and 'Participation' and 'Environmental Factors'. These difficulties were reported in different environments, such as home and school. By analyzing these aspects under the perception of children and adolescents, it could be possible to reveal important informations for the evaluation, therapeutic process and follow-up, which could not always be reported by those responsible or observed in the visits.

In 'Functions of the Body', the participants of the CAF group presented greater difficulty in the categories related to language than the DTF group, as expected due to the characteristics that differentiated the groups. However, listening to the participants revealed information that is not always present in traditional speech assessments. Participants were able to express their feelings about speech, and in many situations they explained why they did not like the way they spoke, usually related to the barrier attitudes of others and the impact that speech changes caused

'Body Functions' is generally the most used component in health care instruments, as they are present in traditional biomedical assessment[9]. However, an evaluation that is restricted to organic aspects will fail to include important elements such as contextual factors. It is important to note that the ICF proposes a biopsychosocial approach, however, it remains a classification and the selection of components and analysis of the phenomenon depends on the professional and his/her epistemic perspective. When using only the ICF categories related to the body, the professional will not benefit completely from the biopsychosocial proposal of this classification.

In the biopsychosocial approach, the ICF 'Activities and Participation' component plays an important role in characterizing the functionality[6]. In the CAF group, speech disorders had repercussions in the categories studied, and some of these repercussions were also reported in studies that analyzed the perception of parents and health professionals[2]. Some aspects in which the CAF group presented greater difficulty than the DTF group were: difficulty to speak and talk to people who do not know them and have difficulty understanding their statements; difficulty in relating to peers and strangers; problems dealing with stress and other psychological demands.

The difficulty in talking was reported at home, some CAF participants reported having little talk with their parents, and at school, they mentioned fewer names of friends than the DTF group, in addition to less participation in the classroom in situations where speech was necessary. These questions, besides influencing the relationship with colleagues, can affect schooling, as they are ashamed to ask their questions or speak in front of the room because they do not want to expose their speech[12], as addressed in a study on school difficulties of people who stutter[13-14]. International literature on the use of ICF in education has demonstrated the importance of this tool for inclusive education, participation in the classroom and the development of policies that include these individuals in society[15].

In 'Environmental Factors, people's attitudes towards participants in the CAF group proved to be a factor that damaged the diverse relationships of this population. Interrupt, complete and correct speech, speak for the child and / or adolescent, exclude play, imitation of stuttering, *bullying* and nicknames related to speech disorders were some of the reported barrier attitudes.

The barrier attitudes made it difficult to perform the routine, limiting participation in environments where people who have

these attitudes are present and creating a difficulty in dealing with the stress of these situations. Stress in children and adolescents resulting from speech disorders is something that professionals must be aware of, as demonstrated by a cohort study conducted in England in which an association was found between stuttering and psychological distress[2].

The professional, when opting for the use of the ICF biopsychosocial theoretical basis, must expand his/her analysis beyond the organic issues that this tool also has, and this will only occur with the characterization of the 'Activities and Participation' and 'Environmental Factors' components. In the area of speech, the last mentioned components are highlighted as really fundamental to a health approach that integrates functionality and disability[1,4,6]. After all, one of the ways to actively include these individuals in society and promote health is to know their difficulties using a conceptual basis that allows a comprehensive look at all the difficulties they present.

To characterize functionality in the perception of children and adolescents provided the knowledge of relevant issues, which are usually analyzed from the point of view of professionals or guardians. Aspects of 'Activities and Participation' and 'Environmental Factors' could be analyzed quantitatively and qualitatively, as the participants reported their difficulties and provided examples of the social impact of speech disorders. Items in which the participants' reports made a difference for the characterization were: main communicative partners, difficulties to perform daily routine, and how to deal with stressful situations and attitudes of people around them in relation to speech disorders. Thus, it is recommended that, during speech monitoring, children and adolescents must be heard about their difficulties and how they deal with them in their follow-up.

The limitation of the research is related to the complexity of the ICF and the way of systematizing what is considered mild, moderate, severe or complete difficulty in each category. Due to the standardization in percentages on the severity of the difficulty, it becomes difficult to apply a rule to be followed when the characterization is carried out with interviews and methods that do not generate results in percentages.

One of the strengths point of this article is the originality in using the ICF in the area of speech and language and attention to children and adolescents in Brazil. The ICF is still little known and widespread in the clinical and research area, but with great potential due to its biopsychosocial approach. Valuing the aspects of functionality proved to be useful in monitoring speech disorders and presents great possibilities in the evaluation and monitoring of other problems that children and adolescents have[16]. The knowledge of the perception of children and adolescents about their speech disorders is also worth mentioning, as there are still few studies that investigate the impact of this change from the perspective of the affected subject.

CONCLUSION

The results showed that, in the perception of children and adolescents, speech disorders reflected in most aspects of 'Activities and Participation' and 'Environmental Factors', with implications for activities such as talking, talking and difficulties in relating to friends, family, acquaintances and strangers. It is noteworthy that the use of the ICF was fundamental for the intended biopsychosocial approach and the survey of the social and environmental repercussions of speech disorders.

Guided by the principles of comprehensive care and health promotion, and using the conceptual basis of the ICF, speech disorders could be correlated with the social and environmental context of this population group. In this way, it was possible to know the difficulties and potential of these children and adolescents, bringing contributions to the communication between professionals, assessing health problems and planning actions in the health care of children and adolescents in the perspective of comprehensive care.

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Authors contributions

ABZ participated in the elaboration of the project, collection and analysis of data and writing of the article. RYSC participated in the elaboration of the project and writing of the article. MLZ participated in the elaboration of the project and writing of the article.

APPENDIX 1. Semi-structured interview script

[Guiding questions were translated and adapted to Portuguese from Speech Participation and Activity of Children (SPAA-C) (McLeod, 2004). Some questions were included for this research]

1. Fale um pouco sobre as coisas que você gosta de fazer.*
2. Com quem você gosta de brincar? Por quê?
3. O que você gosta de fazer na escola (na sala, no recreio)? E do que você não gosta? Por quê?
4. Com quem você gosta de falar? Por quê?
5. Com quais pessoas você não gosta de conversar? Por quê?*
6. As pessoas comentam alguma coisa sobre sua fala? O que elas comentam?
7. As pessoas frequentemente pedem para você repetir o que fala? Que pessoas pedem isso? Como você se sente quando isso acontece? Conte uma situação em que isso aconteceu.
8. O que você faz quando as pessoas não entendem sua fala? Isso acontece muitas vezes? Dê um exemplo de quando isso aconteceu.
9. Você consegue fazer tudo o que precisa no seu dia a dia da escola e de casa?*
10. Como você se sente em relação à sua fala? ☺ ☹ ☺ ◯? Por quê?
11. Como você se sente quando fala com seus amigos? ☺ ☹ ☺ ◯ ? Por quê?
12. Como você se sente quando fala com seus irmãos? ☺ ☹ ☺ ◯ ? Por quê?
13. Como você se sente quando fala com seus pais? ☺ ☹ ☺ ◯ ? Por quê?
14. Como você se sente quando fala com seus professores? ☺ ☹ ☺ ◯ ? Por quê?
15. Como você se sente quando fala com seu fonoaudiólogo? ☺ ☹ ☺ ◯ ? Por quê?*
16. Como você se sente quando fala com estranhos? ☺ ☹ ☺ ◯ ? Por quê?*
17. Como você se sente quando as pessoas não entendem o que você fala? ☺ ☹ ☺ ◯ ? Por quê?

Legenda: ☺ Feliz; ☹ Triste; ☺ Normal; ◯ Outro sentimento; - Não sei

***Five questions were elaborated for Brazilian script version. Translation for questions 1, 5, 9, 15 and 16:**

1. Talk a little about the things you like to do.
5. Which people do you not like to talk to? Why?
9. Can you do everything you need in your daily life at school and at home?
15. How do you feel when you talk to your Speech and Language Pathologist? ☺ ☹ ☺ ◯ ? Why?
16. How do you feel when you talk to strangers? ☺ ☹ ☺ ◯ ? Why?