

Parent perceptions of the impact of stuttering on their preschoolers and themselves

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Abstract

Speech-language pathologists (SLPs) are advised to consider the distress of preschoolers and parents along with the social consequences of the child's stuttering when deciding whether to begin or delay treatment. Seventy-seven parents completed a survey that yielded quantitative and qualitative data that reflected their perceptions of the impact of stuttering on their children and themselves. Sixty-nine (89.6%) parents reported between 1 and 13 types of negative impact (modal = 2). The most frequently reported reactions of children were frustration associated with their stuttering, withdrawal, reduced or changed verbal output, making comments about their inability to talk, and avoidances. The most frequently reported peer reaction was teasing (27.3%). Seventy parents (90.9%) reported that they were affected by their child's stuttering. Their most frequently reported reactions were worry/anxiety/concern, uncertainty about what to do, frustration, upset (parent term), self-blame (fear that they had caused the stuttering), taking time to listen, waiting for the child to finish talking, modifying their own speech, and asking the child to modify speech. Findings support calls for SLPs to consider the distress of preschool children and their parents and the social consequences of the children's stuttering when making the decision to begin or delay treatment.

Learning outcomes: Readers will be able to describe parents' perceptions of the impact of stuttering on their children and themselves. In particular, readers will learn about (1) parents' perceptions of young children's awareness and reactions to their stuttering, (2) parents' perceptions of the social consequences of stuttering for young children; and (2) the emotional effect of stuttering on parents.

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1. Introduction

Stuttering starts in the early years of life, typically between ages 2 and 4 years (Yairi & Ambrose, 2005). Because many children will recover from stuttering without treatment, waiting periods are now commonly recommended to allow natural recovery to occur (e.g., see Yairi & Ambrose, 2005). In a review of the literature, Langevin, Packman, and Onslow (2009) noted that recommendations for wait times ranged from 6 months to 1–2 years, and even as long as 3 years. For example, a watchful waiting period of 1 year is typically recommended before implementing the Lidcombe Program (Onslow, Packman, & Harrison, 2003), as research has shown that waiting for 1 year does not

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jeopardise responsiveness (Packman, Onslow, & Attanasio, 2003). However, although responsiveness to Lidcombe program was not jeopardised in the studies referred to in Packman et al. (2003), this does not mean that the children in those studies were not experiencing negative impacts of stuttering while they were awaiting treatment. If a child is suffering distress, it would not be ethical to defer treatment for 1 year, simply on the grounds that there is no evidence that the child will suffer ill-effects while awaiting treatment. As Packman et al. (2003) state “it is not known whether children who are frustrated by their stuttering, or teased because of it, will suffer any long-term psychological problems if treatment is delayed for some period within the preschool years” (p. 49). Indeed, little is known about the consequences of stuttering for young children who are awaiting treatment with Lidcombe Program or any other treatment approach.

When deciding whether to begin or delay treatment, speech-language pathologists (SLPs) have been advised to consider persistence risk factors, such as gender, age at onset of stuttering, time since onset of stuttering, and family history of stuttering (e.g., Yairi & Ambrose, 2005). They have also been advised to consider the child’s reactions to stuttering, parent distress, and the social consequences of stuttering (Curlee & Yairi, 1997; Ingham & Cordes, 1998; Packman et al., 2003; Pan Canadian Alliance Fluency Wait List Committee, 2008; Yairi & Ambrose, 2005). While there is convincing evidence that many preschoolers become aware of their stuttering and react negatively to it, little is known about the social consequences of early stuttering. This is in stark contrast to the larger body of knowledge that shows that school-age children (who in the reviewed studies ranged from 8 to 18 years of age) are perceived negatively (Langevin, 2009; Langevin & Hagler, 2004; Langevin, Kleitman, Packman, & Onslow, 2009), teased (Blood & Blood, 2004, 2007; Hugh-Jones & Smith, 1999; Langevin, Bortnick, Hammer, & Wiebe, 1998), less accepted socially, less likely to be perceived as leaders, and more likely to be categorized as “bully-victims” than are non-stuttering children (Davis, Howell, & Cooke, 2002). In addition, very little is known about the impact of early stuttering on parents.

1.1. Awareness of and reactions to stuttering in young children

Existing research suggests that many young children become aware of their stuttering and react negatively to it. Research using parent report has consistently shown that many young children indicate either directly (e.g., saying “I can’t talk”) or indirectly (e.g., crying when they are not able to talk) that they are aware of their stuttering and that it is affecting them negatively. In a 1960 review of clinical records, Bloodstein (Bloodstein & Bernstein Ratner, 2008) found that at age 3 years about half of the children were reported to exhibit behaviours such as “hitting themselves on the mouth, crying, laughing, looking down and blushing, placing their hands in front of their face, hitting the wall with their hands, or saying ‘I can’t talk,’ ‘Why can’t I talk?’ ‘Help me talk.’” (Bloodstein & Bernstein Ratner, p. 34). In a survey of 121 parents of preschool children who stutter, Onslow, Harrison, and Jones (1993; reported in Packman et al., 2003) found that 30% of parents indicated that their children were aware of their stuttering and were reacting negatively to it, in some cases immediately after onset. Indeed, Yairi (1983) reported that 18% of parents perceived that their 2- and 3-year-old children became aware of their stuttering close to the time of onset.

Recently Boey et al. (2009) used parents’ reports of remarks made by the child (e.g., “I can’t talk”) or “unambiguous non-verbal reactions” (p. 338) (e.g., sighing) to investigate awareness of and reaction to stuttering in children age 2–7 years. Using an interview protocol, data were gathered from parents of 1122 children. Parents first were asked how their child reacted to speech difficulties, whether they thought their child was aware of the problem (response options were yes/no/doubt/or unknown), and how they knew that the child was aware. Then parents were asked about specific reactions (e.g., whether the child stopped talking during a moment of stuttering, or if the child asked for help). Boey et al. found that 75.1% of the children were reported to exhibit stuttering-associated reactions, with 42% of children exhibiting two types of reactions, and 36.5% exhibiting 3 types of reactions. Awareness increased with age from 56.7% in 2-year-olds to 89.7% in 7-year-olds. Parents most frequently reported that children made remarks about their speech, asked for help, and showed awareness through their attitude or posture, became cross or sad, cried about their speech, ceased to talk, or left the situation.

Experimental studies of awareness of stuttering in young children conducted by Ambrose and Yairi (1994) (with children aged 2–6 years) and Yairi and Ambrose (2005) (with children aged 23–56 months at the initial visit) used a paradigm in which children were asked to point to the puppet who talked like they talked. Awareness of stuttering was inferred if the child pointed to the puppet who stuttered; conversely awareness of fluency was inferred if the child pointed to the fluent puppet. Yairi and Ambrose (2005) indicated that 15% of the children who stuttered in the 1994 study indicated possible awareness of stuttering, whereas approximately 10% of the children in the follow-up study

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