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Review Article

Psycho-Social Effects of Stuttering in Children

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Abstract: The emotional needs of a child who has fluency disorder (stammering) is as important if not more important than the educational development. Many parents are concerned so much especially when they are not able to deal with the problem of fluency disorder in their children. Often times, this causes embarrassment in homes. Children who stammer are easily aggressive and this may be due to the fact that they find it difficult to express their views on a particular issue or occasion. This situation can also be frustrating and causes them to feel withdrawn and not to socialize, as it feels so terrible knowing what to say, but cannot express it the way it ought to be said due to some speech challenges. It is on that note that this research was carried out, to investigate the psycho-social effects of stuttering/stammering in the affected children as well as proffer some solutions or make some suggestions that will go a long way in helping to improve the lives of the children affected with stuttering.

Keywords: Stuttering/Stammering, Psycho-social, Fluency disorder, embarrassment, emotional.

INTRODUCTION

Stuttering (or stammering) has been one of the most extensively examined communication disorders in the clinical literature. It is also one of the few communication disorders that holds a position of prominence among members of the public. Worthy of mention here is that the disorder is about four times more common in males than females (Cohen, 2014). Notwithstanding the intense professional and public scrutiny that this disorder has received, stuttering remains to this day an elusive disorder that has evaded most attempts to capture its nature (Cummings, 2008). Wingate (2002) remarks that the three 'most thoroughly supportable and significant facts about stuttering' are that 'its cause is unknown, its essential nature is not understood and there is no known cure". Therefore, this work will leave aside perennial questions about cures for stuttering and turn attention instead to a number of other concerns relating to the characterization and management of this disorder.

It is important to note that this disorder can be managed in so many ways and it can go a long way to improve the quality of lives of the children that are affected and at the same time give them a sense of belonging. Specifically, the prevalence of stuttering and current thinking about the aetiology of this disorder will also be examined in this work. While there are different assessment techniques which are used to assess and treat stuttering, several of these techniques are examined with particular emphasis on the methods that have proven very effective that can be used to treat stuttering. Clinicians are more concerned about the efficacy of the techniques that are available for the treatment and management of children and adult stutterers.

Despite being the most prominent and extensively investigated disorder of fluency, stuttering is not the only fluency disorder that is assessed and treated by clinicians. There are other types of fluency disorders but the focus of this research is mainly on stuttering. According to Cummings (2008), while there is little clinical consensus on issues such as the cause of stuttering or the most effective methods of treatment for this disorder, clinicians are largely in agreement on the presenting features of stuttering. Wingate (2002) defines stuttering as a speech disorder in which there is 'a unique

anomaly in the flow of speech characterized by iterative and/or perseverative speech elements involving word/syllable-initial position' (2002:9). The 'speech elements' that are involved in iterations are single speech sounds or two speech sounds. For example, in attempting to say 'spoke', the stutterer may engage in iteration of /s/ or /sp/. A vowel sound, typically a schwa, may also be involved in the iteration, e.g., /spa/ for 'spoke'. The 'speech elements' that are involved in perseverations or protraction are always single speech sounds. The protracted sound may be unreleased, as in /s/ for 'soap'. Both iterations and protraction may be silent or audible and occur only in word- and syllable-initial position. This initial-position feature is frequently overlooked in discussions of stuttering (Wingate 2002). In as much as there are features of iteration and protraction of speech sounds in the speech of stammerers, it is also important to distinguish the dysfluencies of stammering from non-fluencies that occur in normal speech. As well as speech features, stutterers may present with one or more accessory or secondary features. These behaviours are diverse in nature and include eye blinking, grimace and lip tremor.

The Concept of Stuttering

Stuttering or stammering has been listed as a mental disorder in the International Classification of Diseases, 9th revision (Andrews, 1981, pp. 105-109). Stuttering according to Andrews (1981), is a disorder in the rhythm of speech in which the individual knows what to say, but at the same time is unable to say it because of an involuntary repetition, prolongation or cessation of sound. It shares a category with other focal but unrelated disorders such as anorexia. Young children develop speech and they also often repeat small words and phrases. This situation is a normal scenario for children and in most children tends to become infrequent as soon as they enter school. Children who will stutter certainly show these normal non-fluencies, but in addition, tend to fragment this particular sound- p- p-please-and this behaviour seems to be independent of the normal or developmental non-fluencies (Yairi, 1972; Bjerkan, 1980).

Stuttering has also been viewed by the National Institute on Deafness and other Communication Disorders (2016) as a speech disorder which is characterized by repetition of sounds, syllable, or words; prolongation of sounds; and interruptions in speech known as blocks. Verbal or situational avoidance behaviour and involuntary movements may develop over time in patients diagnosed with stuttering (Mulligan, Anderson, Jones, Williams & Donaldson, 2001; American Psychiatric Association, 2013). An individual who stutters exactly knows what he or she would like to say but has trouble producing a normal flow of speech. These speech disruptions may be accompanied by struggle behaviours, such as rapid eye blinks or tremors of the lips. Stuttering can make it difficult for the affected child to communicate with other people, which often affects a person's quality of life and interpersonal relationships. Stuttering can also negatively influence job performance and opportunities, and treatment can come at a high financial cost.

Stuttering always begins in childhood and half of those who are going to stutter will have begun by age five years and virtually all will have begun by puberty. Stuttering that persists into adulthood can lead to significant restrictions in quality of life and social and professional development (McAllister, Collier, & Shepstone, 2012). It is worthy of note that at least half of the stutterer's fluent speech must have been fully developed before the onset of their stuttering. This simply means that stutterers don't just start stuttering. They would have developed their speech in the normal way like their non-stutterers but along the line stuttering was developed. The lifetime risk of ever being a stutterer is about 3%.

Spontaneous remission is common. In those cases which do not remit, stuttering can follow a well-defined course to become a severe and incapacitating disorder. Initially the fragmented words and repetitions of sounds are episodic and long periods of freedom intervene. But as the disorder becomes more persistent, the repetitions of sounds and syllables are joined by prolongations of the vowels and continuous consonants and actual involuntary cessations of sounds called 'blocks', particularly on the stop consonants. Speaking therefore becomes difficult and the child exerts muscular effort to overcome these breaks in the rhythm of his speech (Bloodstein, 1960, 1961, Andrews, 1964).

In severe stutterers this effort to overcome the moment of stuttering enlarges to include tics and other involuntary body and face movements related to the moment of stuttering. The stutterer, now commonly at puberty, begins to identify certain words as likely to provoke a stutter and fears and tries to avoid them. By late adolescence, the severe stutterer is preoccupied with difficulties of speaking at school or in social situations and begins to avoid situations, often feeling guilty for not trying, yet ashamed of his stuttering when he does try. In adulthood some accept that stuttering does not negate their self-worth and they proceed, quite bravely given the level of the handicap, to participate in life (Bloodstein, 1960, 1961; Andrews, 1964).

Stuttering according to Fraser (2010), is no simple impediment. It is a complicated disorder which has both physical and emotional aspects. Fraser (2010) is of the opinion that to illustrate the later, the statement can be made that stuttering is largely what the stutterer does trying not to stutter. In other words, stuttering is like an incredible trick you play on yourself. As you tense in reaction to your stuttering and your feelings about stuttering, you are likely to stutter more. Stuttering affects one emotionally since being a stutterer can be rough. Possibly you may even think it is a disgrace to be a stutterer even though that is not so. As a result, you may have become extremely sensitive about your difficulty.

It is true that the experience of being blocked or not being able to say what you want to say without stuttering can be really frustrating. As a result, under some circumstances you may become so embarrassed and humiliating that you suffer from feelings of helplessness, shame, inferiority, depression and sometimes self-hatred. Your emotions may generate so much fear and anxiety that they can affect your attitude towards others and life in general (Fraser, 2010).

Prevalence of Stuttering

According to National Institute on Deafness and other Communication Disorders, stuttering occurs most often in children between the ages of 2 and 6 as they are developing their language skills. Approximately 5 to 10% of all children will stutter for some period in their life, lasting from a few weeks to several years. Boys are 2 to 3 times likely to stutter more than girls and as they grow older this gender differences begin to increase; the number of boys who continue to stutter is three to four times larger than the number of girls. Most children outgrow stuttering. Approximately 75 percent of children recover from stuttering while for the remaining 25 percent who will continue to stutter, stuttering can persist as a lifelong communication disorder. Stuttering persists after puberty in approximately 1% of the general population, with a male to female ratio of 4 to 1(Yairi & Ambrose, 2013).

The aetiology of stuttering is likely to be multifactorial in nature. Genetic factors have been known for some time to play an important role in the development of this disorder. Felsenfeld, Kirk, Zhu, Statham, Neale & Martin (2000) screened a large population based twin sample from the Australian Twin Registry for stuttering. These researchers discovered that approximately 70 per cent of the variance in liability to stuttering was found to be attributable to additive genetic effects, with non-shared environmental effects accounting for the remaining variance. This implies that many stutterers have a positive family history for stuttering. Among a clinical population of 169 adult and adolescent stutterers, Poulos and Webster (1991) found that 112 subjects (66 per cent) reported a family history of stuttering. In the same vein, Viswanath, Rosenfield, Alexander, Lee, & Chakraborty (2000) also discovered that the biological relatives of stutterers have a higher risk of stuttering than that in the general population.

Ambrose, Yairi, & Cox (1993) found that 71 per cent of their sample had a positive family history of stuttering in their immediate or extended families. This decreased to 43 per cent when only first-degree relatives were considered. In the course of carrying out this study, it was also found out that the frequency of stuttering was significantly higher among the male relatives of pro-bands in this study than among the female relatives. This simply means that males are more prone to stuttering more than their female counterparts. For male pro-bands, the male-to-female ratio of stuttering relatives was 3.49.

This ratio decreased to 1.50 for relatives of female pro-bands. Ambrose *et al*., concluded that the inheritance of liability for stuttering in the families in this study is most consistent with transmission of a single major genetic locus. As well as genetic factors being linked to the development of stuttering, neurological factors have also been found to play a role in the aetiology of the disorder. This has been the case for an acquired form of stuttering called neurogenic stuttering more than in developmental stuttering. Ward (2006) remarks that in contrast to the limited number of regions identified as associated with developmental stuttering, most cortical and sub-cortical areas, with the exception of the occipital lobe, have been implicated in neurogenic stutter.

On the same note, Aremu, Afolabi, Alabi and Elemunkan (2011) carried out research on the epidemiological profile of speech and language disorder in North central Nigeria and they discovered that speech and language disorder was commonest among under-five's with non in the elderly. There was a higher prevalence among males than females. According to them, speech and language disorders can be divided into three major categories, the first and most common are the articulation disorders. These problems involve the production of defective speech sounds and sound combinations that may be distorted, omitted, substituted, or added as accessory sounds. Sometimes, articulatory disorders are the result of neurogenic disorders and dysarthria's.

A second type of disorder according to them is the impairment of speech fluency, which is known as stuttering or stammering and also the topic for this research. This is repetition of sounds, syllables, words, or phrases; sound prolongations; atypical pauses (hesitations); word substitution; and use of word fillers that characterize dysfluent behaviours. Those who stutter are without awareness on their part that these mannerisms are different or abnormal. A third category is variously labeled impairment, linguistic disability, or faulty symbolization, which refers to disorders in both expression of thought through verbal language and its comprehension. This category includes various disorders, ranging from delayed/ deviant language development to neurogenic disorders known as aphasia (Aremu, *et al*., 2011).

Practically, all stutterers are seen as not talking right or having some form of difficulty saying words or expressing themselves by people or even their parents. It is usually the mother who is the first to notice and express concern about the child's speech difficulty. Studies have shown that those male stutterers outnumber female stutterers by about 3 to 1 similar to finding in the literature and this could be from physical stand point. Shames (1990) has it that the family is a critical

factor in dealing with the young child stuttering because the family can either reinforce or counteract the efforts of the speech-language pathologist. However, they advise that an advanced, or secondary, stutterer should seek the assistance of a qualified speech-language pathologist.

Intervention Procedures for Stuttering

According to Cohen (2014), addressing the anxiety is an important part of treatment. Although there is no consensus on the most effective treatment for stuttering, the most common modality is speech therapy, often with cognitive therapy to address anxiety. However, Cohen further asserts that in traditional speech therapy for stuttering, a counselling component focuses on modifying client reactions to his or her stuttering. Traditional treatment protocols involve attempting to alter features of stuttering as the person begins to stutter. Clients are taught to speak in a more relaxed mode; they are also taught to attempt to "glide'' or "slide"' through blocks once they begin, and they are taught to stutter on purpose in order to face their disorder more directly and purposefully. Treatment also often involves group therapy and taking part in support groups, such as those offered through the National Stuttering Association.

Extensive clinical and research effort have been directed towards the treatment of stuttering. There are numerous treatment programmes which are now in use with preschool, school-age and adult clients who stutter. These treatment approaches variously aim to modify the client's speaking environment (in the case of the preschool and school-age child), address attitudes related to speaking and stuttering (cognitive approach), train clients in the use of techniques designed to enhance fluency (fluency-shaping approach) and encourage clients to produce less effortful stuttering (stuttering modification approach). In reality, two or more of these approaches may be integrated within a single treatment programme.

An issue of central significance in stuttering research and practice is the efficacy of treatment. This issue has once again been brought into sharp focus by a recent study STUTTERING 389 by Kalinowski, Saltuklanoglu, Dagalu, and Guntupalli (2005), which found that therapy for stuttering in children may not contribute any improvement beyond that which comes about through natural spontaneous remission. This rather depressing finding is an important reminder that we still have some way to go in terms of our understanding and treatment of this speech disorder. At a minimum, it indicates that a key component of any future research agenda in stuttering must be the development of new techniques and/or revision of current techniques with a view to improving the efficacy of treatment methods.

However, for very young children who stutter, early intervention may help to prevent developmental stuttering from becoming a lifelong problem. Certain strategies can help children to improve their speech fluency while developing positive attitudes toward communication. Health professionals generally recommend that a child should be evaluated if he or she has stuttered for 3 to 6 months, exhibits struggle behaviours associated with stuttering, or has a family history or related communication disorders. On the other hand, some researchers recommend that a child be evaluated every 3 months to determine if the stuttering is increasing or decreasing. The treatment for stuttering often involves teaching parents about ways to support their child's production of fluent speech. Parents may be encouraged to do the following:

- A very relaxed home environment should be provided for the child so as to allow many opportunities for the child to speak. This includes setting aside time to talk to one another, especially when the child is excited and has a lot to say.
- Listen attentively when the child speaks and focus more on the content of the message, rather than responding to how the message was said. Avoid interrupting the child whenever he or she speaks as it makes the child feel shy and withdrawn.
- When speaking with the child, speak in a slightly slowed and relaxed manner. This can help reduce time pressures the child may be experiencing.
- Listen attentively when the child speaks and wait for him or her to say the intended words. Don't try to complete the sentences for the child. Also, help the child learn that a person can communicate successfully even when stuttering occurs.
- Talk openly and honestly to the child about stuttering if he or she brings up the subject. Help the child understand that even though some disruptions can occur in one's speech, it is not entirely bad.

There are many of the current intervention approaches designed for teens and adults who stutter. They focus mainly on helping them learn various ways to minimize the effect of stuttering when they speak, such as speaking slowly, regulating their breathing, or gradually progressing from single-syllable responses to longer words and more complex sentences.

Psycho-Social Effects of Stuttering

Stuttering no doubt can have a wide range of psycho-social impact on the affected children. This is particularly for children and adolescents who may have to face additional physical, emotional and personality changes as they grow into adulthood. Research has proven that children who stutter have below average self-perceived communication competence, high level of communication apprehension especially when called upon to make a speech or when asked an

impromptu question. It was also discovered through oral interview with a stutterer that they always feel so tense when trying to discuss with others and this makes them feel so withdrawn. On the other hand, it was also discovered that, stutterers don't stutter when they are singing, speak slowly or calm. This case makes them so vulnerable to verbal bullying at school.

These children are teased and bullied more often than their fluent counterparts, and this makes them to keep their stuttering secret (Erickson & Block, 2013). There are high levels of emotional strains, family conflict as well as difficulty managing the child's frustrations. News and Features (2018-2022) is of the opinion that recent surveys of their members showed that stammering can have a significant impact on a person's career, social life and mental and emotional well-being. Unsurprisingly, people who stammer can develop strong negative thoughts and feelings about their stammering and many studies have supported this. According to News and Features (2018-2022), in 1998, Corcoran and Stewart (1995) carried out an in-depth interview with adults who stutter and identified suffering as the principal theme, with people reporting feelings of helplessness, shame and fear, which in turn makes them to resort to avoidance as a way of hiding their stammering.

In terms of employment, stammering is a significant vocational handicap (Hurst and Cooper, 1983). Many employers hold negative attitudes towards people who stammer (Hurst and Cooper, 1983a) and this can impact on the likelihood of successful recruitment or promotion. Klein and Hood (2004) who carried out research on 232 adults to determine the impact of stammering on job performance and employment rate discovered that 70% of the adults who took part agreed that stammering reduced one's chances of being hired. More than 33% believed stammering interfered with their job performance and 20% had turned down a job or promotion because of their stammering.

In the same vein, stuttering also impacts negatively on the quality of one's life. Quality of life can be described as the general well-being of a person or society, defined in terms of health and happiness. It is worthy of note that people who stutter frequently have a reduced quality of life and the ability to fulfil their life ambitions has been limited due to their stammering status. Craig, Blumgart and Tran's (2009) study compared a group of adults who stammered with a group of 200 adults who didn't stammer. Both groups were asked to rate on a scale their quality of life. The results showed that stuttering negatively affects vitality (a measure of a person's energy levels or fatigue); social functioning (the extent to which to which one carries out social activities); emotional functioning (the extent to which a person's emotional problems impacts on daily work activities). It was also discovered that a person's self-esteem can be impacted negatively by stammering.

CONCLUSION AND RECOMMENDATIONS

There is no doubt that children and adolescents who are impacted with stuttering face some negative social consequences and barriers to opportunities, such as employment and relationships. Because stuttering is a disorder which usually unfolds in childhood and may be resolved early in life when detected on time. Those who stutter into later stages of their lives are likely to have lower odds of recovering from stuttering and greater odds of facing more negative social consequences. Although there are many severity levels of stuttering behaviours determined by the presence of various core and secondary behaviours, most adolescents and young adults who stutter experience social consequences from stuttering (Hunsaker, 2011).

Since the importance of fluent speech cannot be overemphasized and language and speech are great asset to man, stuttering brings with it a lot frustrations, stigmatization, shame, embarrassment to both the person involved as well as the family. It also come with emotional setbacks on the part of the families involved. Since most of these children seek remedy in schools, there is great need for the language teacher to acquire the basic skills needed to handle these children with stuttering. People who stutter are often stigmatized by the society. They are unfairly stereotyped into a group which is often believed to be less intelligent or capable than the average individual (Blood, Blood, Gabel, & Tellis, 2003). This often makes them to have a very low self-esteem as well as negative attitudes and feelings that is brought about by their inability to communicate well.

As a result of stuttering, people who stutter avoid social interaction as much as possible and this can limit their chances of getting involved in a romantic relationship. It can also reduce their chances of getting true friends. Since stuttering has a negative social effect, it is important to mention that Speech-language pathologists (SLPs) should be fully informed about the challenges that people who stutter face due to the dysfluencies. Well-informed professionals are more likely to have empathy for the client, which is valuable in professional practice (Hunsaker, 2011). In order to improve public awareness about the real causes and implications of stuttering, it is important to establish a support system for people with stuttering (PWS) in order to help them overcome challenges and discrimination related to it

Early intervention and detection measures are of great importance in the lives of these children who stutter especially when carried out on time. Seminars and training should be organized by the government in order to create awareness on the issue. The code of practice values the roles of parents as equal status to that of teachers and other

professional. Therefore, it recognizes that parents have a vital part to play in contributing to how their children's educational needs can be met (Squires & McKeown, 2006, p.6). Since parents are their child's first teachers, they can contribute important information about the problems the child faces at home.

Parents should develop strategies for supporting the child's organization or for checking how well the child is doing at school. It is pertinent that parents should have personal resources and time that they commit to the support of the child. They can help with monitoring and carrying out simple remedial programmes under the guidance of the teachers. The schools are not left out here as they also have a role to play in order to help children who stutter. Schools should encourage parents to participate during regular meeting with teaching staff and/or supporting staff. In doing this, the lives of these children would be impacted positively. Schools should also run courses to help parents develop specific skills to support their children. In view of the present-day innovations in teaching and learning, government should provide adequate teaching facilities in schools. They should also provide screening and assessment materials.

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