Speech and Language Disorders

A Senior Project submitted in partial fulfillment of the requirements for the Bachelor of Science Degree in Child Development

By

Haley Wilson

Psychology and Child Development Department

College of Liberal Arts

California Polytechnic State University

San Luis Obispo

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Faculty Advisor: Jennifer Jipson

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CHAPTER ONE

INTRODUCTION

Speech impediments can take place because of genetic influences, physical deformities or neurological malfunctions. No matter the origin, most impediments become evident in early childhood and continue to affect the speaker's life for years to come. One result of a speech impediment is the obstruction of clear speech. This disruption in communication can often lead to social isolation and bullying for the speaker (Hugh-Jones & Smith, 1999). These social implications are so powerful that they have the potential to influence self esteem, depression levels and academic success (Blood, Tellis, & Gabel, 2003). The consequences of speech disorders are multifaceted and go beyond the clarity of the individual's speech. With such life altering implications, it would be assumed an individual would gladly attend speech therapy. Clients should be eager to sit down and improve on their speech with a professional. Unfortunately, this scenario is not always true.

Clients of speech pathology, especially young children and adolescents, report low satisfaction surrounding their experience It is a phenomenon that has been understudied, but could hold the key to providing our students with the most efficient and successful therapy. Analysis of surveys completed by 129 clients of speech pathology revealed that there is dissatisfaction with service (Toczek-McPeake & Matthews, 1995). While the study concluded that conflict and dissatisfaction is inevitable when evaluating any type of therapy, I challenge this idea. I believe that we can come closer to pinpointing missing facets in speech pathology and provide a more comprehensive service for clients.

Prior literature has shown a disconnection between speech pathologists and clients perception of social isolation. It has been found that pathologists view emotional hardships as a much less threatening issue than physical bullying and often lack emphasis on emotional support in speech therapy (Blood, Blood, Tramontana, Sylvia, & Boyle 2011). However, the perception of social isolation is regarded as very harmful by many individuals suffering from a speech impediment. Students with a stutter reported high levels of victimization and bullying that caused them to be less optimistic about life than their non-stuttering peers (Blood, Blood, Tramontana, Sylvia, Boyle, Motzko, 2011). It is evident many individuals in speech therapy could benefit from the incorporation of emotional support.

I aimed to study whether the lack of emotional support could be an explanation of the unfavorable speech therapy experiences frequently reported. Further, if the incorporation of emotional support could propel a clients success in speech therapy. To do this, I interviewed a speech pathologist, emotional support counselor, student who has experienced both types of therapy, and her mother. The interviews supported the trend of prior literature, revealing differing opinions of the necessity of emotional support in speech pathology. The participant who was a client of speech therapy revealed feeling unsupported and uncomfortable. While the participant who is a speech pathologist showed very little enthusiasm to deal with emotional hardships in therapy; which could possibly make the client feel supported and comfortable. The results elude that there could be a clear connection between a supportive speech therapy setting that addresses emotional hardships and a clients experience in a program.

CHAPTER TWO

SPEECH AND LANGUAGE LITERATURE REVIEW

The power of speech has advanced our species in incalculable ways since our earliest homosapien ancestors began communicating close to 3.5 million years ago. It has given us a tool by which we can relay our needs, provides potential to share our wants and desires with the people around us. Speech gives us a means by which we can connect and build intimate relationships with others. Speech is an incredible part of our daily living. However, it does not come readily and smoothly for all. Speech disorders are frequently frustrating for the speaker as they know what to say but are impaired in doing so. Structural defects that disrupt a child's ability to speak clearly occur in approximately 1 out of every 700 births (Sataloff, 2011). Neurological malfunction and anxiety levels also result in cluttered speech for individuals. Speech impediments are far reaching disorders that can be derived from various abnormalities in a child's development.

Having a speech impediment can increase stress and anxiety levels in social situations for the speaker. Hugh-Jones & Smith (1999) found that a majority of stuttering students self-reported encountering bullying at school, as well as difficulty in making friendships. Blood, Blood, Tellis, & Gabel (2003) report that the stigmatization associated with speech disorders may influence self esteem, as individuals with speech disorders often experience depression, social isolation, and poorer performance on academics and standardized tests. To best support those with speech disorders, it is imperative that speech pathologists be informed about the origins and types of such disorders, typical interventions enacted by speech pathologists, impacts of speech disorders across developmental domains, and opportunities for supporting the

socioemotional development of individuals with speech disorders. Said information will assist speech pathologists in providing a well-rounded and balanced intervention program for their clients.

Origins and Types of Speech Disorders

There are dozens of specific speech disruptions that an individual can suffer from. A main distinction of speech impediments is whether it is a dysfluent event or an artiflulation disorder. Howell (2011) defines dysfluent events as occurrences that interrupt otherwise normal and fluid speech. Within the umbrella term of dysfluent events, speech disruptions are broken up into smaller categorizes. These branches are interjections, word repetitions, part word repetitions, prolongations, broken words, incomplete phrases (abandonments), and revisions (Howell 2011). Each of the dysfluent events listed assume that the speaker is unable achieve fluid speech because of a temporary neurological disruption. Articulation disorders, however, occur because of a physical abnormality that prevents clear speech. Cleft palate, underdevelopment in the lingual frenulum, and verbal dyspraxia are all forms of articulation disorders.

Possible Causes of Speech Disorders

Speech impediments can be caused by genetic influences, physical deformities, or neurological malfunctions. Genetic influences and physical deformities are both typically caused by an abnormal occurrence during development. The abnormal physical occurrences can affect an otherwise normally developing child, and can be passed on genetically from parent to offspring. Neurological malfunctions are often a multifaceted interaction of the individual, their environment, and perceptions about self. The disruption takes place in the neuro-pathways of the

individual, temporarily causing them to jumble their words. While each occurrence varies greatly, they each result in unclear speech for the individual.

Genetic influences. The link between speech disruption and genetic causation has long been studied. Drayna and Kang (2011) located a central area of the DNA that appears to be responsible for the disruption of the lysosomal pathway, a particular passageway of enzymes. The researchers looked at the genome of stutterers to pinpoint the difference between an individual who stutters and one who does not. They found a region on chromosome 12 that shows mutation in the GNPTAB and NAGPA genes in many of their stuttering participants. The authors concluded that the mutations found in the GNPTG and NAGPA genes cause a disruption in the lysosomal pathway. This interrupted the direction of the individual's enzymes. Enzymes, which typically travel along an undisrupted lysosomal pathway, are responsible for regulating calmness in our brains. Individuals who stutter experience confusion and jumbled thoughts which Drayna and Kang (2011) attributed to the disarray of enzymes.

Speech disorders can also be directly passed to offspring through DNA. Shriber, Tomblin, McSweeny, and Karlsson (2005) studied phenotype markers in genetically transmitted speech delays. The study reports the first findings of diagnostic markers that signify a genetically inherited speech delay. By looking at 72 preschoolers and their nuclear families, Shriber et al., (2005) discovered commonly inherited speech problems. The most typically inherited impediments are errors on the late-8 consonants. The late-8 consonants include "sh", /s/, "th", and /r/ sounds. A visit to a genetic counselor would reveal chances of inheritance of unclear speech.

Physical deformities. In order for clear speech to occur, proper formation of mouth, nasal passageway, and throat must occur. Some physical deformities in infants will prevent smooth speech from ensuing. A cleft palate, velopharyngeal dysfunction, and resonance disorders all have one thing in common; airflow disruption. Normal airflow contributes to normal word pronunciation and speech. Without this, the individual will experience side effects "including weak or omitted consonants, short utterance length, nasal grimace, and compensatory articulation productions" (Kummer, 2011, p. 198). Typically, the larger the structural defect, the more devastating influence it will have on speech.

Structural defects in children affect articulation, language expression, and fluency. Sataloff (2011) researched the major defects that cause palpable effects on speech. The cross sectional study found that many children whose origin of speech disruption was unknown shared one trait in common: an extremely short lingual frenulum. The lingual frenulum is the visible stretch of membranes that connects the underside of the tongue to the floor of the mouth. When the frenulum is too short, the individual is unable to accurately manipulate their tongue and articulate sounds (Sataloff, 2011). Physical flaws, such as a short lingual frenulum and cleft palates, inhibit typical syntax and phonology production. However, they can be corrected by therapy or surgery.

Neurological malfunction. Cluttered speech is speech that is broken because of hurried, nervous, or stammering words. Leung and Robson (1990) describe that situations with high levels of stress can trigger intermittent episodes of stuttering in many people, while some individuals may experience chronic bouts of cluttered speech. Certain individuals are more prone to neurological malfunctions than others and experience persistent attacks in almost all social situations. Individuals who have a persistent stutter worry about it appearing in speech,

which increases the possibility of a neurological malfunction. Johnson (1936), who studied stuttering remedies, explained that stutters wish to not experience the stuttering, yet this extreme desire is what inhibits their clear speech. The anxiety surrounding the stammer is so great it could be the factor that elicits the cluttered speech.

The neuro-physiological disturbances that are correlated with muddled speech are highly connected to confidence and beliefs about self. Cluttered speech is triggered by a complex interaction between a person's physical makeup and the environment around them (Ibiloglu, 2011). Stutterers are typically physically and developmentally normal, but their fears surrounding speaking are not. Johnson (1936) found in his study of stutter triggers that personal hygiene and perceived judgment by others were two of the most common. Stress and nerves can agitate the individual, temporarily disrupting the typical neurological process. Interestingly, when tired, bored, or otherwise relaxed most stutters will be able to speak clearly and fluently (Ibiloglu, 2001). Thus, the appearance of worry acts as a toxin and temporarily impedes on normal brain processing. However, in a study comparing senior stutterers with young stutterers, Davis, Shisca and Howell (2007) concluded that self perception surrounding the stuttering affects the speech more than anxiety levels. This alludes that with increased acceptance of the stutter, individuals may gain relief. Davis et al. (2007) reported that acceptance typically comes from living with the impediment for years and gradually becoming desensitized to it. This suggests that increased tolerance of the speech disorder could be a major therapy tool. Incorporating emotional support into speech pathology could offer clients the chance to work with any possible negative emotions associated with their impediments. Thus, enhancing self perceptions and increasing the rates of obtaining clear speech.

The causes of these neurological malfunctions have yet to be determined. However, it has been discovered that teratogens, or agents that disrupt the development of an embryo, could be one of the initiators. The developmental impacts of teratogens are broad, leaving language formation no exception. Exposure to medication can impair language development in otherwise normally developing children. *Brown University* (2007) conducted a study in which they studied the effects of the drug used to treat schizophrenia, Clozapine. Children born by mothers who ingested Clozapine during pregnancy had no prenatal complications and developed completely normally aside from their speech. It was found that the children had very limited speech until they turned 3, and by age of 4 the presence of an unrelenting stutter impaired the speech they had gained (*Brown University, 2007).* Follow up on the children revealed that speech therapy did not generate standard results found in children not exposed to Clozapine.

Impact on Life

The act of communication aids humans in bonding with others. However, when communication is problematic for an individual much is affected. Social acceptance, confidence, and overall life satisfaction can be at stake. Without the ability to hold fluent and successful conversations, many huge milestones such as maintaining friendships could be unsuccessful. Individuals with speech impediments could become a target for exclusion and bullying. Broken speech affects far more than the individuals verbal conversations.

Social acceptance. Inability, or hesitancy, to communicate hinders connections to others. Often individuals who struggle with language will have a tougher time making and maintaining friendships. This can be seen as early as preschool. Ross and Weinberg (2006) studied the socialization of 109 preschoolers who suffered from language impairments. By using the

Preschool Language Scale, a standardized measure of expressive and receptive language, and observations that studied the play habits of the preschoolers, they determined that children with any type of language delay had a harder time socializing with peers. According to the study, the children scored significantly lower on engagement and socialization domains. Researchers observed the daily interactions of the children who scored low in these domains and noted that their peers grew uninterested in figuring out what the children were trying to say and rarely chose them as playmates. Ross and Weinberg (2006) concluded that this isolation in such early years set the foundation for experiences and friendships later in life which explains the seclusion individuals with language impairments often report feeling.

A major milestone of childhood is making and building friendships. While in contrast, being explicitly left out and excluded can be a form of active bullying. Davis, Howell, & Cooke (2002) found that children who stutter are more likely to be bullied and hold a lower social position than their peers who do not. They surveyed 144 students in 16 classrooms in which at least one student had a stutter or other speech impediment. Surveys addressed the possible perceptions peers have about students with speech impediments. Findings indicated children with speech disorders were most likely to be nominated by their peers as a 'bullied' child and described under the category of 'seeks help'. The surveys also revealed that the students with impediments were rejected as 'a friend' significantly more often than their peers who did not have a speech delay. Similarly, they were significantly less likely than their classmates to be perceived as popular, and were rarely nominated as 'leaders' by their classmates. These results demonstrate that the dissimilarity felt by students with speech and language disorders is sensed by the speaker as well as their peers.

Successful peer interactions are made possible through appropriate conversation. According to Craig (1993), children with language impairments could struggle with bonding with peers because of their unique set of social skills. Students with impediments are not always able to carry out conversations fluently, leading their peers to perceive the conversation as forced or without a personal connection. Craig (1993) looked at the social interaction between normally developing students and students with language impairments by asking students to complete a close ended questionnaire. These questionnaires were only administered to classrooms that had at least one student with a speech impediment. The students were asked to rank classmates by answering questions such as "listens to what I have to say" and "enjoys talking to me". After comparing scores, he concluded the most important conversational skills that students with speech disorders appear to lack are responsiveness and assertiveness. While most children with speech disorders are adequately responsive in conversations, peers confuse their anxiety in conversation as aloofness and disinterest. According to Craig (1993), children with speech impediments have low levels of assertiveness while holding a conversation. The lack of assertiveness is attributed to the anxiety felt while holding a conversation. Their peers confuse this with disinterest in the conversation, which makes bonding hard to obtain.

In addition to challenges with bonding with peers, individuals who have a speech impairment are more likely to have lower life satisfaction (Blood, Blood, Tramontana, Sylvia, Boyle, Motzko, 2011). The researchers asked 54 students who stuttered, and 54 students who did not stutter to complete a survey that tested life satisfaction. Students who stuttered reported lower levels of self-esteem and were less optimistic about life than their peers who did not stutter. The author found that 44.4% of the students with a stutter identified victimization as a life experience, while only 9.2% of the non stuttering students did. The results revealed that

students who stutter and reported high victimization had statistically significant negative correlations with optimistic life orientation, high self-esteem, and high satisfaction with life score. The high levels victimization brought on by bullying and exclusion have a substantial affect on life satisfaction. Torment from others effects not only the stutterers perception of life's quality, but their confidence as well.

Confidence. Johnson (1936) named confidence as both the element of psyche that is most affected by language disorders, as well as a powerful tool in combating it The fear surrounding speech directly affects one's self confidence. Through his interviews of individuals between ages 13 and 25 who had persistent language disorders, he determined in unfamiliar social settings individuals often worry that each time they speak it will not be with clarity. This manifests an element of self doubt. Jumbled speech is a source of embarrassment and the speaker often views it with great disdain. The power of embarrassment is so great on confidence in fact, that a parent who is too overbearing or strict could become a trigger for a stutterer (Leung and Robson, 1990). In an observational study of children from ages 3 to 6, the power of parents demeanors were tested. Lueng and Robson (1990) reported that parents whose demeanors were unsupportive and unaccommodating of a stutter directly affect the confidence of their children and frequency of cluttered speech. Children with less supportive parents had higher rates of interrupted speech than those whose parents were understanding and considerate of the impediment. This demonstrates that stutterers could greatly benefit from a support system that is responsive to their confidence levels and uses emotional support as a technique. Similarly, Johnson (1936) found that unemotional attitudes and higher confidence also decreased the presence of the impediment. Both emotional detachment and higher confidence are often traits associated with years of living with the language disorder.

Conclusion

Speech disorders are without doubt life altering. They affect lives in multifaceted ways and require regular intervention to maintain. However, as reported by Wankoff (2011), adolescence and later life can be improved with early identification and proper intervention. This occurs as the impediment is combated against early, stopping it from becoming an overpowering and predominant disability. Early and adequate intervention increases success rate and allows the individual to grow up with a higher confidence surrounding speech, thus lessening the negative effects correlated with speech impediments. In a longitudinal study, Wankoff (2011) found that earlier speech intervention yielded a much higher satisfaction and confidence in adolescence and decreased negative experiences in school. Ward (1999) designed a study to test the impact of receiving speech intervention at various ages. The study, outlined to challenge the age at which children are typically referred for speech therapy, split 122 children in the first year of life up into an experimental or control group. The experimental group received regular intervention until the age 3 while the control group did not. The results showed that 85% of the control group still showed a language delay while only 3% of the experimental group did.

Research on how speech disorders relate to development focuses not only on language development, but also examines aspects of social and emotional development. As Ward and Scott (2011) argue, one's educational, social, and vocational life is directly affected by his or her cluttered speech. There is a precious balance in life that is acquired by having successful relationships and endeavors. Communication is at the foundation of each one of these. To give individuals with speech impediments the fair chance they deserve, we must provide therapy that goes beyond the basic therapy that only teaches clear speech. Perhaps there is a powerful element of emotional support that has been overlooked in speech therapy settings.

Blood, Blood, Tramontana, Sylvia, & Boyle (2011) tested speech pathologists perception of bullying and importance of intervention. They surveyed 1,000 school based speech language pathologists (SLPs). The fixed answer questionnaires revealed that SLPs rated physical bullying as the most serious form of bullying and in need of intervention. The SLPs listed top intervention methods for physical bulling were "talking with teacher", "working with school personnel", and "reassuring the child of his safety". However, for verbal and emotional bullying SLPs ranked "ignore the problem" as the best possible solution. Questionnaires did not show a strong trend of emotional support or counseling integrated into speech therapy. Rates of being viewed as a serious matter by the SLPs ranged simultaneously with the physicality of the bullying.

The students with speech disorders often suffer from distinctive traits such as anxiety, stress, nervousness, and a disruption in typical neurological function (Ibiloglu, 2001). Emotional support is a component that has been an area traditionally left out of speech therapy. I aim to better understand this trend through interviews with a speech pathologist, emotional support counselor, student who has undergone both types of therapy, and the parents of the student. The goal of these interviews is to increase understanding between any emotional distress experienced by individuals who suffer from speech impediments and consider the most effective intervention plans. All versions of the survey are engineered to gauge participants' beliefs about the value of the incorporation of emotional support into speech pathology. The emotional support suggested in the surveys was tailored to address commonly experienced distress such as low confidence levels and anxiety.

CHAPTER THREE

METHOD

Participants

The present study included four participants, all of Caucasian ethnicity. The sample group consisted of a male emotional support counselor (Sam), a female student who underwent both speech and emotional therapy (Anna), the mother of the student (Cindy), and a female speech pathologist who was not responsible for Anna's treatment (Mary). For purposes of confidentiality, all participants are referred to with a pseudonym. Sam, Anna, and Cindy live in Arroyo Grande, California; Mary lives in Davis, California. The researcher had professional relationships with all of the participants who participated in the interviews.

Materials

The participants answered the questions from one of four versions of the interview intended to measure their beliefs about emotional support in speech therapy. The different versions of the survey were similar in content, but worded to specifically gain information from participants with different roles in the speech therapy experience. All participants signed a consent form that outlined the objectives of the interview. The questions posed to participants are listed in the Table 1.

Table 1

Interview Questions Proposed to Participants

Participants	Interview Questions
Anna; student with experience of a speech impediment, emotional support counseling and speech pathology	1. What do you judge to be the toughest aspect of growing up with a speech impediment? 2. Have you ever experienced any form of emotional or physical bullying? 3. Have you ever discussed social or emotional challenges accompanying your speech disorders with a counselor outside of your speech pathologist office? 4. Do you believe that speech therapists should diagnose and treat concerns such as social isolation? If not, is there a more appropriate source from which one could receive help in this area? 5. In your experience, did speech therapy directly influence any other aspects of your life?
Cindy; Mother of Anna	1. Has any member of your family ever seen a speech pathologist for help with speech or communication concerns? a. If yes, please describe your families experience with your speech pathologist. 2. Did the family member who saw the speech pathologist also see a psychologist or school counselor? 3. Do you know of any trouble your child has had with making friends? a. If so, what has helped your child overcome this obstacle? 4. Do you believe that it is appropriate for speech therapists to make efforts to diagnose and treat social isolation? If not, is there a more appropriate source to receive such support from?

Sam; Emotional Support Counselor.	1. Which of the following supports do you offer to your clients: a. Diagnose speech and communication disorders b. Treat speech and communication disorders c. Diagnose social or emotional concerns d. Treat social or emotional concerns 2. In your practice, how typical is social isolation for students who grow up with a speech impediment (very to not very). 3. What do you judge to be the toughest aspect of growing up with a speech impediment? 4. Imagine the following scenario: A young client with a speech disorder tells you that she is suffering from bullying. What additional information would you try to elicit from this client? How seriously would you take her concerns? Would you need to determine whether it was emotional or physical bullying before being able to qualify it as a serious issue? Why or why not? 5. Do you believe that it is appropriate for speech therapists to make efforts to diagnose and treat social isolation? If not, is there are more appropriate source to receive such support from?

Mary; Speech Pathologist.	1. What do you judge to be the toughest aspect of growing up with a speech impediment? 2. In your practice, has social isolation been a typical experience of students who have grown up with a speech impediment? 3. Have students ever used their time with you to work on social or emotional concerns related to their speech disorder? 4. Does the potential emotional distress that may accompany a speech disorder have any impact on success or failure in a speech therapy program? 5. If a student with a speech disorder is suffering from bullying, would you need to determine whether it was emotional or physical bullying before being able to qualify it as a serious issue? Why or why not? 6. Do you believe that speech therapy should include diagnosis and treatment of topics such as social isolation? If not, is there a more appropriate source from which to receive help in this are?

Procedures

Sam, Anna, and Cindy participated in individual face-to-face interviews at Arroyo Grande High School. Each interview session lasted 15 minutes, on average. Mary participated in the interview over the phone. The researcher explained to each participant that they would be read each question out loud and that their answers should be provided verbally. All answers to the open ended questions were written down by the researcher so the results could later be

evaluated. The researcher stuck to the script and did not ask any follow up questions. However, participants occasionally deviated from original question to explain an experience.

CHAPTER FOUR

RESULTS AND DISCUSSION

Participants' responses to the interviews all provided greater perspective on the value and use of emotional support in speech pathology. The interviews revealed intriguing perspectives of the influence that vulnerability and embarrassment can have in speech therapy sessions. Although much of what participants reported was similar, some were unique to their individual perspectives. In general, Sam, Anna, and Cindy had the highest level of similarity among their answers, whereas Mary offered a unique perspective most often. Interpretation of these commonalities and difference in light of existing literature helps evaluate whether treatment of social isolation by a speech therapist could increase a client's success in speech pathology.

Upon evaluating the responses, it became clear that participants showed many common perspectives on the challenges faced by individuals with speech disorders, as well as on the appropriate ways to provide support. All participants, for example, agreed that individuals with speech impediments face unique hardships and/or social isolation. Sam, Anna, and Cindy described these hardships as related to bullying, social stigmas, exclusion, and embarrassment. Cindy spoke about the difference in treatment her daughter experienced not only with peers but also with teachers. She explained that teachers would call on Anna less and asked her to read aloud less than other children. Cindy wrapped up her answer by asking "can you imagine what that does to a girl growing up?" Anna, however, recalled the social isolation to be the toughest part of growing up. She spoke of peers mimicking the way she pronounced her words and recounted being branded as the student who it was un-cool to be friends with. Sam listed the typical experiences of students with speech impediments as dealing with social stigmas, social

ridicule, and the impact on self esteem. During the interview Sam rationalized his answers by pensively stating out loud that "there are a lot of mean kids out there". These viewpoints are consistent with the findings of Blood, Blood, Tramontana, Syliva & Boyle (2011) who reported that individuals with speech impediments face unique hardships and/or social isolation.

In addition to their appreciation of the social isolation related to having a speech disorder, Sam, Anna and Cindy agreed that speech pathologists are an appropriate source from which clients could receive treatment for such concerns. All three deducted that it would help the speech therapy process. Sam explained that emotional support would be beneficial in pathology because it could build a relationship of trust between client and pathologist. He remarked that if clients felt that their speech pathologists understood and were nonjudgmental of their pain, they would be able to sit down and be vulnerable with them. Anna supported Sam's notion. She described her pathology sessions as uncomfortable, awkward, and her "least favorite thing in the whole world." Anna believed that if her pathologist had accounted for her discomfort surrounding her impediment, they could have had a better experience and relationship which could have allowed her to talk more freely in the sessions. Cindy verified that her daughter disliked therapy and recalled that Anna would give her the silent treatment everyday on the way to speech pathology, and constantly made her promise not to tell others that Anna was in speech therapy. These reports of negative experience with speech pathology support the findings of Craig (1993). Craig (1993) found that individuals with speech disorders have a tougher time communicating and bonding with others because of the unique set of hardships they experience. Similar to his conclusion, Anna had a challenging time bonding with her speech pathologist. Anna's speech therapist may not have recognized her low levels of assertiveness, confidence, and high anxiety surrounding her speech. This lack of support may have prevented Anna from

forming a typical connection with her speech therapist, thus hindering her chances of working comfortably and relaxed in her sessions.

Mary responded in a manner consistent with the idea that speech pathologists may not fully appreciate the social and emotional ramifications of having a speech disorder. When asked what the toughest aspect of growing up with a speech disorder, Mary provided a less emotion-and-experience based response than the others by listing "not being born with the ability to speak clearly like the rest of the world" as the major hardship. Mary was asked if social isolation is a typical experience of her clients. She responded that while there is a correlation between having a speech impediment and having trouble making friends, she found that her clients are normally developing aside from their speech, and did not know if friendships were the reigning issue in all of their lives. This is a stark difference from the complication with social acceptance that Sam, Anna and Cindy revealed. Instead, Mary labeled concerns of "why can I not articulate this 'r' sound" to be the most prevailing hardship in her client's lives. Mary's response reflects the unique-lesson based experience she has with her clients, as she disclosed her clients do not sit down to discuss emotional concerns with her.

In response to being asked whether she thought the potential emotional distress that may accompany a speech disorder could have any impact on success or failure in a speech therapy program, Mary responded that it may depend more on the client's personality. Mary explained that a client's emotional distress could motivate them to work harder in their speech therapy sessions or it could cause an obstacle that feels too great to overcome, causing them to give up. She then questioned whether the researcher knew any statistics on this, intrigued to know the answer. Mary's answer conflicted with Sam's response to the same question. As discussed earlier, Sam said with total assurance that emotional distress could disrupt one's success in

speech pathology because of its effect on the client and therapists' connection and rapport. Sam's support of rapport and bond between client and speech therapist agrees with the findings of Lueng and Robson (1990). Lueng and Robson (1990) reported that strong support systems caused children with speech impediments to experience lower levels of interrupted speech. If clients felt their speech pathologist was considerate and nonjudgmental of their disorder, they could be able to feel at ease and comfortable during sessions.

Not surprisingly, when Mary discussed whether speech pathology should include diagnosis and treatment of such social concerns as isolation, she replied with a more practical direction than did Sam, Anna, and Cindy. Mary questioned where this responsibility would fit into the speech pathology session. She did not completely disapprove the idea, aside from questioning aloud if she was even qualified to give such counseling. Instead, she said it would require either additional time being added onto the speech pathology sessions, which clients may be reluctant to agree to, or it would have to cut into time spent on speech practice, which seemed counterproductive to her. Mary stated that while it is not a bad idea, neither option seemed ideal for the client. When asked the same question, Cindy thought that if pathologists do not incorporate emotional support into therapy, perhaps they could provide resources to prepare the family for the road ahead. Cindy's experience with her daughter's speech impediment was so emotionally tough she questioned her ability as a mother a number of times throughout her survey and admitted she wished she would have found counseling for her daughter at a younger age.

Mary's responses aligned with the trend found by Blood, Blood, Tramontana, Sylvia, & Boyle (2011). Similar to the pathologist in their study, Mary did not show a strong desire to incorporate emotional support into speech therapy and did not view social isolation as

detrimental whereas Sam, Anna and Cindy did. Mary did not endorse the idea that a deeper bond with clients could help them feel more comfortable in pathology and provide an enhanced learning atmosphere.

CHAPTER FIVE

DISCUSSION AND CONCLUSIONS

The goal of this project was to assess the need for emotional support in speech pathology. Prior literature states that speech therapists found emotional isolation as such a miniscule difficulty that they believe it is best to "be ignored" (Blood, Blood, Tramontana, Sylvia, & Boyle, 2011). In contrast, research demonstrates that children who stutter are more likely to be bullied and hold a lower social position (Davis, Howell, & Cooke 2002), be chosen less often by peers as a friend (Ross and Weinberg 2006), and more likely to have lower life satisfaction (Blood, Blood, Tramontana, Sylvia, Boyle, Motzko, 2011). The disagreement between prior literature and speech pathologist perspective demonstrates a clear disconnect on the importance of attending to issues of social isolation. The current findings support this notion: interviews with individuals in various roles revealed that the speech pathologist considered emotional hardships a great deal less influential than the individual with a speech disorder and her support system did.

Based on these findings, I argue that to best support speech therapy clients we should continue to consider the power of emotional support. If we intend to support students with speech impediments in gaining increases in life satisfaction and confidence levels, we must consider changing the way we look at speech therapy and intervene at an appropriate age with appropriate techniques (Wankoff, 2011). This requires further consideration of the potentially powerful impact that negative emotions commonly associated with speech impediments may have on development and on the speech therapy itself. For example, if brought into the speech

therapy setting, negative emotions could cause have an unfavorable effect and produce the extreme dislike and aversion experienced by Anna.

Based on these findings, several improvements in speech therapy may maximize a client's potential. Speech pathologists should have an above average ability to bond with others, high levels of empathy and desire to help others. Rapport between speech therapist and client should be used as a lubricant in the therapy setting. Duchan and Kovarsky (2011) support the concept of incorporating emotional support into speech pathology. Their observational study which looked at rapport and relationships in speech therapy settings concluded that the pathologists who did establish an emotionally supportive relationship expanded their client's success rates greatly. The collaborative process that takes place during discloser of such topics as social isolation facilitates further achievement in the speech therapy setting. Duchan and Kovarsky (2011) regarded this emotional relationship as a key component to the goals of speech therapy, and judged any practice without it as only addressing part of the issue. Speech therapists must be able to acknowledge the hardships their clients experience surrounding forming relationships. The relationship between client and patient could be an excellent opportunity to model ways to successfully navigate interactions with peers. Speech therapy has traditionally incorporated only a semantic concentration. However, it would now be inattentive to not incorporate a focus on emotional support.

To strengthen the presence of emotional support in pathology, incoming speech therapists should be required to complete several courses that focus on supporting and counseling individuals. These courses would have a concentration on supportive techniques specific speech impediments, and the hardships that may accompany them. This would eliminate the apprehension that Mary felt when asked if speech pathologists should provide support for topics

similar to social isolation. That Mary questioned aloud whether she was even qualified to provide such a service to her clients demonstrates the uncertainty that many pathologists feel surrounding emotional support. The foundation of their training is comprehensive and thorough techniques to foster language development, and this what they provide. Without the incorporation of techniques for empathetic support into their training, many may exclude it from their speech pathology practice. And, as we learned from Anna's experience, without this aspect in the speech therapy process clients will not be able to incorporate benefits of emotional support into their own lives. By finding the earliest point of disconnection and fixing it is the only way to most effectively solve this issue. Here, we can assume that the earliest and most effective way of intervening is to start at the source and foundation of speech pathologists; their education. Speech impediments are not just inability to speak clearly. Impediments often become an overarching issue that affects multiple parts of the individual's life. It is time that we acknowledge this, and rejuvenate speech therapy to address these issues as a way of providing intervention that is even more comprehensive.

References

Blood, G., Blood, I., Tramontana, I., Sylvia, A., Boyle, M., Motzko, G., (2011). Self-reported experience of bullying of students who stutter: Relations with life satisfaction, life orientation, and self-esteem. *Perceptual and Motor Skills*, *113*(2), 353-364.

Blood, G. , Blood, I. , Tellis, G. , & Gabel, R. (2003). A preliminary study of self-esteem, stigma, and disclosure in adolescents who stutter. *Journal of Fluency Disorders*, *28*(2), 143-159.

Blood, G. , Boyle, M. , Blood, I. , & Nalesnik, G. (2010). Bullying in children who stutter: Speech-language pathologists' perceptions and intervention strategies. *Journal of Fluency Disorders*, *35*(2), 92-109.

Craig, H. (1993). Social skills of children with specific language impairment: Peer relationships. *Language, Speech, and Hearing Services in Schools*, *24*(4), 206-215.

Davis, S. , Howell, P. , & Cooke, F. (2002). Sociodynamic relationships between children who stutter and their non-stuttering classmates. *Journal of Child Psychology and Psychiatry*, *43*(7), 939-947.

Davis, S. , Shisca, D. , & Howell, P. (2007). Anxiety in speakers who persist and recover from stuttering. *Journal of Communication Disorders*, *40*(5), 398-417

Drayna, D. , & Kang, C. (2011). Genetic approaches to understanding the causes of stuttering. *Journal of Neurodevelopmental Disorders*, *3*(4), 374-380.

Duchan, J. , & Kovarsky, D. (2011). Rapport and relationships in clinical interactions. *Topics in Language Disorders*, *31*(4), 297-299.

Effects of clozapine during pregnancy and lactation: Possible delayed speech acquisition. (2007). *The Brown University Child and Adolescent Psychopharmacology Update*, *9*(8), 8.

Fowler, J. (2009). *Connected: The surprising power of our social networks and how they shape our lives.* New York, NY: Little, Brown and Company.

Howell, P. (2011). Language-speech processing in developmental fluency disorders. , 435

Hugh-Jones, S. , & Smith, P. (1999). Self-reports of short- and long-term effects of bullying on children who stammer. *British Journal of Educational Psychology*, *69*(2), 141-158.

462.

Ibiloglu, A. (2011). Kekemelik. *Psikiyatride Guncel Yaklasimlar*, *3*(4), 704-728.

Johnson, W. (1936). Stuttering: Research findings and their therapeutic implications. *Journal of the Iowa State Medical Society*, 1-15.

Kummer, A. (2011). Disorders of resonance and air flow secondary to cleft palate and/or velopharyngeal dysfunction. *Seminars in Speech and Language*, *32*(2), 141-149.

Leung, A. , & Robson, W. (1990). Stuttering. *Clinical Pediatrics*, *29*(9), 498.

Linn, G. , & Caruso, A. (1998). Perspectives on the effects of stuttering on the formation and maintenance of intimate relationships. *The Journal of Rehabilitation*, *64*(3),

Marquardt, T. , & Kiran, S. (2011). Acquired neurogenic language disorders. , 271-291.

Messaoud-Galusi, S. , Hazan, V. , & Rosen, S. (2011). Investigating speech perception in children with dyslexia: Is there evidence of a consistent deficit in individuals?.\ *Journal of Speech, Language, and Hearing Research*, *54*(6), 1682.

Ross, G. , & Weinberg, S. (2006). Is there a relationship between language delays and behavior and socialization problems in toddlers?. *Journal of Early Childhood and Infant Psychology*, *2*, 101-116.

Sataloff, R. (2011). Speech, language, and voice disorders. *Ear, Nose and Throat Journal*, *90*(11), 506.

Savage, R. (2005). Friendship and bullying patterns in children attending a language base in a mainstream school. *Educational Psychology in Practice*, *21*(1), 23-36.

Schleicher, A. (2011). Lessons from the world on effective teaching and learning environments. *Journal of Teacher Education*, *62*(2), 202.

Shriberg, L. , Lewis, B. , Tomblin, J. , McSweeny, J. , Karlsson, H. , et al. (2005). Toward diagnostic and phenotype markers for genetically transmitted speech delay. *Journal of Speech, Language, and Hearing Research*, *48*(4), 834.

Toczek-McPeake, A. , & Matthews, M. (1995). Quality management: A survey of client and carer satisfaction with speech pathology and physiotherapy services in a rehabilitation setting. *Journal of Cognitive Rehabilitation*, *13*(5), 12-18.

Wankoff, L. (2011). Warning signs in the development of speech, language, and communication: When to refer to a speech-language pathologist. *Journal of Child and Adolescent Psychiatric Nursing*, *24*(3), 175-184.

Ward, D., & Scott, K. (2011). *Cluttering: A handbook of research, intervention and education.* New York, NY: Psych Press.

Ward, S. (1999). An investigation into the effectiveness of an early intervention method for delayed language development in young children. *International Journal Of Language & Communication Disorders*, *34*(3), 243-264.