Section: Otolaryngology

Original Research Article

IMPACT OF SOCIAL AND ATTITUDINAL ENVIRONMENT ON PARTICIPATION EXPERIENCES IN LIFE SITUATIONS IN ADOLESCENTS AND YOUNG ADULTS WITH STUTTERING

Prabhakar Upadhyay[1], Kamlesh Sharma[2], Gouri Shankar Patil[3], Ramanadham Thejesh[4]

[1]*Audiology & Speech Language Pathology Division, Department of ENT, Lady Hardinge Medical College & associated hospitals, New Delhi.*
[2]*Department of Physiology, ESIC Dental College & Hospital, Rohini, New Delhi, India.*
[3]*Ali Yavar Jung National Institute of Speech and Hearing Disabilities (Divyangjan) Secunderabad, India.*
[4]*Department of ENT, Christian Medical College, Vellore, Tamil Nadu, India*

Received *: 30/04/2025*
Received in revised form *: 18/06/2025*
Accepted *: 05/07/2025*

Corresponding Author:
Prabhakar Upadhyay
Audiology & Speech Language Pathology Division, Department of ENT, Lady Hardinge Medical College & associated hospitals, New Delhi.
Email: prabhakarsujaya@gmail.com

DOI: 10.70034/ijmedph.2025.3.76

Source of Support: Nil,
Conflict of Interest: None declared

Int J Med Pub Health
2025; 15 (3); 415-418

ABSTRACT

Background: Stuttering is a multifactorial disorder involving both physiological and psychosocial components and formed by both biological and social constructs. Stuttering-related experiences frequently involve affective, behavioural, and cognitive responses, affecting daily activities and overall quality of life. When fluency is emphasized over content, stuttering can significantly impact an individual's ability to engage in education, employment, relationships, and social life. This study aims to explore how social and attitudinal environments influence participation in various life domains among adolescents and young adults who stutter. Specifically, it examines factors affecting communication, interpersonal relationships, education, employment, community participation, and personal identity. By adopting a holistic perspective, the research seeks to expand existing knowledge on subjective psychosocial dimensions of stuttering, ultimately contributing to more effective therapeutic approaches.

Materials and Methods: This study employed a qualitative descriptive research design with purposive sampling technique including adolescents and young adult participants aged 14 and older with diagnosis of Stuttering and competent in primary skills of English. Data was collected through the International Classification of Functioning, Disabilities, and Health (ICF) Checklist (Version 2.1a, Clinician Form) to assess activity limitations, participation restrictions, and environmental influences affecting individuals who stutter.

Results: Results aligning with the previous research highlight the dual influence of environmental factors—facilitators contribute to a sense of inclusion and reduced stuttering-related disruptions, while barriers significantly hinder social participation. Immediate family members and friends emerged as substantial facilitators, offering emotional support that mitigates the psychological burden of stuttering. Conversely, societal attitudes, norms, and institutional ideologies were reported as severe barriers, restricting individuals' ability to engage in professional, educational, and social contexts.

Conclusion: The findings of present study emphasize that conceptualizing the stuttering experiences on the sociocultural model is highly appropriate for viewing Stuttering as both a biological construct and a social construct and multifactorial in origin. It is, therefore, vital to incorporate into clinical practice, psychosocial dimensions of stuttering such as feelings and the significance of stuttering in the individual's life. Furthermore, to enhance therapy outcomes for the person who stutters, speech-language pathologists should constantly be aware of the influences of stuttering on the individual's life in terms of social and attitudinal environment like family relationships, problems experienced in the workplace and emotional needs.

Keywords: Attitudinal environment, ICF, Stuttering, Sociocultural construct.

INTRODUCTION

Human beings exist as members of dynamic social and cultural systems.[1,2,3,4] Moreover, individuals develop their identity through social interactions that take place within cultural routines. Identity is not an innate something that emerges out of the developing self but rather results from actions taken during social interactions with others.[5] Thus, individuals learn who they are by how they compare to others, and in relation to the values of his or her culture.[6,7] According to Vygotsky, one cannot understand an individual without understanding his or her social experiences and the historical context that framed those experiences. His development of sociocultural theory conceptualizes the human experience as consisting of individual characteristics, interactions with other people and social institutions, and cultural context in which humans, interactions, and institutions are embedded.[8,9] The sociocultural framework acknowledges the biological, social, and cultural constructs that frame human functioning. Thus, this framework is highly appropriate for the study of stuttering.[10]

Stuttering has been described as a multifactorial disorder.[11,12,13] A person who stutters may exhibit speech disfluencies, but it takes interactions with others who are not disfluent and with a culture that values fluent speech to develop an identity as a person who stutters. Stuttering is therefore both a biological construct and a social construct. In many cases, stuttering forms a primary part of the person's identity. It may be a part of themselves that they hate, a part on which they place many other troubles, a part they want to eradicate. After years of emotional pain and anguish, these persons have grown accustomed to themselves as people who stutter.[14] The experience of stuttering for the person who stutters may include negative affective, behavioural, and cognitive reactions, both from the speaker who stutters and the environment. This experience may also involve significant limitations in the individual's ability to participate in daily activities and a negative effect on the person's overall quality of life. The enjoyment of many of life's meaningful activities can be severely restricted when people attend to the manner of speaking more than the message it carries, which may be the case with stuttering. Consequently, stuttering is likely to exert a profound influence on the person at all stages of the life cycle.[15]

International Classification of Functioning, Disabilities, and Health (ICF) Framework is more specific to the disability experience. As with the social constructivist perspective, the ICF framework emphasizes the individual's experiences in relation to his or her environment. Because of its multidimensional focus, the ICF has been a useful framework for conceptualizing the experience of Persons with Stuttering.[5,16] The ICF and social constructivist perspectives acknowledge the role of the individual in relation to social activities and environmental demands. People who stutter express a vast array of psychosocial experiences associated with stuttering. The psychosocial processes of people who stutter are complexly related to their speech production behaviour.[17,18] So Speech-language pathologists need to consider the life context of people who stutter, for example, in terms of family and society. Such a perspective is likely to assist them in seeing the individual who stutters as a unique person, and as a functioning individual interacting with a number of people. "The personal meaning that stuttering has for an individual must be woven into the 'who am I?' identity issue for it to be understood as an integral part of the life tapestry".[19]

Consequently, the purpose of this study was to describe the impact of social and attitudinal environment on the participation experiences in life situations of people who stutter; on the various life domains at the adolescent and young adulthood stages of the life cycle where questions of identity are paramount, and their effect on their quality of life as viewed from their perspective. Specific life domains targeted included undertaking tasks and demands, communication, interpersonal interactions and relationships, education, employment, domestic life, community, civic and social life. It was envisaged that this study would contribute to existing knowledge regarding subjective psychosocial dimensions related to stuttering which could supplement the therapeutic process.

MATERIALS AND METHODS

A qualitative descriptive research design with purposive sampling technique was used. 10 Participants were selected according to the following criteria: Diagnosis of stuttering: Participants were required to have been given a diagnosis of stuttering by a speech-language pathologist, following a formal assessment ; Language: Participants were required to be competent in primary skills of English in order to minimize the misinterpretation of the questions, but appropriate translation thereof had been provided if needed.; Age: As this study focused on the perspectives of adolescents and young adults, participants were required to be over 14 years of age. The participants were seated in distraction free quiet room, and they were informed about the entire procedure. An informed consent from the participants or their caregivers was taken. Detailed case history including demographic information and brief health information was documented.

The subparts d2 (d210 & d220), d3 (d310, d315, d330, d335 & d350), d6 (only d620), d7 (d710, d720, d730, d740, d750, d760 & d770), d8 (d810, d820, d830, d840, d850, d80 & d870), d9 (d910, d920, d930, d940 &d950) of part 2 (Activity Limitation & Participation Restriction) and e3 (e310, e320, e325, e330, e340, e355 & e360), e4 (e410, e420, e440, e450, e455, e460 & e465) of part 3 (Environmental Factors) of ICF CHECKLIST Version 2.1a, Clinician

form for International Classification of Functioning, Disability and Health was administered to participants. Participants had to rate from 0 to 4 (0 for no difficulty, 1 for mild difficulty, 2 for moderate difficulty, 3 for severe difficulty& 4 for complete difficulty) for subtests of part 2. For the subtests of part 3, participants had to identify the environmental factors as barrier or facilitator; with barriers to be rated from 0 to 4 (0 for no barrier, 1 for mild barrier, 2 for moderate barrier, 3 for severe barrier & 4 for complete barrier) and facilitators to be rated from 0 to +4 (0 for no facilitator, +1 for mild facilitator, +2 for moderate facilitator, +3 for substantial facilitator & +4 for complete facilitator).

Table 1: Subparts of ICF Checklist that were administered on Participants with Stuttering

Subpart	Assessed	Rating	Examples of Items
Subpart 2	Activity Limitation & Participation Restriction	0-4	d3= communication; d7= interpersonal interactions & relationships. d8= major life areas. d9= community, social & civic life
Subpart 3	Environmental Factors as barrier or facilitator	0-4	e3= support & relationships. e4= attitudes of family, friends, authority, etc;
General Questions	Capacity & Performance	How much is the difficulty/ problem	In present state, compare with someone else; before the problem

RESULTS

The study measured the difficulty the participants experience in doing things that they want to do them i.e., performing while being fully involved in life situations. Therefore, responses indicated "the lived experience" of participants in the actual context of social and attitudinal world in which they live. The social and attitudinal world context included immediate family, Friends, Acquaintances, peers, colleagues, neighbours and community members, People in position of authority, Personal care providers and personal assistants, Health professionals, Health related professionals, Societal attitudes, Social norms, practices and ideologies.

As shown in table 2, the participants rated difficulty in speaking and conversation as mild to complete. Almost all considered immediate family members and friends and their individual attitudes as facilitator (moderate to complete) and rated their difficulty in family relationships and informal social relationships as either none or mild. Only one found immediate family members as neither barriers nor facilitators and friends as severe barriers and reported difficulty with family relationships as moderate and with informal relationships as severe. They rated difficulty in intimate relationships as moderate to severe. Almost all termed acquaintances, peers, colleagues, neighbours community members and People in position of authority as moderate to severe barriers and reported difficulty with formal relationships as moderate to severe. Each participant found the individual attitudes of Personal care providers and personal assistants, Health professionals and Health related professionals as moderate to complete facilitators. But they found Societal attitudes, Social norms, practices and ideologies as severe to complete barrier and consequently, reported moderate to complete difficulty in undertaking multiple tasks, acquisition of goods and services (shopping etc.), participating in community life, political life and citizenship, exercising their human rights, recreation, leisure, religion and spirituality and relating to strangers. Further, they reported mild to moderate difficulty in basic interpersonal interactions and moderate to complete difficulty in complex interpersonal interactions. They termed difficulty in school education and higher education as moderate to complete but mild to moderate difficulty in informal education. Both participants who are still studying and who are searching for remunerative employment either anticipate or rate their difficulty in achieving remunerative employment and economic self-sufficiency as moderate to severe..

Table 2: Example of few items and their rating done by Participants with Stuttering

Subpart 2 Item	Rating 0	Rating 1	Rating 2	Rating 3	Rating 4
d7,1; Basic interpersonal interactions	0*	0	3	6	1
d7,3; Relation with Strangers	0	2	4	4	0
d7,6; Family Relationships	1	0	5	4	0
Subpart 3 Items	Rating 0 (no difficulty)	Rating 1	Rating 2	Rating 3	Rating 4
e3,1; Immediate family	0	0	0	1	0
e3,2; Friends	0	0	5	4	0
e4,55; Attitude of Health-related Professionals	0	0	0	4	4
e4,6; Societal Attitude	1	0	0	7	1
	Rating 0 (no barrier)	Rating + 1	Rating + 2	Rating + 3	Rating + 4
e3,1; Immediate family	0	0	5	2	2
e4,1; Attitude of Immediate Family	0	0	2	5	3
e4,2; Attitude of Friends	1	0	3	5	0
e3,3; People in Authority	1	1	3	3	1
e4,50; Attitude of Health Professionals	0	1	6	3	0

* = Number of Participants; Barrier (0= no barrier; 1= mild barrier; 2= moderate barrier; 3=severe barrier; 4= complete barrier); Facilitator (0= no facilitator; +1= mild facilitator; +2=moderate facilitator; +3= substantial facilitator; +4 = complete facilitator).

DISCUSSION

The purpose of this study was to gain a detailed understanding of impact of social and attitudinal environment on participation experiences in life situations in adolescents and young adults who stutter. Prior research has shown that stuttering can play a major role in shaping an individual's personal experience, such as their identity construction, personality development, thoughts, feelings, and behaviours.[20,21,22,23,24] Findings of these prior studies were also reflected in the present study of participation experiences. The social and attitudinal contexts which are termed as facilitators result in reducing stuttering to a condition that is of no consequence to tolerable in the persons' life situations occurring less than 25% of the time only. Support from family members is a good example of this. But the social and attitudinal contexts which are termed as barriers have exacerbated stuttering as a condition that is interfering to partially disrupting to totally disrupting in the persons' life situations occurring less than 50% to more than 95%of the time. This is evident in case of the societal attitudes, social norms, practices and ideologies as their barrier nature encompasses a whole lot of life domains.

In fact, the need to view the person who stutters holistically and first and foremost as a person, should be the cornerstone of therapy. Findings from the study highlighted the profound impact of stuttering on all the participants in the study as well as the effect of this disorder on virtually all life domains. These results suggest a need for people in educational settings, work environments and the broader community to increase their awareness and understanding of stuttering to improve communication channels and thereby enhance the quality of lives of people who stutter. Findings from the study underline the value of personal accounts of the life experiences of people who stutter, in deepening our theoretical knowledge and understanding of stuttering and thereby enhancing the effectiveness of therapy.

However, in order to critically evaluate this study, it is necessary to consider the limitations inherent in the research design and analysis of the study. Firstly, as this research employed a qualitative, small group research design and a non-probability convenience sample, generalizations of the results to the wider population of adults who stutter may be limited. Secondly, the sample was not proportionately represented in terms of the gender and marital status. Third limitation was the presence of the researcher during the face-to-face interviews, which may have influenced the information given by participants since they may have provided answers that they thought the researcher might probably like. Furthermore, since the study considered feelings and personal accounts of participants, there is the possibility that they may have furnished socially desirable responses or denied the existence of negative experiences, especially since the study focused on very sensitive and private domains of life.

CONCLUSION

The findings of present study emphasize that conceptualizing the stuttering experiences on the sociocultural model is highly appropriate for viewing Stuttering as both a biological construct and a social construct and multifactorial in origin. It is, therefore, vital to incorporate into clinical practice, subjective aspects, such as feelings and the significance of stuttering in the individual's life. Furthermore, in order to enhance therapy and treatment for the person who stutters, speech-language pathologists should constantly be aware of the influences of stuttering on the individual's life in terms of social and attitudinal environment like family relationships, problems experienced in the workplace and emotional needs. Therapists should also be aware of the need for counselling when treating a person who stutters in terms of social and family relationships and dealing with the emotional needs of these clients.

REFERENCES

1. Ogbu, J. U. Origins of human competence: A cultural-ecological perspective. Child Development.1981; 52(2):413-429.https://doi.org/10.2307/1129158.
2. Ogbu, J. U. (1992). Understanding cultural diversity and learning. journals.sagepub.com 1992;21(8).https://doi.org/10.3102/0013189X021008005
3. Rogoff, B. Apprenticeship in thinking: Cognitive development in social context. Oxford University Press. (1990).
4. Rogoff, B. The cultural nature of human development. Oxford University Press. (2003).
5. Hagstrom, Fran & Wertsch, James. (2004). Grounding Social Identity in Professional Practice. Topics in Language Disorders. 24. 162-173. 10.1097/00011363-200407000-00004.
6. Daniels, Derek & Gabel, Rodney. (2004). The Impact of Stuttering on Identity Construction. Topics in Language Disorders. 24. 200-215. 10.1097/00011363-200407000-00007.
7. Tatum, B. D. (1999). Why are all the Black kids sitting together in the cafeteria: And other conversations about race. New York, NY: Basic Books.
8. Vygotsky, L. S. (1978). Mind in society: The development of higher psychological processes. Cambridge, MA: Harvard University Press.
9. Vygotsky, L. S. (1987). Thinking and speech. In R.W. Rieber & A.S. Carton (Eds.), The collected works of L.S. Vygotsky, Volume 1: Problems of general psychology (pp. 39–285). New York: Plenum Press. (Original work published 1934.)
10. Hagstrom, F., & Daniels, D. E. Social Identity and Stuttering Experience. Communication Science and Disorders.2004; 31:215-224.https://doi.org/10.1044/cicsd_31_F_215.
11. Smith A. (1990). Factors in the etiology of stuttering. In Cooper J. A. (Ed.), Research needs in stuttering: Roadblocks

and future directions (pp. 39–47). Rockville, MD: American Speech-Language-Hearing Association.
12. Smith A., & Kelly E. (1997). Stuttering: A dynamic, multifactorial model. In Curlee R. & Siegel G. (Eds.), Nature and treatment of stuttering: New directions (pp. 204–217). Boston, MA: Allyn & Bacon.
13. Smith A. (1999). Stuttering: A unified approach to a multifactorial, dynamic disorder. In Bernstein Ratner N. & Healey E. C. (Eds.), Stuttering research and practice: Bridging the gap (pp. 27–44). Hove, United Kingdom: Psychology Press.
14. Peters, T.J., and Guitar, B. (1991). Stuttering." An integrated approach to its nature and treatment. Baltimore: Williams and Wilkins.
15. Yaruss JS, Quesal RW. Stuttering and the International Classification of Functioning, Disability, and Health: an update. J Commun Disord. 2004 Jan-Feb;37(1):35-52. doi: 10.1016/S0021-9924(03)00052-2. PMID: 15013378.
16. Yaruss JS. Describing the consequences of disorders: stuttering and the International Classification of Impairments, Disabilities, and Handicaps. J Speech Lang Hear Res. 1998 Apr;41(2):249-57. doi: 10.1044/jslhr.4102.249. PMID: 9570580.
17. Conture, E. G. (2001). Stuttering: Its nature, diagnosis and treatment. San Diego: Singular Publishing Group.
18. Conture, E. G. (2004). Stuttering: The long and winding road from the womb to the tomb. In K. Baker & D.Rowley (Eds.), Proceedings of the Sixth Oxford Dysfluency Conference. Leicester, UK: KLB Publications.
19. Kathard, Harsha. (2001). Sharing Stories: Life History Narratives in Stuttering Research. International journal of language & communication disorders / Royal College of Speech & Language Therapists. 36 Suppl. 52-7. Doi:10.3109/13682820109177858.
20. Corcoran JA, Stewart M. Stories of stuttering: A qualitative analysis of interview narratives. J Fluency Disord. 1998;23(4):247–64. doi:10.1016/S0094-730X (98)00020-5.
21. Crichton-Smith I. Communicating in the real world: accounts from people who stammer. J Fluency Disord. 2002;27(4):333–51. doi:10.1016/s0094-730x (02)00161-4.
22. Hottle E. Making myself understood: The labeling theory of deviance applied to stuttering. Va Soc Sci J. 1996; 31:78–85.
23. Daniels DE, Hagstrom F, Gabel RM. A qualitative study of how African American men who stutter attribute meaning to identity and life choices. J Fluency Disord. 2006;31(3):200–15. doi: 10.1016/j.jfludis.2006.05.002.
24. Petrunik M, Shearing CD. Fragile facades: Stuttering and the strategic manipulation of awareness. Soc Probl. 1983;31(2):125–38. doi:10.1525/sp.1983.31.2.03a00010.