

Cross-cultural attitudes toward speech disorders.

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CROSS-CULTURAL ATTITUDES TOWARD SPEECH DISORDERS

Contents

1. [KEY WORDS: cross-cultural, attitudes, speech disorders, speech therapy](#)

Speech-language pathologists serving multicultural populations may encounter unfamiliar beliefs about *speech disorders* among the members of different cultures. This study used a questionnaire to look at *attitudes toward* four *disorders* (cleft palate, dysfluency, hearing impairment, and misarticulations) among 166 university students representing English-speaking North American culture and several other cultures (e.g., Chinese, Southeast Asian, Hispanic). The results showed significant group differences on items involving the subjects' beliefs about the emotional health of persons with *speech disorders* and about the potential ability of *speech*-disordered persons to change their own *speech*.

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Attitudes toward speech and language *disorders* are important to the therapist's work; the *attitudes* of the client (or prospective client), the client's family, and the client's community *toward* the causes, effects, and treatment of the *disorder* can be crucial in the therapeutic process. In many modern settings, especially urban ones, the *speech* and language therapist's service population is multicultural, consisting of many recent immigrants, second-generation North Americans, or members of a non-English-speaking *cultural* community. (For relevant population estimates regarding children from non-English-language backgrounds, see Erickson & Walker, 1983.) Because *attitudes toward disorders* are likely to be culture-bound (Payne, 1986), the *speech* and language professional cannot assume that the *attitudes* of his or her own culture hold true for the client's culture, nor that therapy and assessment techniques or norms developed for members of the majority North American culture will be appropriate (Cheng, 1989; Erickson & Iglesias, 1986; Holland & Forbes, 1986; Meyerson, 1983; Shames, 1989). As Cheng (1989) says, "professionals need to become *cross-cultural* communicators in order to provide adequate services when working with . . . a culturally and linguistically diverse population" (p. 7).

Some research has been conducted on *attitudes toward* people with communication *disorders*, but it has largely focused on single *disorders* and has looked only at the *attitudes* of members of

a single culture. For example, much of this research has focused on *attitudes toward* stutterers. Of those studies that look at the *attitudes* of people other than the stutterers themselves, the most recent studies have considered specific groups, reporting on the *attitudes* of clinicians and teachers (Cooper & Cooper, 1985; Cooper & Rustin, 1985; Crowe & Walton, 1981; Horsley & FitzGibbon, 1987; Yeakle & Cooper, 1986), vocational rehabilitation counselors (M. A. Hurst & Cooper, 1983), or employers (M. I. Hurst & Cooper, 1983).

Attitudes toward another group, the deaf, have been explored by a number of investigators. Kottke, Mellor, and Schmidt (1987) used normal-hearing American undergraduates as subjects; Furnham and Lane (1984) and Togonu-Bickersteth and Odebiyi (1985) compared the *attitudes* of deaf and hearing subjects in the United Kingdom and in Nigeria, respectively. Studies of the perceived vocational prospects of the deaf have been done in Nigeria (Togonu-Bickersteth & Odebiyi, 1986) and in Italy and the United Kingdom, where DeCaro, Dowaliby, and Maruggi (1983) did a bicultural comparison of parents and teachers of the deaf. In another study, teachers of deaf children in the United States and Denmark were not found to differ in their judgments of the children's social-emotional adjustment (Meadow & Dyssegaard, 1983).

Although these works had differing purposes and methods, the results generally indicated that the subjects (clinicians, teachers, etc.) held negative views about the communication-disordered persons.

Few recent studies have looked at *attitudes* about cleft palate and misarticulations. However, employers were found to react negatively to a prospective employee with a cleft palate (Scheuerle, Guilford, & Garcia, 1982), as were classroom teachers *toward* misarticulating children (Ruscello, Stutler, & Toth, 1983). A study that compared university students' attitudes *toward* speakers simulating one of several *disorders* (stuttering, hypernasality, and lateral lisp) found negative reactions in comparison to a normal speaker (McKinnon, Hess, & Landry, 1986).

No studies to date have addressed the question of *cross-cultural attitudes toward* a number of different communication *disorders*, especially where the surveyed subjects do not belong to any special group such as teachers. If *attitudes* of the potential family members and communities of *speech*-disordered individuals are to be investigated, then a more random *cross*-section must serve as the subject population.

The current study surveyed students from a number of cultures who were living in the United States and Canada, either as immigrants or foreign students, and compared their responses with those of monolingual students who were at least second-generation North Americans.

The subjects were surveyed by means of a questionnaire that contained items about *attitudes toward* persons with four *speech disorders*: stuttering, profound hearing impairment, cleft palate, and misarticulations. The items were chosen to probe topics that would be of concern to *speech*- and language-care providers, such as perceived causes of the *disorder*, the family's and community's attitude *toward* persons with the *disorder*, and the desirability of the person's seeking professional help. (n1) The choice of topics also was influenced by the discussion of *attitudes toward* disabilities in general that is found in Livneh (1984), and by a round-table

discussion with foreign students from the People's Republic of China, who were considered to be representatives of one of the major *cultural* groups being surveyed. As Cheng (1989) notes, variables such as religious and *cultural* background can have enormous effects upon people's *attitudes toward* the efficacy or desirability of intervention, *toward* the perceived sources of illness, or *toward* handicapped people, especially children. For example, Fain (1990) asserts that some immigrants may come from areas where people believe that "a [communicative] *disorder* represents an act of God or demons and should not be tampered with" (p. 45).

Method Questionnaire

The questionnaire contained a section for each of the four *disorders* (severe adult stuttering, *speech* of the hearing impaired, cleft palate, misarticulating older children), followed by a brief demographic section. Each section began with a definition of the *disorder* and an example in simple English. (The cleft palate definition also included a line drawing of an unrepaired unilateral cleft.) The subject was first asked to indicate his or her familiarity with the *disorder* on a checklist. Twelve statements were then given (e.g., "Severe adult stutterers have trouble making friends or getting married") and the respondent was asked to mark his or her opinion on a 4-point scale for which the points were labeled probably no, maybe no, maybe yes, and probably yes. The statements were the same in content and ordering across the four *disorders*, except for necessary changes in wording. (See the Appendix for a list of the statements used.)

Subjects

The questionnaire was administered to 166 students (17-48 years of age, $M = 24.15$ years, $SD = 4.85$) in two universities, one in California and one in Ontario, who were attending writing or other courses in English departments or advanced courses in an ESL (English as a second language) institute. The nonnative English speakers had either passed standardized exams admitting them to an English-speaking university or were judged by their ESL teachers to be capable of understanding the level of English used in the questionnaires. Of the total subjects, 18% were monolingual English speakers, and 26% were born in North America.(n2) All of the subjects were included in those data analyses that contrasted North-American-born with foreign-born subjects. However, in order to look more closely at the effect of the subjects' native languages and countries of origin, a few subjects were omitted from other analyses. For the purpose of those latter analyses, five major native-language groups and six major geographical-origin groups were extracted from the subject sample.(n3) Those groups and their proportions are as follows: (a) language groups: English, 22%;(n4) Chinese (all dialects), 50%; Japanese, 12%; Spanish, 8%; and Vietnamese, 7%; and (b) geographical (country) groups: United States/Canada, 28%; Hong Kong/Singapore/Malaysia/Taiwan, 27%; Southeast Asia, 14%; People's Republic of China, 14%; Japan, 11%; and Latin America, 6%.(n5)

Procedure

The questionnaires were distributed by classroom instructors. They were self-administering and were filled out voluntarily either at home or in the classroom. Subjects were instructed not to include their names.

Results

The data were analyzed (a) for North-American born versus foreign-born groups, (b) for the six major country-of-origin groups and for the five major first-language groups, and (c) across *disorders* without regard to subject groups. For purposes of analysis, the responses to the statements were coded from 1 to 4 (probably no to probably yes). There was no effect for subjects' familiarity with the *disorders*; that variable was dropped from further analysis.

Significant differences between the North-American-born and foreign-born groups were found for two of the statements across the four *disorders* ($p < .05$ for all eight pairs): "[...]s could [speak better] if they tried" and "Many [...]s are emotionally disturbed." As shown in Figures 1 and 2, subjects born outside of North America tended to give responses that indicated more agreement with the questionnaire statements; that is, they were more in agreement with the ideas that (a) *speech*-disordered persons could improve their *speech* if they "tried harder" (Figure 1) and that (b) *speech* disordered persons were likely to be "emotionally disturbed" (Figure 2). (See Table 1 for complete results and significance information for the North-American-born vs. foreign-born subject groups.)

The data also were analyzed with respect to the five major language groups (English, Chinese, Vietnamese, Japanese, Spanish) and the six major geographic-origin groups (North America; Hong Kong area; Southeast Asia; Mainland China; Japan; Latin America). Not surprisingly, the most striking group differences appeared for the same two questionnaire items as in the two-group analysis described in the previous paragraph (North-American vs. foreign-born). For Item 8 ("[...]s could [speak better] if they tried"), the most revealing distinctions were found among the country-of-origin groups. That is, the results generally showed that for all four *disorders*, subjects from the Southeast Asia, China, and Hong Kong groups were more likely than members of other groups to respond that the *speech*-disordered persons could do better if they tried. (See Figure 3 for an example of this pattern and Table 2 for information on significance levels.)

For the other item, Item 11 ("Many [--]s are emotionally disturbed"), the clearest group differences appeared for particular language groups (rather than geographic groups) and were significant for only two of the *disorders*, cleft palate and hearing impairment. In this case, speakers of Chinese were more likely to indicate that the *speech*-disordered person would also be "emotionally disturbed" than were speakers from the other language groups (Figure 4). (As Table 3 shows, this effect reached significance for Chinese vs. English on both items.) No notable patterns of significant differences between first-language or country-of-origin groups were found for other questionnaire items.

Discussion

The results of this survey suggest the presence of *cultural* differences that could have an impact in therapy situations. For example, it was found that subjects born outside of North America are more likely to consider people with disordered *speech* to be emotionally disturbed. This could mean that *speech*-disordered members of those cultures will, on average, be treated as more abnormal by their communities than are similarly disordered members of other *cultural* communities. Further speculation is possible if we assume that our subjects are representative of

potential therapy clients or their parents (whose basic *attitudes*, we presume, would not change substantially upon finding themselves in such a role). In this case, our results might mean that parents or clients would view depression or other treatable emotional problems as normal concomitants of the *speech disorder* and would not seek help for them. Such attitudes and conditions could have a negative impact upon the progress of therapy, and therapists need to be aware of potential culturally derived conflicts between therapist and client in order to resolve such conflicts as quickly and unobtrusively as possible.

Foreign-born (especially Asian) subjects were more likely to state that the *speech*-disordered person could improve his *speech* if he "tried hard." This finding lends itself to many interpretations, all of which have reference to motivation, a major factor in therapy (Emerick & Haynes, 1986). For example (again making the assumption that our young-adult subjects are potential parents), it could mean that Chinese parents would not seek therapy for a stuttering child because they feel that the child is simply not "trying hard" enough. Conversely, it could mean that Asian clients or their families would be more likely to have false expectations about the efficacy of therapy, believing that success is guaranteed as long as the client "tries hard." In any case, therapists' awareness of typical *cultural attitudes* in their service population could allow them to cope more efficiently with problems arising from differences between their belief systems and those of their clients.

Many of the significant differences in *attitudes* in this study held true across a diversity of *speech disorders*. This consistency of *attitudes* across *disorders* suggests that these *attitudes* may reflect more general *cultural attitudes* that could be relevant in the *speech*- and language-therapy context. For example, Matsuda (1989) mentions that many Asian cultures consider only physical disabilities in children to be worthy of professional treatment, and that the Japanese usually feel that children's problems in school are all due to their "not trying hard enough" (p. 48). Likewise, Lee (1989) states that a common Chinese attitude is that "everyone is expected to excel, which can be done if only one tries hard enough" (p. 41). Although there is clearly a diversity of *attitudes toward* such matters within any culture, and *cultural* stereotyping must be avoided, the therapist should be aware of areas in which a particular client's *cultural* background makes certain *attitudes* more likely.

Although some valuable resource materials are available (such as Cheng, 1989), much more research is needed in this area to provide reliable guidance for the *speech* and language professional who is working with clients from a culture other than his or her own. (n6) The subjects surveyed here were from an educated subpopulation who may not be representative of their cultures, and there were relatively few subjects from each culture. However, we did find significant differences in our limited sample, and we hope to probe these differences in the future for selected cultures, using a socioeconomically broader subject base and questionnaires translated into the subjects' first language.

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(n1) The items used were necessarily general in nature for several reasons: (a) to ensure comparability across the four *disorders*, the items had to be applicable to all of the *disorders*; (b) the language of the questionnaire had to be relatively simple to avoid problems for the nonnative speakers; (c) the items had to be as culture-neutral as possible.

(n2) Some of the native English speakers of North-American birth indicated that they were bilingual.

(n3) The language and geographical groupings used in this study were created with linguistic and *cultural* similarities in mind, but with the full consciousness that some differences were being ignored for the purposes of this exploratory project.

(n4) The percentage of English speakers given here (22%) and the percentage of United States/Canada subjects (28%) differ slightly from the percentages given above in the North-American-born versus foreign-born section because of the omission here of foreign-born subjects--such as speakers of Greek or Indonesian--who spoke languages or came from areas not included in the five language subgroups or the six geographical subgroups.

(n5) Sample sizes for different language and geographical groups were unequal, and, in particular, the number of Latin Americans in our study was quite small. The between-group differences reported in this study are based on statistical procedures that adjust for differences in group size. However, these adjustments mean that the smaller the group, the larger the differences in the data must be in order to reach statistical significance. It is not surprising, therefore that no significant differences were found between the Latin American (Spanish-speaking) subjects and other subgroups. None of the discussion in the Results or Discussion sections makes reference to data obtained from the smallest subgroups, and when reference to such data is made in the tables, the sample sizes are clearly indicated.

(n6) ASHA recognized the need for such information when it stated (1986) that the *speech* language pathologist who proposes to work with limited-English-proficient clients in their other language not only should be fluent in that language, but also should be able to recognize *cultural* factors which affect the delivery of *speech* language pathology . . . services" (p. 191).

[TABLE 1. Descriptive statistics and t scores for North-American-born versus foreign-born groups on all questionnaire items.](#)

Item	Stuttering			Hearing loss		
	North Amer.	For. born	t	North Amer.	For. born	t

1.	Few friends						
	M	2.52	2.48	0.25	2.41	2.77	-2.14[*]
	SD	0.95	1.00		0.87	0.98	
2.	See a doctor						
	M	2.77	3.11	-1.84	2.84	3.19	-2.01[*]
	SD	1.17	0.99		1.14	0.93	
3.	Jokes OK						
	M	1.75	1.57	1.09	1.57	1.40	1.18
	SD	1.14	0.89		1.09	0.71	
4.	Job problems						
	M	3.05	2.81	1.57	3.18	2.96	1.37
	SD	0.75	0.89		0.69	1.00	
5.	Punished by God/fate						
	M	1.02	1.32	-2.80[**]	1.14	1.31	-1.57
	SD	0.15	0.70		0.63	0.62	
6.	Less intelligent						
	M	1.18	1.35	-1.66	1.25	1.44	-1.54
	SD	0.50	0.59		0.69	0.69	
7.	Go to non-doctor						
	M	3.14	3.15	-0.07	3.09	3.06	0.17
	SD	1.05	0.94		1.14	1.04	
8.	Could try harder						
	M	1.86	2.83	-5.92[**]	1.91	2.69	-4.27[**]
	SD	0.99	0.90		0.97	1.04	
9.	Hide at home						
	M	1.00	1.18	--[b]	1.02	1.16	-1.96
	SD	0.00	0.48		0.15	0.45	
10.	Teaching OK						
	M	1.50	1.35	1.13	1.41	1.32	0.72
	SD	0.95	0.66		0.92	0.58	
11.	Emotionally disturbed						
	M	2.00	2.52	-2.90[**]	1.69	2.45	-4.43[**]
	SD	1.03	1.01		1.00	0.94	
12.	Should get help						
	M	3.61	3.50	1.00	3.39	3.31	0.49
	SD	0.69	0.66		0.84	0.85	

Cleft palate

Misarticulation

Item	North Amer.	For. born	t	North Amer.	For. born	t
1. Few friends						
M	2.37	2.59	-1.24	2.00	1.94	0.35
SD	0.98	0.97		1.01	0.92	
2. See a doctor						
M	2.98	3.16	-1.14	2.72	2.93	-1.08
SD	1.01	0.86		1.18	1.02	
3. Jokes OK						
M	1.50	1.40	0.69	1.55	1.48	0.47
SD	1.07	0.72		1.07	0.76	
4. Job problems						
M	2.26	2.63	-2.09[*]	--[a]	--[a]	
SD	0.99	0.98		--[a]	--[a]	
5. Punished by God/fate						
M	1.07	1.28	-2.19[*]	1.07	1.21	-1.59
SD	0.45	0.57		0.45	0.52	
6. Less intelligent						
M	1.14	1.36	-2.11[*]	3.16	2.97	1.11
SD	0.51	0.65		0.94	1.00	
7. Go to non-doctor						
M	3.00	2.94	0.32	1.25	1.45	-1.71
SD	1.07	1.02		0.49	0.71	
8. Could try harder						
M	1.88	2.78	-5.43[**]	2.39	3.13	-4.46[**]
SD	0.93	0.93		1.06	0.89	
9. Hide at home						
M	1.02	1.23	-2.31[*]	1.05	1.13	-1.37
SD	0.15	0.57		0.21	0.41	
10. Teaching OK						
M	1.32	1.32	0.01	1.32	1.31	0.06
SD	0.83	0.67		0.83	0.63	
11. Emotionally disturbed						
M	1.43	2.17	-4.18[**]	1.57	2.10	-3.17[**]
SD	0.82	1.06		0.85	0.99	
12. Should get help						
M	3.26	3.25	0.01	3.39	3.33	0.37
SD	0.95	0.89		0.90	0.89	

Note. Sample sizes for all statistics in this table range from 42-44 for the North-American-born group and 118-122 for the foreign-born group because data on some items were missing.

[a] Item 4 (concerning employment) was omitted from the questionnaire in this *disorder* section; it was not relevant in reference to school-age children.

[b] t score cannot be calculated because SD for one variable is zero.

[*] $p < .05$,

[**] $p < .01$.

TABLE 2. Results for Item 8 ("could try harder") for the six major country-of-origin groups, with significant group differences as indicated by F-ratio scores and Tukey HSD multiple post hoc comparisons.

Legend for Table:

- A - *Disorder*
- B - US/Canada
- C - Japan
- D - Latin Amer.
- E - S.E. Asia
- F - China
- G - Hong-Kong
- H - F-ratio

A	B	C	D	E	F
Stuttering					
M	1.80	2.31	2.14	3.14[a]	3.00[a]
SD	0.94	1.01	0.69	0.85	0.92
n	40	16	7	21	20
Hearing loss					
M	1.85	2.86[a]	2.38	2.86[a]	2.58
SD	0.98	0.95	1.06	1.01	0.96
n	40	14	8	21	19
Cleft palate					
M	1.85	2.60[a]	2.38	3.10[a]	2.65[a]
SD	0.92	0.99	0.74	0.72	0.99
n	40	15	8	20	20
Misarticulation					
M	2.29	2.94[a]	3.00	3.30[a]	3.00
SD	1.03	0.93	1.00	0.87	0.94
n	41	16	7	20	19
A	G	H			
Stuttering					
M	3.10[a]	12.82[**]			
SD	0.71				

n	40	
Hearing loss		
M	2.93[a]	5.89[**]
SD	1.00	
n	40	
Cleft palate		
M	3.13[a]	10.23[**]
SD	0.80	
n	39	
Misarticulation		
M	3.45[a]	7.56[**]
SD	0.68	
n	40	

[a] Identified as significantly different ($p < .01$) from US/Canada by the Tukey HSD multiple-comparison test.

[**] $p < .01$.

[TABLE 3. Results for Item 11 \("emotionally disturbed"\) for the five major first-language groups, with significant group differences as indicated by F-ratio scores and Tukey HSD multiple post hoc comparisons.](#)

Legend for Table:

A1 - Group
A - **Disorder**
B - English
C - Japanese
D - Spanish
E - Chinese
F - Vietnamese
G - F-ratio

	A1					
A	B	C	D	E	F	G
Stuttering						
M	2.03	2.31	2.46	2.68	2.20	2.30
SD	1.07	1.14	1.21	0.94	1.03	
n	30	16	11	68	10	
Hearing loss[a]						
M	1.73	1.94	1.89	2.72	2.10	6.79[**]
SD	1.05	1.06	1.17	0.87	0.99	
n	30	16	9	67	10	
Cleft palate[a]						
M	1.50	1.44	1.46	2.49	1.63	8.72[**]
SD	1.08	0.73	0.82	1.00	0.92	
n	30	16	11	68	8	
Misarticulation						
M	1.55	1.63	2.18	2.28	1.78	3.72[*][b]
SD	0.95	0.72	1.33	0.93	1.30	

n 29 16 11 67 9

[a] For this *disorder*, the Tukey HSD multiple-comparison test identified English as significantly different from Chinese ($p < .01$).

[b] For misarticulation, the Tukey HSD multiple-comparison test identified no individual language groups as significantly different.

[*] $p < .01$.

GRAPH: FIGURE 1. Mean ratings of item 8 ("could try harder") by North-American-born (US/CAN) subjects versus foreign-born (NON-NA) subjects.

GRAPH: FIGURE 2. Mean ratings of item 11 ("emotionally disturbed") by North-American-born (US/CAN) subjects versus foreign-born (NON-NA) subjects.

GRAPH: FIGURE 3. Mean ratings of the stuttering version of Item 8 by subjects from the six major country-of-origin groups. (Text of item: Severe adult stutterers could stutter less if they tried hard.)

GRAPH: FIGURE 4. Mean ratings of the cleft-palate and hearing-impairment versions of item 11 by subjects from the five major first-language groups. (Text of Items: Many deaf people [or, Many people with cleft palates] are emotionally disturbed.)

References

American Speech-Language-Hearing Association (1986). Clinical management of communicatively handicapped minority language populations. In O. Taylor (Ed.), *Treatment of communication disorders in Culturally and linguistically diverse populations* (pp. 187-195). San Diego, CA: College-Hill Press.

Cheng, L. (1989). Service delivery to Asian/Pacific LEP children: A *cross-cultural* framework. *Topics in Language Disorders*, 9(3), 1-14.

Cooper, E., & Cooper, C. (1985). Clinician *attitudes toward* stuttering: A decade of change (1973-1983). *Journal of Fluency Disorders*, 10(1), 19-33.

Cooper, E., & Rustin, L. (1985). Clinician *attitudes toward* stuttering in the United States and Great Britain: A *cross-cultural* study. *Journal of Fluency Disorders*, 10(1), 1-17.

Crowe, T., & Walton, J. (1981). Teacher *attitudes toward* stuttering. *Journal of Fluency Disorders*, 6(2), 163-174.

DeCaro, J., Dowallby, F., & Maruggi, E. (1983). A *cross-cultural* examination of parents' and teachers' expectations for deaf youth regarding careers. *British Journal of Educational Psychology*, 53(3), 358-363.

Emerick, L., & Haynea, W. (1986). Diagnosis and evaluation in *speech* pathology. Englewood Cliffs, NJ: Prentice-Hall.

Erickson, J., & Iglesias, A. (1986). Assessment of communication *disorders* in non-English proficient children. In O. Taylor (Ed.), Nature of communication *disorders* in culturally and linguistically diverse populations (pp. 181-218). San Diego, CA: College-Hill Press.

Erickson, J., & Walker, C. (1983). Bilingual exceptional children: What are the issues?. In D. Omark & J. Erickson (Eds.), The bilingual exceptional child (pp. 3-22). San Diego, CA: College-Hill Press.

Fain, M. (1990,May). Opportunities for service in third world countries. *Asha*, 32, 45-46.

Furnham, A., & Lane, S. (1984). Actual and perceived *attitudes toward* deafness. *Psychological Medicine*, 14(2), 417-423.

Holland, A., & Forbes, M. (1986). Nonstandardized approaches to *speech* and language assessment. In O. Taylor (Ed.), Treatment of communication *disorders* in culturally and linguistically diverse populations (pp. 49-66). San Diego, CA: College-Hill Press.

Horsley, I., & FitzGibbon, C. (1987). Stuttering children: Investigation of a stereotype. *British Journal of Disorders of Communication* 22(1) 19-35.

Hurst, M. A. & Cooper, E. (1983). Vocational rehabilitation counselors' *attitudes toward* stuttering. *Journal of Fluency Disorders*, 8(1), 13-27.

Hurst, M. I., & Cooper, E. (1983). Employer *attitudes toward* stuttering. *Journal of Fluency Disorders*, 9(1), 1-12.

Koltke, J., Mellor, S., & Schmidt, A. (1987). Effects of information on *attitudes toward* and interpersonal acceptance of persons who are deaf. *Rehabilitation Psychology*, 32(4), 239-244.

Lee, A. (1989). A socio-*cultural* framework for the assessment of Chinese children with special needs. *Topics in Language Disorders*, 9(3), 38-44.

Livneh, H. (1984). On the origins of negative *attitudes toward* people with disabilities. In R. Marinelli & A. Dell Orto (Eds.), The psychological and social impact of physical disability (pp. 167-184). New York: Springer.

Matsuda, M. (1989). Working with Asian parents: Some communication strategies. *Topics in Language Disorders*, 9(3), 45-53.

McKinnon, S., Hess, C., & Landry, R. (1986). Reactions of college students to *speech disorders*. *Journal of Communicative Disorders*, 19, 75-82.

Meadow, K., & Dyssegaard, B. (1983). Social-emotional adjustment of deaf students: Teachers' ratings of deaf children: An American-Danish comparison. *International Journal of Rehabilitation Research*, 6(3), 345-348.

Meyerson, M. (1983). Genetic counseling for families of Chicano children with birth defects. In D. Omark & J. Erickson (Eds.), *The bilingual exceptional child* (pp. 285-298). San Diego, CA: College Hill Press.

Payne, K. (1986). *Cultural* and linguistic groups in the United States. In O. Taylor (Ed.), *Nature of communication disorders in culturally and linguistically diverse populations* (pp. 19-46). San Diego, CA: College-Hill Press.

Ruscelio, D., Stutler, S., & Toth, D. (1983). Classroom teachers' *attitudes toward* children with articulatory *disorders*. *Perceptual & Motor Skills*, 57(2), 527-530.

Scheuerle, J., Guilford, A., & Garcia, S. (1982). Employee bias associated with cleft lip/palate. *Journal of Applied Rehabilitation Counseling*, 13(20), 6-8, 45.

Shames, G. (1989). Stuttering: An RFP for a *cultural* perspective. *Journal of Fluency Disorders*, 14(1), 67-77.

Togonu-Blskersteth, F., & Odebiyl, A. (1985). Prior contacts and perception of the deaf by the non-deaf in Nigeria. *Social behavior and Personality*, 13(1), 43-53.

Togonu-Bickersteth, F., & Odeblyl, A. (1986). Vocational capabilities of the deaf as assessed by the deaf and non-deaf in Nigeria. *International Journal of Rehabilitation Research*, 9(3), 283-286.

Yeakie, M., & Cooper, E. (1986). Teacher perceptions of stuttering. *Journal of Fluency Disorders*, 11(4), 345-359.

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Appendix

Text of Questionnaire Statements

The wording for the stuttering section is used here as an example; the statements for the other three *disorders* were the same except for the minimal necessary changes in wording.

1. Severe adult stutterers have trouble making friends or getting married.

2. Severe adult stutterers should go to a doctor for help with their *speech*.
3. It is OK to make jokes about stuttering if no stutterers are listening.
4. Severe stutterers have trouble getting a good job.
5. Severe stutterers or their families are being punished (by fate or God, for example).
6. Severe stutterers are likely to be less intelligent than other people.
7. Severe stutterers should go to a person who cures or helps people (not a doctor) for help with their *speech*.
8. Severe adult stutterers could stutter less if they tried hard.
9. The family should keep a severe adult stutterers at home to hide the problem from other people.
10. It is sometimes OK to tease or make fun of adult stutterers.
11. Many severe stutterers are emotionally disturbed.
12. Severe stutterers should get help with their *speech* problem at some time in their lives.

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