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Management and Attitudes Towards Victims of Speech and Language Disorders – A Case Study Margaret Lawrence University

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Research Article

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Abstract

Research has established that people living with speech and language disorders are often subject to social maltreatment relative to their peers with normal speech. It featured data from one-on-one interactions with students living with speech and language disorders. The data is analyzed by considering the nature of the disorder (NOD); the rate of its interference with communication (ROI); the respondent's personal efforts at controlling the interference (PEC); perceived social attitude against the affected (PSA); response of the affected to the social attitude (RSA); the level of awareness of the cause of the disorder (AOC), and the level of awareness of clinical remedy to the disorder. Varied levels of experience are discovered after the analysis. More research in the area is recommended for a wider coverage, and improved social re-orientation be massively embarked upon to end this negative social classification.

1.0 INTRODUCTION

Individuals who have speech or language disorders are at risk for social challenges (Connaghan et al, 2022) as they face increased risk of social, emotional, and/or academic challenges, discrimination, and relegation relative to their peers with normal speech (Hitchcock, Harel & Byun, 2015). Language (and its use in communication) is central to human existence, development, thinking, and thought; it is the tool that help bring realities into existence **(**Igiri, 2017; Crystal & Alan, 2023; Nicholas & Stephen, 2009; Nnamdi-Erachalu, 2025). All the activities of man in society are executed through language – without language, there can be no society, and without language, communication, interactions, and relations among humans will be unimaginable (Nnamdi-Erachalu, 2017, 2025). Communication disorders affect an individual's social, emotional, cognitive, and behavioral well-being (Thakur, Kale, & Swami, 2023). Therefore, the study of speech and language disorders becomes critical, especially for understanding human communication, improving the quality of life, and advancing clinical and educational interventions (Hitchcock, Harel & Byun, 2015; Pistav, Kayhan & Akmese, 2024).

Speech, according to Thakur, Kale & Swami (2023), refers to sounds produced by the oral mechanism, including the lips, tongue, vocal cords, and related structures for communication; it is the ability to organize and articulate speech sounds (Banu et al, 2023). Speech disorder can be explained as any of the disorders that affect human speech production (Arnold, 2025; Eske, 2023; G I. Nnamdi-Eruchalu, lecture notes, 2025; Jijo et al, 2019). Speech (and language) disorders affect an individual's communication, social, emotional, cognitive, psychological, and behavioural health. A study of their prevalence and management can assist in prevention, early identification, intervention, rehabilitation and counselling (Arnold, 2025; Jijo et al, 2019). Human communication and interactions rely fundamentally on the faculty of speech accompanied by the production of speech sounds (Arnold, 2025). The production and reception of these sounds require a properly functioning ear and auditory system, intact and healthy vocal and sound-generating acoustic organs.

The act of speaking requires accurate coordination of these organs, including the head, neck, chest, and breath control (Cummings, 2018; Eske, 2023). Spoken communication and interaction often become difficult, if not completely impeded, by deformities in any of the speech organs used in speech and sound production or by disorders affecting areas of the brain that process the sounds (Arnold, 2025; Cummings, 2018). The application of linguistic theories, methods and descriptive findings to the analysis of medical conditions or settings involving a disorder (or pathology) of language. The branch or aspect of linguistics that works in collaboration with speech pathologists/therapists, audiologists, and others in helping to assess, diagnose, and remediate disorders of the production and comprehension of spoken or written language is referred to as clinical linguistics – these disorders may occur in educational as well as clinical settings (Arnold, 2025; Crystal & Alan, 2023). Speech and language disorders are discovered to be more predominant among children, especially pre-school children. It is said to affect 1 in 12 children, or 5% to 8% of preschool children (Calonge et al., 2006; Jijo et al., 2019; Thakur, Kale & Swami, 2023).

Research in speech and language disorders is, however, essential for comprehending human communication, improving quality of life, and advancing clinical and educational interventions (Crystal & Alan, 2023; NIDCD, 2023; Yorkston,

Beukelman, & Traynor, 2010). It fosters an understanding of human communication: The study helps provide insights into the cognitive and neurological processes underlying communication. Research in this area helps map brain functions related to language processing, informing fields like neurolinguistics and cognitive science. The study of aphasia (language impairment due to brain injury), however reveals how specific brain regions, like Broca's or Wernicke's areas, contribute to language production and comprehension (Bishop, 2014; Cummings, 2014; McLeod & Goldstein, 2012; NIDCD, 2023; Paul & Norbury, 2012; Yorkston, Beukelman, & Traynor, 2010).

This paper studies the management and attitude towards people living speech and language disorders with focus on school environment. It studies these by undertaking a field study of people living with speech and language disorder on the Margaret Lawrence University (henceforth, the University), Abuja campus. The University, a private institution, was established in 2022. It is a rather young university with the prospect of recruiting as many qualified students as possible and make a name among the already existing universities in Nigeria and Abuja. The University, in her mission statement avers to provide an avant-garde educational programme which shall empower the minds of professionals with varying interests and abilities, amongst other (MLU, 2025).

2.0 AN OVERVIEW OF SPEECH AND LANGUAGE DISORDERS

Eske (2023) explains language disorder as a condition that affects a person's ability to learn words

or understand what others say to them, and a speech disorder as any condition that affects a person's ability to produce sounds that create words. Language disorders are categorized into *receptive, expressive*, and *mixed receptive-expressive* (Cummings, 2018; Eske, 2023; Jijo et al, 2019; Nnamdi-Erachalu, 2025; Werge, 2023). Receptive language disorders include challenges in understanding language, expressive language disorders include challenges in producing language, while mixed receptive-expressive language disorder features the challenges experienced in both understanding and producing language (Cummings, 2018; Eske, 2023; Jijo et al, 2019; Nnamdi-Erachalu, 2025; Werge, 2023).

Following the account of Arnold (2025), Cummings (2018), and Eske (2023), communication disorders are, from physiological considerations, classified into disorders of voice and phonic respiration, articulatory disorders, and language disorders. Voice disorders are also referred to as dysphonia. The types of dysphonia are subdivided according to the cause. These include a vocal disorder resulting from paralysis of the larynx (paralytic dysphonia); injury (trauma) of the larynx often leading to traumatic dysphonia, while endocrine dysphonia reflects the voice changes resulting from disease of the various endocrine glands such as the pituitary (Arnold, 2025; Cummings, 2018; Thakur, Kale & Swami, 2023).

One of the recurrent speech disorders are those that disturb the child's acquisition or learning of language. This is classified a developmental disorder. Research works have shown identified general language disability from genetic features with a familial (inherited) pattern mainly from the paternal side, and acquired language disorders resulting from to damage sustained before, during, or shortly after birth (ie, perinatally) as the most common among children with developmental language disorders (Arnold, 2025; Cummings, 2018; Sidhu & Bhutani, 2016). These perinatal damages include the gamut of toxic, infectious, traumatic, nutritional, hormonal, and other damages that may hurt the infant. Some children experience unexpected difficulties in mastering the patterns of articulation of their mother tongue. These children are said to manifest articulatory immaturity (infantile dyslalia). This may be caused by delayed maturation of psychomotor skills in the absence of an organic cause (Arnold, 2025; Cummings, 2018; Eske, 2023; Kuhl, 2010; Sidhu & Bhutani, 2016).

Articulatory disorders include: cluttering, lisping, stuttering or stammering, dysphasia, and aphasia. Cluttering (also tachyphemia) features hasty, sloppy, erratic, stumbling, jerky, and poorly intelligible speech that may often resemble stuttering. It is different from stuttering clearly in that the clutterer is usually unaware of it. The clutterer often remains unconcerned and does not seem to fear speaking situations (Arnold, 2025; Cummings, 2018). Lisping manifests in several ways. It occurs with: the tongue tip protruding between the front teeth, with a slurping noise in the cheek pouch, with the tongue too far back along the palatal midline, with excessive tongue pressure against the teeth; in several snorting and

nasal subtypes, as well as through substitute hissing deep in the throat or even within the larynx, such as in cleft-palate speech. Stuttering (stammering), is also referred to in academic context as dysphemia. Stuttering is the most frequent and conspicuous post-puberty type of disturbed speech often encountered. To stutter is to talk with continued involuntary repetition of sounds. Dysphasia features the partial or total loss of language as a result of wounds in the part(s) of the brain concerned with language function. For instance, stroke and head injury are usual causes of dysphasia. Aphasia is the case when the left side of the brain is affected. It often results in the paralysis of the right arm and leg (Arnold, 2025; Cummings, 2018; Kuhl, 2010; Thakur, Kale & Swami, 2023; Sidhu & Bhutani, 2016).

The various types of communication disorders that develop from structural injuries or metabolic disturbances are categorized as symptomatic speech disorders. Disturbed speech that results from injuries in the nervous system is known as dysarthria. Intellectual disability often affects the development of language ability as it does intellectual capacity. This disorder is referred to as dyslogia. Language disorders can also result from mental disturbances, as seen in the peculiar (dysphrenic) mode of speech among sufferers of schizophrenia. Hearing loss often results in the distortion of the speech pattern for which various names have been coined – audiogenic dyslalia. Defects in oral articulators affect the mechanics of articulation. These, therefore, affect the quality and intelligibility of speech. A situation as this is referred to as dysglossia – shaking palsy, Parkinson's disease, Chorea, etc (Arnold, 2025; Kuhl, 2010; Thakur, Kale & Swami, 2023; Sidhu & Bhutani, 2016).

3.0 THE DEVELOPMENT OF THE STUDY OF SPEECH AND LANGUAGE DISORDERS

According to Pointe (2013), early studies of speech and language disorders can be traced to ancient philosophers who explored language as a cognitive and social phenomenon. Some of the disorders were however, poorly understood and often attributed to supernatural causes or moral failings. Pointe (2013) traces the development of its to Ancient Greece by making reference to Hippocrates (460–370 BCE), who laid early groundwork for linking neurological damage to communication impairments by noting speech difficulties in patients with brain injuries. However, it was not until the Renaissance, speech and language disorders were rarely studied systematically. Most of the treatments at this time focused on general medical or spiritual interventions (Pointe, 2013). Tesak & Code (2008) unveil that in the 19th century, there was a rise in neurology as Paul Broca (1861) and Carl Wernicke (1874) identified brain regions (Broca's and Wernicke's areas) associated with language production and comprehension while studying patients with aphasia caused by brain damage.

Their study strengthened the neurological basis for language disorders. Phrenology (now discredited) incited popular interest in brain localization, for instance early linguists like Wilhelm von Humboldt began work on language structure, which indirectly influenced the study of language impairments (Tesak & Code, 2008). Alexander Graham Bell, an educator, (known for his work with the deaf) began developing methods for teaching speech to individuals with hearing impairments in Europe and the U.S. He laid the foundations for speech therapy (Beukelman & Mirenda, 2013; Duchan, 2011). The discovery of the FOXP2 gene in the 1990s, connected to language and speech impairments, made the provision for a genetic basis for disorders like SLI (Fisher & Scharff, 2009). This landmark spurred research interests toward molecular and genetic underpinnings.

According to Hickok & Poeppel (2007), technological developments like fMRI and PET scans gave room for researchers to map brain activity during language tasks, advancing the understanding of disorders like aphasia, autism spectrum disorder (ASD), and developmental apraxia of speech. Also, the rise in autism diagnoses led to increased focus on pragmatic language impairments. Helen Tager-Flusberg, for instance, (Tager-Flusberg et al., 2005) explored communication deficits in ASD, emphasizing social language use.

There was interdisciplinary integration and further technological advancement in the 21st Century. The study of speech and language disorders assumed an interdisciplinary approach by integrating linguistics, neuroscience, psychology, and education. Collaborative research activities have led to more comprehensive models of disorders like developmental language disorder (DLD) (Bishop, 2017). There is also the development of sophisticated Augmentative and Alternative Communication (AAC) tools in this same era. These tools include speech-generating devices and apps that help improve communication for individuals with severe disorders (Beukelman & Mirenda, 2013).

Other activities that have further advanced the development of the study of speech and language

disorders include: research works emphasizing early intervention (eg for children with language delays) and evidence-based therapies (programs like the Hanen Program which focus on parent-mediated interventions; increased attention to multilingualism and cultural factors that has shaped research on language disorders in diverse populations (addressing issues like bilingual language impairment); AI and machine in use to analyze speech patterns and predict disorders, enhancing early detection (e.g., automated screening for autism or aphasia); advances in genomics and neuroimaging (paving the way for tailored therapies based on individual genetic and neurological profiles) (Girolametto & Weitzman, 2006; Hoff, 2003; Morgan & Vogel, 2008), etc.

4.0 SOME STATISTICS ON GLOBAL PREVALENCE OF SPEECH AND LANGUAGE

DISORDERS

The table below provides data on the key global prevalence statistics by disorder, type, and region. These are the data within the reach of this research:

Table 1
Global Prevalence Statistics of Speech and Language Disorders.

DISORDER TYPE	PREVALENCE RANGE	REGION/NOTES	REFERENCE
Speech and Language (General)	7.7% (ages 3–17)	U.S., boys (9.1%) > girls (5.2%)	Black et al. (2015)
Speech Sound Disorders	8–9% (young children)	Global, 5% by first grade	Kutest Kids (2024)
Language Disorders (DLD)	7–8% (children)	Global, 6.6–20.6% (ages 4–5), 3.4–18.9% (ages 7–11)	Tomblin et al (1997)
Stuttering	1% (current), 5% (lifetime)	Global, boys 2–3 times > girls	NIDCD (2025)
Voice Disorders	3–9% (general population)	U.S., 20–50% in teachers, 2% in children	Beaming Health (2025)
Aphasia	2 million (current cases)	U.S., 180,000 new cases annually	NIDCD (2025)
Communication Disorders	4.29% (school children)	Ballari, South India, 1.04% speech/language	Saraswathi (2021)
Speech Delay	27% (children under 3)	India, higher than Western estimates	Sidhu & Bhutani (2016)
Speech/Language Impairments	16.2–21.8% (age 5)	Ottawa-Carleton, Canada, kindergarten children	Kutest Kids (2024)

5.0 KEY PREVALENCE STATISTICS IN ABUJA AND NORTH CENTRAL NIGERIA

According to Nwosu (2018), a number of works have investigated the prevalence of speech and

language disorders in developed countries. He [Nwosu, 2018] avers that Nigeria needs prevalence works

that will compare the number of individuals with speech and language disorders with the total population within a given area. According to him, there is insufficient information on the prevalence of speech and language disorders among children within the school system in Nigeria. Ayo-Aderele, (2013) and Nwanze (2013) say that there is the shortage of speech and language pathologists in Nigeria.

Bello-Mojeed et al (2011) however makes available some statistics unveiling that a five-year retrospective review (2005–2009) of referrals to the speech and language therapy unit at the ENT Department in North Central Nigeria reported 146 patients with speech and language disorders. Of these, 61% were under 5 years, 21.9% were aged 5–10 years, 13.7% were 11–20 years, and 1.4% were 21–34 years, with no cases observed in the elderly. The most common diagnosis was deaf-mutism (57.5%), followed by delayed speech development (21.2%). Aphasia was the least common, at 1.4%. Male preponderance was noted, with a male-to-female ratio of 1.9:1, consistent with global trends where boys are more affected by disorders like stuttering.

Research on deaf communities in Abuja highlights that over 75% of childhood deafness is caused by preventable illnesses (e.g., meningitis, measles) during critical developmental years (0–5 years), contributing to speech and language disorders like deaf-mutism (Asonye, Emma-Asonye & Edward, (2018). These disorders are recognized as significant public health concerns, particularly among children, especially as these disorders impact their education, and social integration of the individual and have long-term outcomes (Nwosu, 2015). Abuja's diverse population, including various ethnic and linguistic groups, compounded by limited access to specialized services and cultural factors influencing awareness and stigma, add complexity to the diagnosis and intervention in speech and language disorder cases (Aremu et al, 2011; Asonye, Emma-Asonye & Edward, 2018; Nwosu, 2015). Specific data on speech and language disorders in Abuja are scarce. However, some key information from studies conducted in North Central Nigeria, including Abuja, helps provide critical insights. Based on available data, the following disorders are

prominent in Abuja and North Central Nigeria:

1. Deaf-Mutism (57.5%) – resulting in severe communication challenges, as affected children lack access to spoken language and often face delays in sign language exposure due to low parental signing proficiency (Bello-Mojeed et al., 2011; Asonye et al., 2018).
2. Delayed Speech Development (21.2%): This is common in children under 5. It is associated with environmental factors (eg limited linguistic input), socioeconomic challenges, and lack of early intervention programs. In Abuja, cultural practices and late school starts for deaf children exacerbate this issue (Asonye et al., 2018).
3. Stuttering: Specific data on the prevalence of stuttering in Abuja is not readily available (NIDCD, 2025). NIDCD (2025) provides a global estimates that suggests that 1% of the population stutters, with a higher prevalence in boys.
4. Aphasia (1.4%): According to Bello-Mojeed et al., (2011) aphasia has a low rate prevalence in the North Central Nigeria study reflects the focus on pediatric cases. Conditions like childhood apraxia of speech (CAS) and voice disorders are also less documented in Abuja but are globally estimated at 1–2 per 1,000 for CAS and 3–9% for voice disorders (ASHA, 2023).

6.0 SOCIAL ATTITUDE TOWARDS PEOPLE WITH SPEECH AND LANGUAGE DISORDERS.

Research has it that both children, youths, and adults with speech, language and hearing disorders are usually adjudged more negatively than peers without speech disorders (Alighieri et al, 2023; Kiogora, 2021); they experience negative social consequences (Batten et al., 2014; Connaghan et al, 2022; Durkin & Conti-Ramsden, 2007; McCormack et al., 2009;

Rusiewicz et al., 2018). They are at a greater risk for social challenges (Connaghan et al, 2022). They often face an increased risk of social, emotional and/or academic challenges and discrimination relative to their peers with typical speech (Hitchcock, Harel & Byun, 2015).

Regarding the school setting, Kiogora (2021) explains that one of the challenges experienced in the

school environment by people living with speech and language disorders often include lack of worry-free

social integration. He notes that there are also challenges for their parents and teachers in meeting these children's developmental and educational needs. According to him, these challenges centre on the need for specific expertise in the school setting and access to professional services to support these students' engagement in the learning and social environments of school in which they find themselves. According to findings, Hitchcock, Harel & Byun (2015), explain that a large number of parents of students with speech and language disorders express frustration that their children's speech deficits were deemed ineligible for treatment in the school setting due to a lack of impact on academic performance. From a more subjective perspective (Hitchcock, Harel, & Byun, 2015), the parents believed that a child with speech and language challenges could exhibit strong academic performance despite having speech disorders. Hategekimana & Gratien (2024) are also of the opinion that they are not given proper support to help learn and succeed in their educational journeys due to these communication deficiencies. Hitchcock, Harel & Byun (2015) conclude that there is a clear need for follow-up research based on their findings using a refined questionnaire and a larger sample size.

Attitudes towards these category of learners range from positive and supportive to negative and exclusionary. These attitudes are influenced by factors such as the severity of the disorder, the age and maturity of the individuals involved, and the level of education and awareness about communication differences (Kiogora 2021; Pistav, Kayhan & Akmese, 2024). Pistav, Kayhan & Akmese, (2024) conclude that positive support from teachers increase social acceptance of students with speech and language disorder in their classrooms. The severity of the speech or language disorder can however influence social attitudes, and a rather severe disorder may lead to more negative social reactions. Promoting positive social attitudes towards individuals with speech and language disorders in the school environment requires a multi-faceted approach that includes education, support, and awareness-raising efforts for both teachers and students (Kiogora, 2021; Hategekimana & Gratien, 2024; Pistav, Kayhan & Akmese, 2024; Rusiewicz et al., 2018).

7.0 METHODOLOGY

This paper features data from field-based one-on-one interactions with fifteen respondents (students) living with a speech and language disorder at Margaret Lawrence University, Abuja campus. Twelve of these are students gave usable responses, while three did not. Each respondent voluntarily shared relevant experience. Personal information of the respondents is not presented in this work for confidentiality to uphold research ethics (Bhandari, 2024; Kang & Hwang, 2023). The data analysis is done in tabular form for easier presentation and accessibility. The analysis presents: (1) the nature of the disorder (NOD); (2) information on the rate of interference with communication or severity (ROI) of the observed impairment with the communication of the respondent; (3) personal efforts at controlling (PEC) the speech organ concerned for clearer communication (4) perceived social attitude resulting from the disorder (PSA); (5) response to the perceived social attitude (RSA); (6) awareness of the cause of the disorder (AOC), and (7) awareness of clinical remedy (ACR). The analysis is presented below.

Table 2
An Analysis of Data of Got from One-on-one Interaction with Respondents from Margaret

sn		NOD	ROI	PEC	PSA	RSA	AOC	ACR
1	Respondent 1	Stammering	Not often, only when talking fast	Keeps quiet most of the time or talks slowly.	Negative: mockery.	Gets angry and sad.	Not aware.	Not aware.
2	Respondent 2	Articulatory disorders: lisp and stammering	Stammers occasionally, especially when in a state of panic or when angry. This articulatory disorder is usually minimal in rapid speech.	Talks slowly. Rushes over words with /s/ to avoid obvious wrong articulation.	Negative.	Gets extra careful.	Not aware.	Not aware.
3	Respondent 3	Articulatory disorder: lisp	Not glaring in rapid speech – not often	Rushes over words with /s/ to avoid obvious wrong articulation.	Negative.	Cares less	Not aware.	Not aware.
4	Respondent 4	Articulatory disorder: bilabial sounds and labia sounds	Always.	Avoids much talk.	Not quite glaring.	Cares less	Aware. One side of the lips is flatter.	Not aware.
5	Respondent 5	Cluttering.	Always.	Taps, jerks, and struggles to let out words.	Negative: laughter and mockery.	Feels ashamed and fights back.	Aware – mimicking of a stammerer, at a much younger age.	Not aware.
6	Respondent 6	Articulatory disorder: velar clusters	Always.	Retries, changes the word or avoids talking, especially in public.	Negative: laughter and mockery.	Gets angry.	Not aware.	Not aware.
7	Respondent 7	Articulatory disorder: Lisp	Always.	Struggles.	Negative: laughter and mockery.	Gets angry.	Aware – clinical negligence at a younger age.	Aware.
8	Respondent 8	Articulatory disorder: lisp, /t/ /f/	Always.	Struggles.	Not noticed.	Not applicable.	Not aware.	Not aware.

sn		NOD	ROI	PEC	PSA	RSA	AOC	ACR
9	Respondent 9	Articulatory disorder: lisp, /r/ /t□/	In spontaneous speech, but often well in isolation.	Avoids talking, especially in public.	Negative: laughter and mockery.	Fights back.	Aware.	Use of braces, but scared to try it.
10	Respondent 10	Articulatory disorder: all sounds	Always.	Struggles. Talks slowly.	Not aware.	None.	Aware - overbite	Yes. On braces already.
11	Respondent 11	Articulatory disorder: /r/	Always.	Gets it right when mind is put to it.	Not aware.	None.	Not aware.	Not aware.
12	Respondent 12	Articulatory disorder: lisp, /r/ /t□/ /□/ /d/ /□/	Always.	Struggles. Talks slowly. Avoids talking, especially in public.	Negative: laughter and mockery.	Feels bad. Avoids them.	Aware: slight tongue twist.	Not aware.

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8.0 RESULTS

Nature of Disorder (NOD)

From the analysis, in the nature of the disorder column, NOD, the twelve respondents experience various articulatory disorders. One stammers (Respondent 1 and 2) and has a lisp, another one clutters (Respondent 5), has a side of the clips flatter than the other parts, leading to challenges in articulating bilabial sounds accurately (Respondent 4). Six experience lisp (Respondent 2, 3, 7, 8, 9, and 12). One experiences disorders in the articulation of velar clusters (Respondent 6). Other articulatory disorders found include difficulties in the articulation of /r/ /t□/ /□/ /□/, /d/, /t/, and /f/ experienced by four of the respondents, as varied in the analysis (Respondents 8, 9, 11, and 12). Figure 1, below, illustrates these.

Rate of Interference (with communication), ROI

In the rate of interference with communication, ROI, column, Respondents 1, 2, 3, and 9 do not experience the effect of their disorder often. However, Respondents 4, 5, 6, 7, 8, 10, 11, 12 experience this effect always. Respondents that experience the interference on their communication often constitute 67% while those whose experience of the interference in not often constitute 33%. Figure 2, below, illustrates these.

Personal Efforts at Controlling (the Concerned Organ), PEC

In the PEC column, (personal efforts at controlling (PEC) the speech organ concerned for clearer communication), the predominant personal efforts are summarized under two options: **to avoid talking** or **struggling ahead**. Some respondents try both, while some try either. Respondents 1–4, 6, 9, 10, and 12 avoid taking. Respondents 2, 10, and 12 try both, 5,7, 8, and 11 struggle ahead, 7–8, 10, and 12 avoid taking. The choice of each is 66.7%, whereas those who chose both constitute 33.3%. Figure 3, below, illustrates these.

Figure 3: A 3-D Clustered column showing the percentage of personal efforts of each respondent.

Perceived Social Attitude, PSA

In the PSA column, (perceived social attitude resulting from the disorder, the predominant perceived social attitude resulting from the disorder towards the respondents are summarized under two options: **negative** or **not aware**. Respondents 1, 5, 6, 7, 9, and 12 said theirs was negative, while Respondents 2, 3, 4, 8, 11, and 10 said they were not aware. Those that experience negative social responses because of their speech disorder constitute 67.7% of the total respondents, while those who responded 'not aware' constitute 33.3%. Figure 4, below, illustrates these.

Response to the Perceived Social Attitude (RSA)

In the RSA column, (response to the perceived social attitude resulting from the disorder, the predominant responses from the respondents are summarized under three options: **gets angry/sad, fights back, and does nothing**. Respondents 1, 2, 6, 7, and 12 get angry and sad, while Respondents 3, 4, 5, and 9 fight back, and Respondents 8, 10, and 11 do nothing. Those that get angry and sad constitute 67.7% of the total respondents, while those that responded 'not aware' constitute 33.3%. Figure 5, below, illustrates these.

Awareness of the Cause, AOC

In the AOC column (awareness of the cause of the disorder), the predominant responses from the respondents are summarized as **aware** and **not aware**, respectively. Respondents 4, 5, 7, 9, 10, and 12 are aware of the cause of their speech disorders, while Respondents 1, 2, 3, 6, 8, and 11 are not aware. Those that are aware of the cause constitute 50% of the total respondents, and those not aware of the cause also constitute 50% of the total respondents. Figure 6, below, illustrates these.

Awareness of Clinical Remedy, ACR

In the AOC column (awareness of the cause of the disorder), the predominant responses from the respondents are summarized as **aware** and **not aware**, respectively. Respondents 7, 9, and 10 are aware of clinical remedies for their speech disorders, while Respondents 1–6, 8, 11, and 12 are not aware of any remedies. Those that are aware of clinical remedies constitute 25% of the total respondents, while those who are not aware constitute 75% of the total respondents. Figure 7, below, illustrates these.

9.0 CONCLUSION AND RECOMMENDATION

From the findings, it is obvious that social attitudes towards people living with speech and language disorders in school environments are rather negative. These attitudes are discouraging as they often get the recipients sad, ashamed, and annoyed. The recipients see themselves as unworthy of public attention and hearing. It fosters demoralization and sense of social mockery and rejection. The findings of this research further validates existing research findings – Alighieri et al, 2023; Connaghan et al, 2022; Kiogora, 2021, and a host of others) – and adds the decision of seclusion by the recipients of these negative attitude. Most of the students living with speech disorders are not aware of the available clinical remedies. Our society, especially need more orientation on how to relate with people with speech disorders towards bringing out

the best in them instead of making them to feel like social rejects.

It is recommended that more research be undertaken in this area across wider areas of coverage. Civil society organizations, governments, and health organizations need increase their efforts at drawing up programmes that will orientate the populace on expected attitudes towards people living with speech and language disorders for fruitful social cohesion and integration.

Declarations

Ethical Approval Statement This study, titled “Management and Attitudes Towards Victims of Speech and Language Disorders – A Case Study of Margaret Lawrence University”, was conducted in accordance with the ethical principles outlined in the Declaration of Helsinki and the relevant national guidelines for research involving human participants. Ethical approval was obtained from the Research Ethics Committee of Margaret Lawrence University. The study protocol (Ref: MLU/REC/2025/EnG256) was reviewed and approved on 26 March 2025. All participants provided informed consent prior to their involvement in the study. Participation was voluntary, and participants were assured of their right to withdraw at any stage without any negative consequences. Confidentiality and anonymity of all respondents were strictly maintained throughout data collection, analysis, and reporting. No identifying information has been disclosed in the research findings. The researchers confirm that the study was carried out in full compliance with the approved ethical protocol.

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Figures

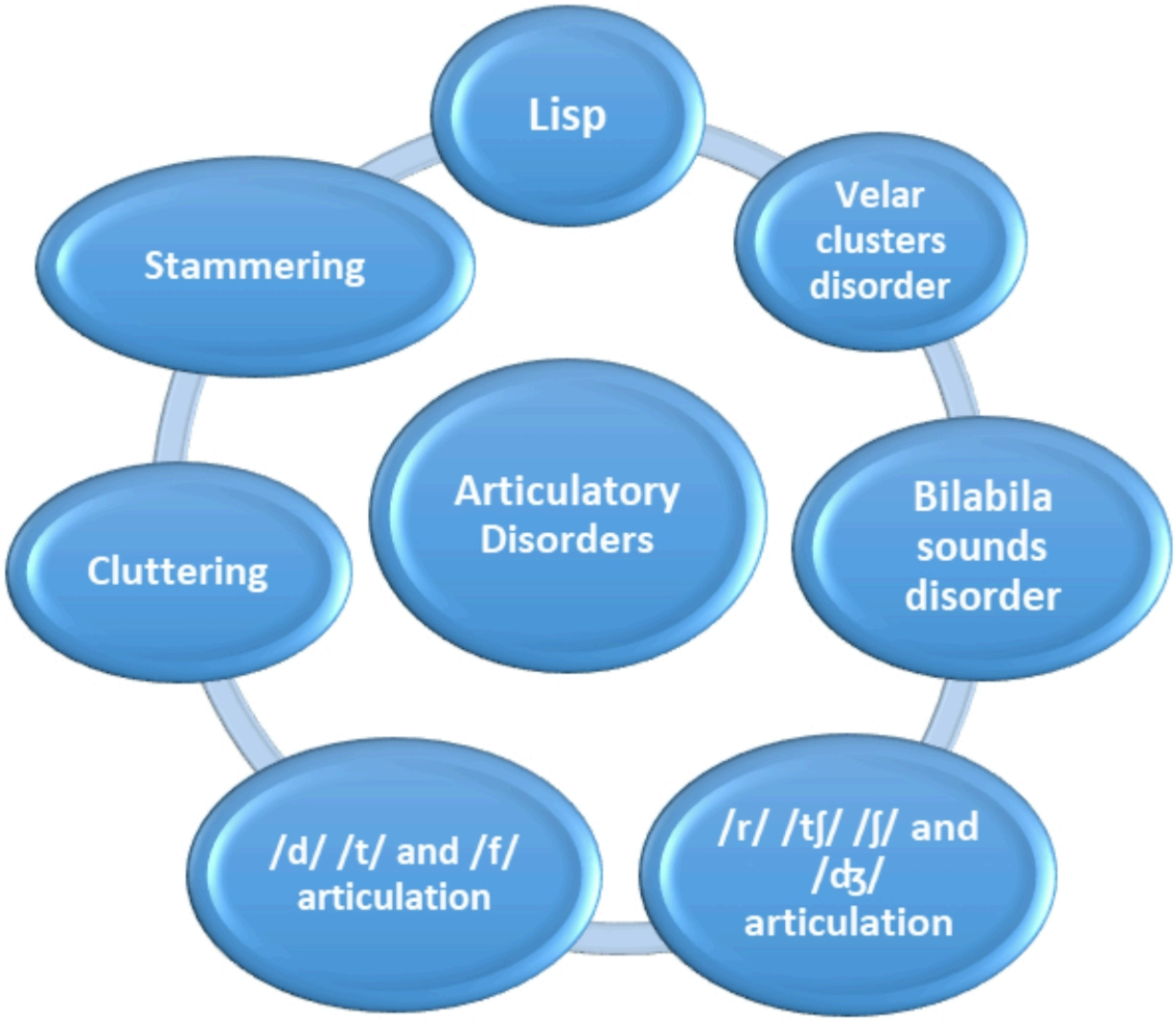


Figure 1

A Radial Cycle showing the Nature of Disorder.

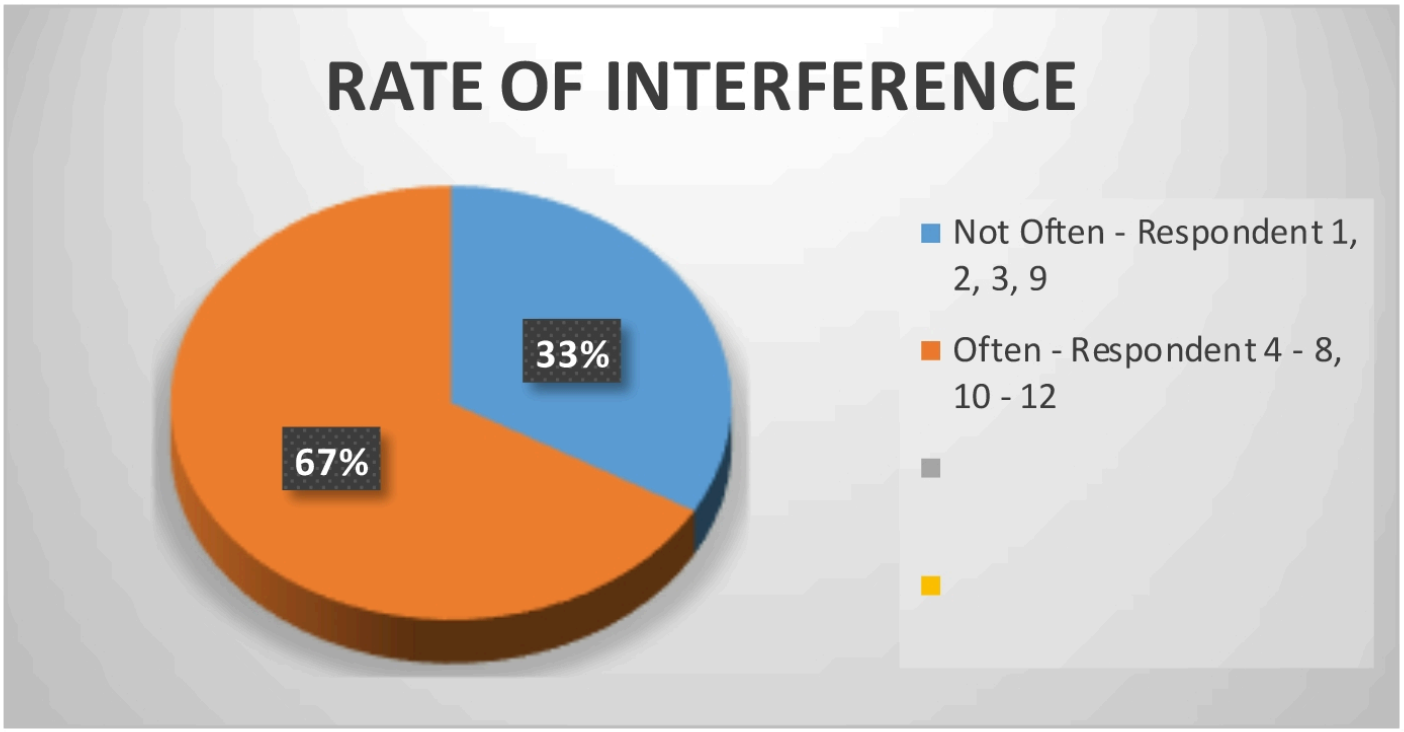


Figure 2

A 3-D Pie Chart showing the percentage of the rate of communication interference.

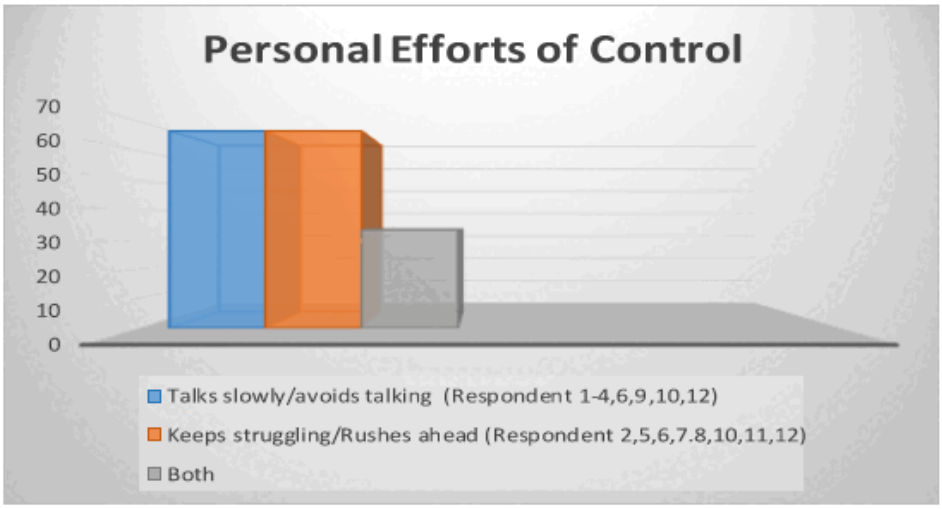


Figure 3

A 3-D Clustered column showing the percentage of personal efforts of each respondent.

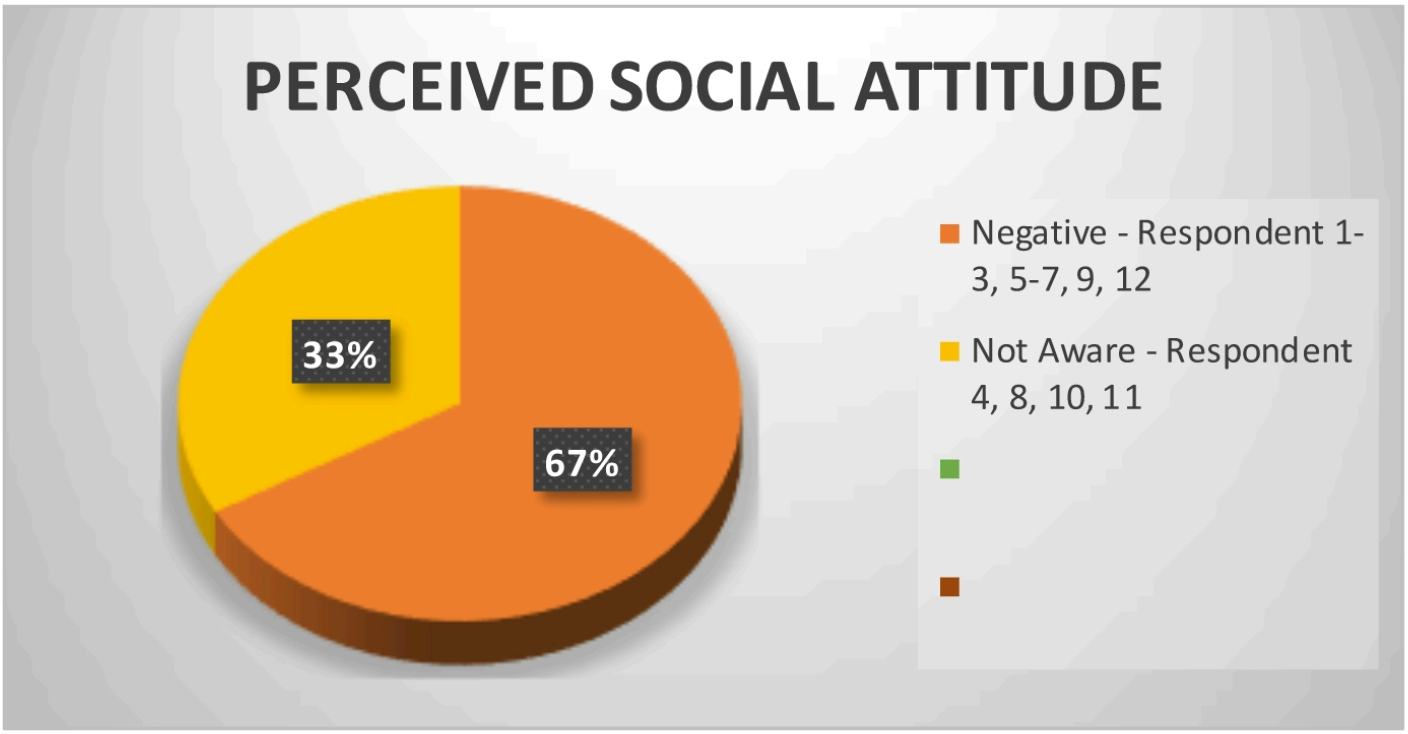


Figure 4

A 3-D Pie Chart showing the percentage of perceived social attitude.

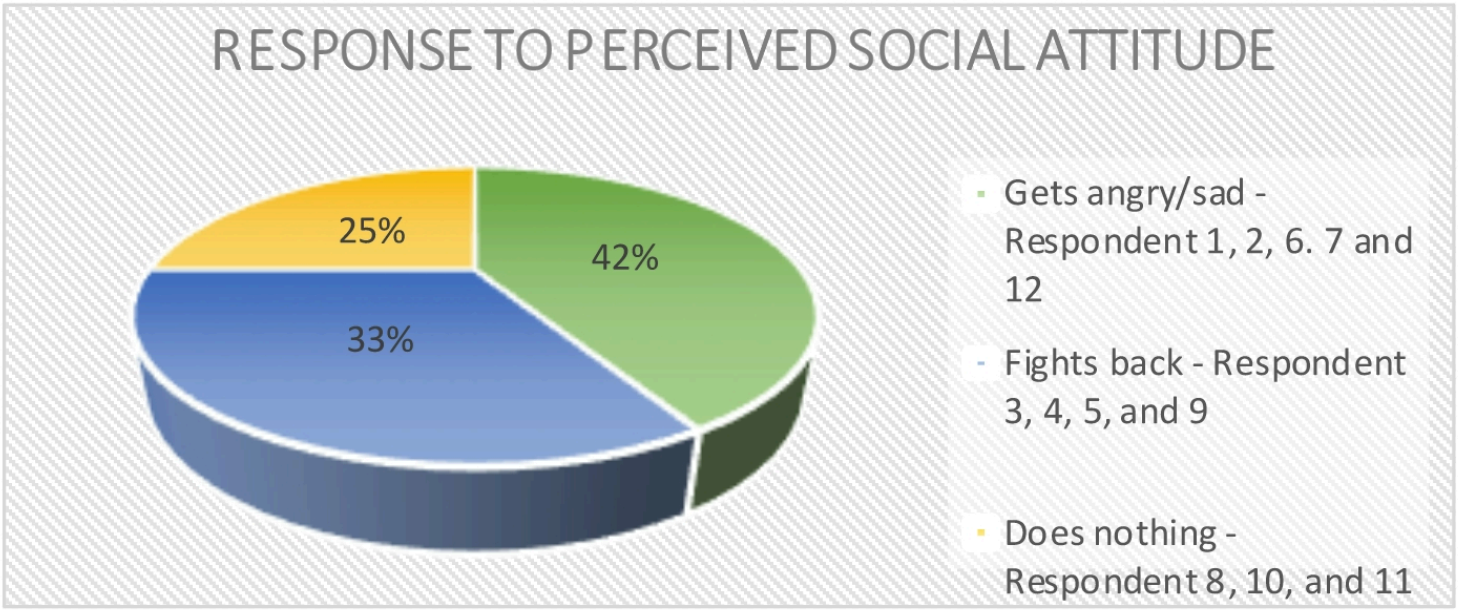


Figure 5

A 3-D Pie Chart showing the percentage of response to perceived social attitude.

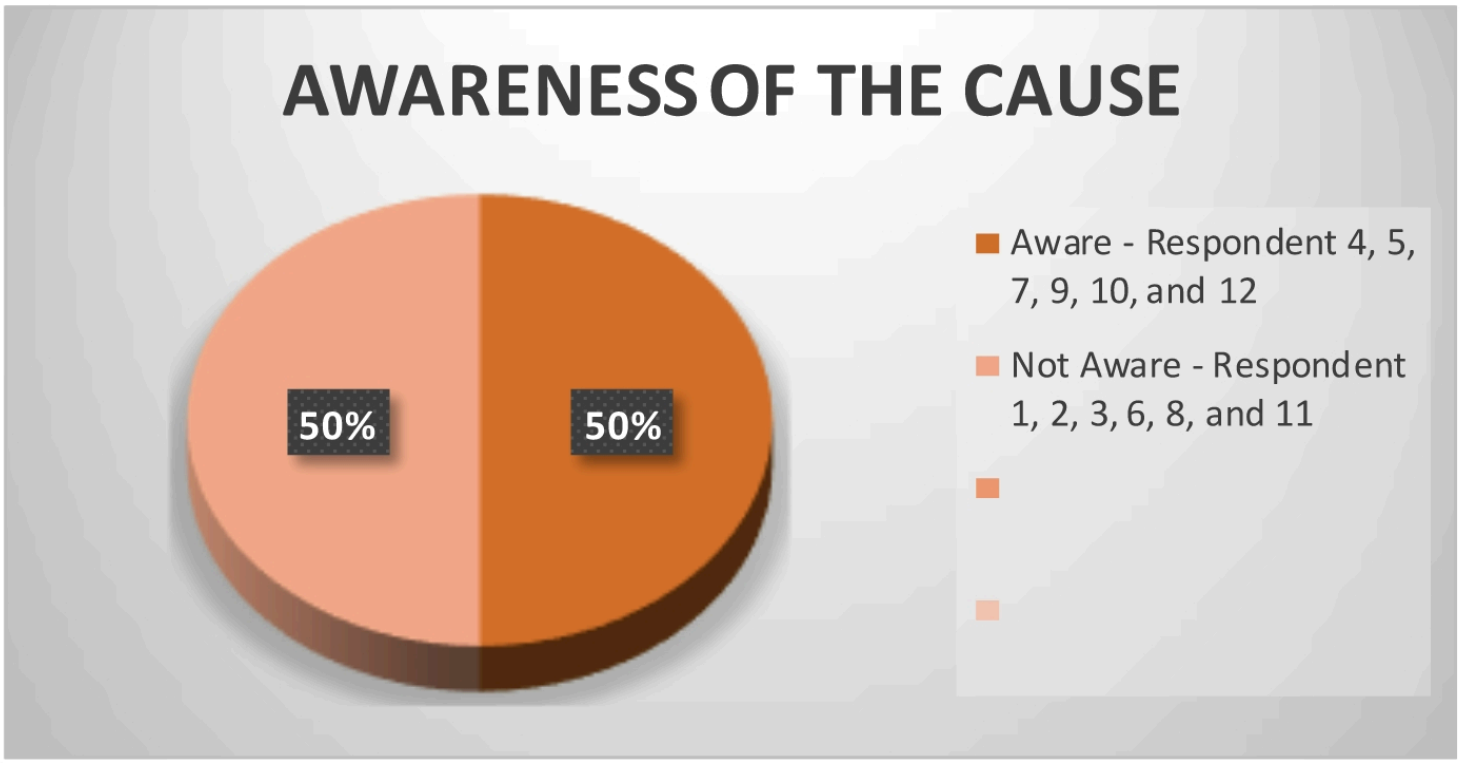


Figure 6

A 3-D Pie Chart showing the percentage of awareness of the cause of the disorders.

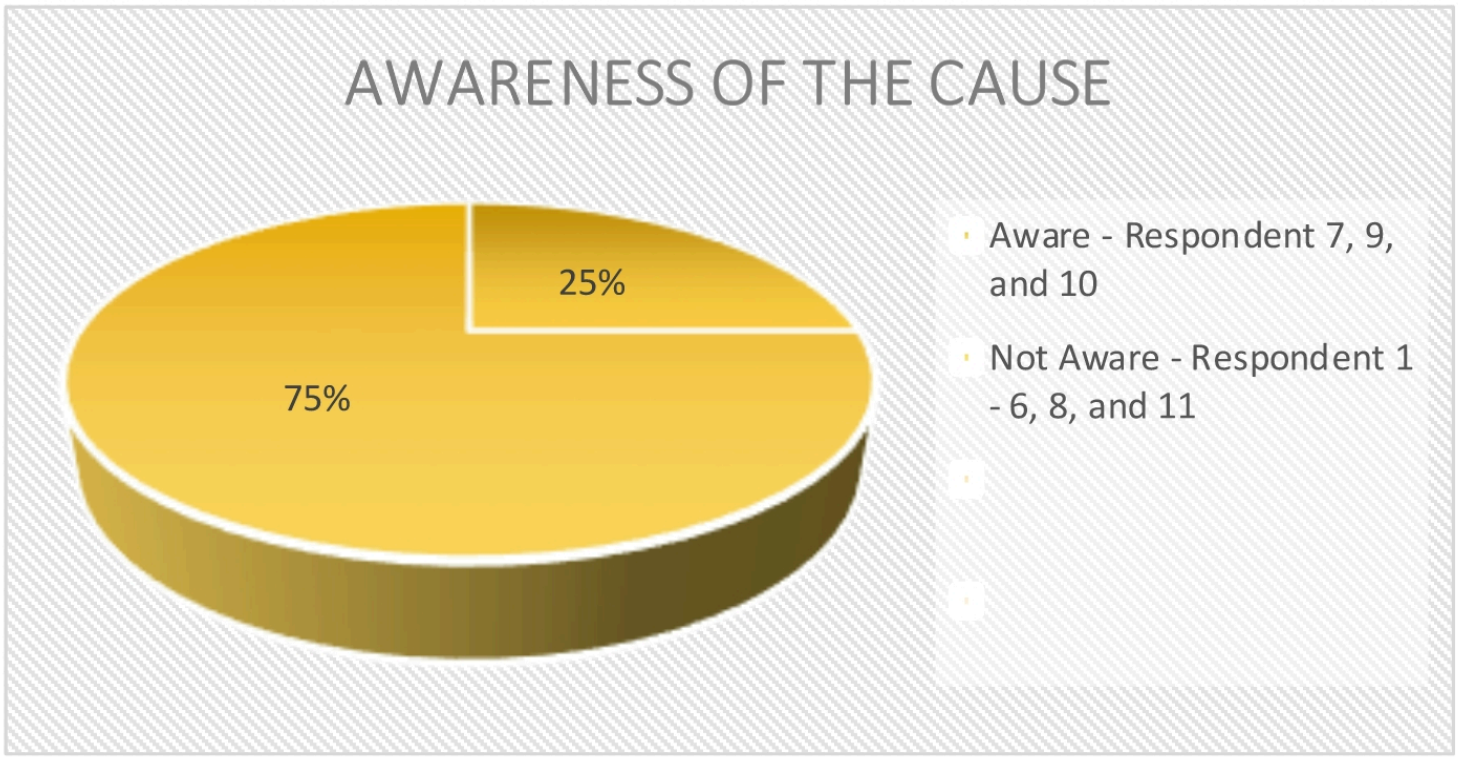


Figure 7

A 3-D Pie Chart showing the percentage of awareness of clinical remedies.