

Coping Strategies in Teachers With Vocal Complaint

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Summary: Objectives. To understand the coping strategies used by teachers with vocal complaints, compare the differences between those who seek and those who do not seek voice therapy, and investigate the relationships among coping and voice perceptual analysis, coping and signs and symptoms of voice, and coping and participation restrictions and limitations in vocal activities.

Study Design. Cross-sectional nonrandomized prospective study with control group.

Methods. Ninety female teachers participated in the study, of similar ages, divided into three groups: group 1 (G1) comprised 30 teachers with vocal complaints who sought voice therapy, group 2 (G2) comprised 30 teachers with vocal complaints who never sought voice therapy, and group 3 (G3) comprised 30 teachers without vocal complaints. The following analysis were conducted: identification and characterization questionnaire, addressing personal and occupational description, recording speech material for voice perceptual analysis, Voice Signs and Symptoms Questionnaire, Voice Activity and Participation Profile (VAPP), and Voice Disability Coping Questionnaire (VDCQ)—Brazilian Version.

Results. In relation to the voice perceptual analysis, there was statistically significant difference between the groups with vocal complaint (G1 + G2), which had showed voices with mild-to-moderate deviation, and the group without vocal complaint (G1), which showed voices within the normal variability of voice quality (mean for G1 = 49.9, G2 = 43.7, and G3 = 32.3, $P < 0.001$). G1 had higher mean of voice signs and symptoms (G1 = 8.6, G2 = 6.6, and G3 = 2.0, $P < 0.001$) and higher scores in almost all dimensions of VAPP ($P < 0.001$), except for the aspects effect on job and effect on social communication. Individuals with vocal complaints who looked for voice therapy (G1) tended to use more problem-focused strategies and had higher scores in VDCQ (G1 = 45.4, G2 = 38.5, and G3 = 9.5, $P < 0.001$). The aspects that were correlated with VDCQ in the three groups were degree of vocal deviation, VAPP total score, VAPP partial scores of self-perceived severity of voice problem, effect on daily communication, effect on emotion, and participation restriction for G1; VAPP total score and partial score of effect on daily communication for G2; and all VAPP scores for G3. No correlation was found between voice signs and symptoms and coping.

Conclusion. Teachers with vocal complaints who looked for voice therapy use more coping strategies. Moreover, they present a tendency to use more problem-focused coping strategies. Voice symptoms prompt the teachers into seeking treatment; however, they are not correlated with the coping itself. In general, the higher the perception of limitation and restriction of participating in vocal activities, the greater the use of coping strategies.

Key Words: Voice–Dysphonia–Teachers–Questionnaires–Voice Symptoms.

INTRODUCTION

Coping refers to the cognitive and behavioral manners that individuals use to cope with stress caused by a specific situation. These manners include thoughts or actions. The type of coping can be related to the individual's personality and can be modified according to different moments of a stressful situation.^{1–9} Coping strategies can be generically categorized into emotional and cognitive strategies.^{2,9} Individuals who deal with a problem using emotional strategies tend to use tools that help control or alleviate emotions, that is, they use affectional functions to deal with stress. On the other hand, the cognitive strategies are ways to deal with problems looking for solutions that change the source of stress, by for

instance finding out information about the problem or searching for medical help.^{2,7–10} Deary et al¹¹ observed that patients with dysphonia tend to use more emotional coping strategies.

There are many aspects that play a role in the way an individual copes with a stressful situation, such as individual factors, personality (flexibility, stubbornness, and proactivity) as well as psychological, personal (age and sex), functional, physical, environmental, and cultural issues.^{7,12,13} The way in which an individual copes with a disease may influence treatment outcomes.⁷ In addition, the use of a specific strategy may be adequate at a certain stage of the disease and inadequate at another. This is an important factor that clinicians should be aware of.⁸

A teacher's main work instrument is their voice, thus, it is very likely that a vocal deviation can produce a negative impact on their professional performance. Frequently, these professionals teach under inadequate conditions, for long periods, for a large number of students, under harmful environmental settings, and without previous voice and communication training. These factors result in teachers having a high prevalence of vocal signs and symptoms (mean of 3.7 signs and symptoms for Brazilian teachers and 4.3 for American teachers) and vocal deviation (57% for American teachers and 63% for Brazilian teachers). There are approximately

Accepted for publication November 15, 2013.

Presentations in Congress: The Voice Foundation's 41st Annual Symposium: Care of the Professional Voice; May 30 - June 3, 2012; Philadelphia, Pennsylvania; and 20th Brazilian Speech-Language Pathology and Audiology Congress; October 31 - November 3, 2012; Brasília, Distrito Federal, Brazil.

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Journal of Voice, Vol. 28, No. 3, pp. 341-348

0892-1997/\$36.00

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<http://dx.doi.org/10.1016/j.jvoice.2013.11.008>

3.87 new cases of voice deviation per year for every 1000 teachers.^{14–22}

Researches show that the use of inadaptative strategies can contribute to the development of a voice problem in teachers and that the professional that treats/trains these individuals should recognize and address these strategies during his/her clinical/educational intervention.^{10,23,24} Based on this perspective, it seems reasonable to have coping strategies addressed during the training of teachers-to-be.^{25,26} However, studies that investigate the relationship between voice disorders and coping strategies are scarce and little is known about how much the type of coping plays a role in the search for medical help. In addition, little is also known about which strategies teachers with vocal complaints use and whether coping can be affected by the presence of vocal signs and symptoms and by the way these individuals perceive the limitation and the restriction imposed by the voice problem.

The purpose of the present study was to understand coping strategies used by the teachers with vocal complaint, compare the differences between those who seek and do not seek for treatment, and check the relationship between coping and perceptual analysis, vocal signs and symptoms, and participation restriction and vocal activities limitation.

METHODS

This research was approved by the Institutional Review Board (protocol number 0789/10). A total of 90 primary, middle, and high school teachers, with age ranging from 21 to 61 years participated in the study. A previous statistical analysis estimated that groups around 30 subjects would be enough to deal with the research question. Then, subjects were subsequently recruited reaching the designed number. Teachers were distributed into three groups: group 1 (G1) comprising 30 female teachers, age ranging from 23 to 49 years and mean of 26.2 (standard deviation [SD] = 7.5), with vocal complaint, and that had sought for voice therapy in a Vocal Health Program; group 2 (G2) comprising 30 female teachers, age ranging from 21 to 51 years and mean of 35.1 (SD = 7.9), with vocal complaint, and that had never sought for voice therapy; and finally group 3 (G3) comprising 30 female teachers, age ranging from 23 to 66 years and 37.2 (SD = 9.8), without vocal complaint. The teachers from groups 2 and 3 were assessed by the researchers during visits to private schools in different areas of São Paulo city. Later, vocal complaints were listed, analyzed, and grouped according to the following list: vocal quality deviation, vocal fatigue and effort, breathiness, lack of pitch control, lack of loudness control, and discomfort speaking²⁷ (Table 1). A chi-square test was used to check the difference between groups G1 and G2 regarding the presence of complaints; nonetheless, due to the small number of all complaints, except for vocal quality, they were pooled and compared under two options: vocal quality and other complaints. Participants from G2 presented with more complaints related to vocal quality when compared with G1 (Table 1).

Exclusion criteria were use of medications for psychiatric disorders during the time of the research, being off work or unemployed, and history of previous voice therapy.

TABLE 1.
Frequency of Vocal Complaints in Teachers who Had Sought (G1) and Had Never Sought (G2) for Voice Therapy

Vocal Complaints	G1	G2
	N (%)	N (%)
Vocal quality deviation	15 (50.0)	25 (83.3)
Vocal fatigue and effort	8 (26.7)	2 (6.7)
Breathiness	—	—
Lack of pitch control	1 (3.3)	—
Lack of loudness control	1 (3.3)	3 (10.0)
Discomfort speaking	5 (16.7)	3 (10.0)

Notes: Vocal quality and other complaints. G1 × G2: $P = 0.006$.

Participants answered a questionnaire for gathering personal and work-related demographic information. They also completed the following procedures: recording of connected speech sample for perceptual analysis of vocal deviation, list of 14 vocal signs and symptoms,¹⁷ Voice Activity and Participation Profile (VAPP)²⁸ and the Voice Disability Coping Questionnaire (VDCQ).⁷

For the perceptual analysis of the vocal deviation, the subjects were asked to count the numbers from 1 to 10 in habitual pitch and loudness. Voice samples were analyzed by a Speech Pathologist specializing in voice (80% of reliability), using a 100-mm visual-analog scale. Voices were considered within the normal range of variability when they had a mean rate lower than 35.5 mm, mild-to-moderate deviation when the mean rate was between 35.5 and 50.5 mm, moderate deviation when the mean rate was between 50.6 and 90.5 mm, and severe deviation when the mean rate was higher than 90.5 mm²⁹

The current absence and presence of 14 signs and symptoms¹⁷ (hoarseness, vocal alteration or fatigue after a short time of use, trouble singing or speaking softly, difficulty projecting the voice, difficulty singing in high pitch, discomfort or effort to speak, monotone voice, dry throat, sore throat, difficulty swallowing, acid and/or bitter mouth taste, and vocal tremor or instability) were investigated.

The impact of the voice disorder on the individual's life was assessed by means of the VAPP³⁰ translated and adapted to the Brazilian Portuguese as *Perfil de Participação e Atividades Vocais*.²⁸ The VAPP has 28 items distributed into five dimensions: Self-perceived severity of voice problem and effects on job, daily communication, social communication, and emotion. This instrument provides an activity limitation score and a participation restriction score.

Coping was assessed by means of the Voice Disability Coping Questionnaire (VDCQ)⁷ translated and adapted to Brazilian Portuguese, entitled *Estratégias de Enfrentamento na Disfonia*.⁹ The VDCQ has 27 items, 10 categorized as problem-focused strategies (items 2, 4, 7, 8, 11, 13, 14, 24, 25, and 26) and 17 items as emotion-focused strategies (items 1, 3, 5, 6, 9, 10, 12, 15, 16, 17, 18, 19, 20, 21, 22, 23, and 27). Its total score varies from zero to 135. Zero indicates no

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