
Vocal habits of children from a Home of Social Care and Early Childhood Education

Hábitos vocais infantis
em um Lar de Assistência e Educação:
percepção de pais e educadores

Hábitos vocales de los niños
de una Casa de Atención Social y Educación
de la Primera Infancia

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Abstract

Introduction: Institutional Environments favor vocal abuse in children. Studies indicate a relationship of vocal behavior in childhood to childhood dysphonia, considering them harmful to human interrelation and potential damage to the speaker self-image. The observation of parents and educators can contribute to the characterization of habits and children's vocal behavior and studies aimed at the creation of programs to promote the vocal health of children. **Objective:** To identify the occurrence of inadequate vocal habits and possible signs associated in children aged five to nine years of a Home of Social Care and Early Childhood Education, as perceived by parents and educators. **Methods:** Two types of questionnaires containing questions about the vocal habits of children of this institution were analyzed, one directed to teachers and other to parents. Of the 67 questionnaires analyzed, 41 were answered by educators and 26 by a parent or caregiver. Data were analyzed using descriptive statistics (absolute and relative frequency). **Results:** According to opinion of the parents, it was found that inadequate vocal habit of higher occurrence was "speak louder than other children" with 57.7% of the sample, followed by

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“constantly screaming” and “making imitation of voices,” both in 46.2% of the sample. In questionnaires given to teachers, there is a higher occurrence of habit of “screaming constantly”, identified in 63.4% of children, followed by “talking too much” with 48.8%. **Conclusion:** Most of the children, in the opinion of parents and educators, had considered abusive habits and risk for dysphonia. Identifying these behaviors implies special attention in vocal care of these children, including guidance for parents and educators.

Keywords: Child; Voice Quality; Habits; Dysphonia

Resumo

Introdução: Ambientes institucionais favorecem o abuso vocal em crianças. Estudos apontam a relação do comportamento vocal na infância às disfonias infantis, considerando-as como prejudiciais à inter-relação humana e potencial prejuízo à autoimagem de falante. A observação dos pais e educadores pode contribuir na caracterização dos hábitos e comportamentos vocais infantis e com estudos que visam à criação de programas de promoção à saúde vocal de crianças. O objetivo deste estudo foi identificar a ocorrência de hábitos vocais inadequados e possíveis sinais associados, em crianças com idade de cinco a nove anos de um Lar de Assistência Social e Educação Infantil, na percepção dos pais e educadores. **Método:** Foram analisados dois tipos de questionários que continham perguntas sobre os hábitos vocais das crianças dessa instituição, sendo um direcionado aos educadores e outro aos pais. Dos 67 questionários analisados, 41 foram respondidos por educadores e 26 por um dos pais ou responsável pela criança. Os dados foram analisados por estatística descritiva (frequência absoluta e relativa). **Resultados:** Segundo opinião dos pais, foi constatado que o hábito vocal inadequado de maior ocorrência foi “falar mais alto que outras crianças” com 57,7% da amostra, seguido de “gritar constantemente” e “fazer imitação de vozes”, ambos em 46,2% da amostra. Nos questionários aplicados aos educadores, destaca-se a maior ocorrência do hábito inadequado de “gritar constantemente”, identificado em 63,4% das crianças, seguido de “falar demais” com 48,8%. **Conclusão:** Foi identificada a ocorrência de hábitos considerados abusivos e de risco para disfonia nas crianças estudadas, segundo a opinião dos pais e educadores. A identificação desses comportamentos implica em atenção especial no cuidado vocal dessas crianças, incluindo orientação aos pais e educadores.

Palavras-chave: Criança; Qualidade da Voz; Hábitos; Disfonia.

Resumen

Introducción: entornos institucionales favorecen abuso de la voz en los niños. Los estudios indican una relación de comportamiento vocal en la infancia a la niñez disfonía, considerándolos perjudiciales para la interconexión humana y el daño potencial para el altavoz auto-imagen. La observación de los padres y educadores pueden contribuir a la caracterización de los hábitos y comportamiento vocal de los niños y los estudios dirigidos a la creación de programas de promoción de la salud vocal de los niños. **Objetivo:** identificar la aparición del inadecuados hábitos vocales y posibles signos asociados en niños de cinco a nueve años de un Hogar de Atención Social y Educación de la Primera Infancia, la percepción de los padres y educadores. **Métodos:** Se analizaron dos tipos de cuestionarios que contienen preguntas sobre los hábitos vocales de los niños de esta institución, uno dirigido a los educadores y otros a los padres. De los 67 cuestionarios analizados, 41 fueron contestadas por los educadores y 26 por un padre o cuidador. Los datos fueron analizados utilizando estadística descriptiva (frecuencia absoluta y relativa). **Resultados:** De acuerdo a la opinión de los padres, se encontró que la inadecuada hábito vocal de mayor ocurrencia se “hablan más fuerte que otros niños” con el 57,7% de la muestra, seguido de “constantemente gritando” y “hacer la imitación de voces”, tanto en 46,2% de la muestra. En los cuestionarios aplicados a los maestros, hay una mayor incidencia del hábito inadecuado de “llorando constantemente,” identificado en el 63,4% de los niños, seguido de “hablar demasiado” con el 48,8%. **Conclusión:** La mayoría de los niños, según la opinión de los padres y educadores, habían considerado hábitos abusivos y riesgo de disfonía. La identificación de estos comportamientos implica una atención especial en el cuidado vocal de estos niños, incluyendo una guía para padres y educadores.

Palabras clave: Niño; Calidad de la Voz; Hábitos; Disfonia

Introduction

Voice is considered an innate neurophysiological function with complex and precise neuromuscular processing, in addition to representing psychological manifestations. As such, this function is a sensitive means to show the emotional variations, attitudes, physical conditions and sociocultural aspects of the speaker,¹ depicting the physical, psychological and social development of the individual, vocal characteristics resulting from the intrinsic factors of the speakers, as well as their social environment².

Environmental influences, such as sound competition, multiple stimuli and intense activities, favor stress and vocal abuse, primarily among children^{3,4} and in institutional environments⁵. These behaviors may result in vocal cord lesions, associated with so-called childhood dysphonia⁶.

Studies show the relation between vocal behavior in childhood and the emergence of childhood dysphonia⁷⁻⁹. Moreover, some authors believe that there may also be an association between the presence of voice changes in children and the occurrence of allergies and other respiratory tract diseases⁸.

With respect to vocal behavior, inadequate vocal habits are considered those involving incorrect use of the voice, causing phonatory overload and favoring the development of laryngeal lesions. These habits are related to speaking in a noisy environment and characterized by increased voice intensity, effort and tension^{9,10}.

Thus, shouting, speaking loudly, strained vocalizations, speaking excessively, reverse phonation, explosive vocalization or abrupt vocal attack, clearing one's throat, speaking in a noisy environment, laughing or crying excessively, coughing, imitating the voices of other individuals, among others, are considered harmful habits^{1,9,10}.

It is important to remember that vocal behavior that leads to dysphonia may be the result of interacting factors, such as anatomic and physiological characteristics, social and emotional behaviors and/or environmental factors. Thus, when dysphonia occurs, it may compromise human communication and interrelationships. Furthermore, premature voice changes are potentially harmful to the speaker's self-image, which compromises the overall health of the individual, demonstrating the importance of taking care of children's voices^{6,11}.

Even though voice is considered an essential part of communication in social relations, most parents and educators are not concerned with voice changes in children¹¹⁻¹³ and are sometimes inadequate models of voice production^{10,14,15}.

As such, some authors believe that speech therapists should promote prevention programs in institutional environments, specifying intervention that considers the perception of changes^{11,15-18}.

Given that most children are enrolled in preschool, and considering that teachers spend a large part of the day in contact with them, and that their perception is a significant influence on determining child behavior¹⁹, the present investigation sought to add this perception to the parents' opinion, in order to obtain a more reliable indication of the inadequate vocal habits of the children under study.

These results could contribute to the creation of a vocal health program, in order to alert parents and teachers regarding the importance of taking care of a child's voice and promoting vocal health at the institution.

Accordingly, the aim of this study was to identify the occurrence of inadequate vocal habits in children aged between five and nine years at a Center for Child Care and Education, according to the perception of parents or teachers.

Methods

This study is part of a larger project approved by the Research Ethics Committee of the Health Science Center of the Federal University of Pernambuco, under protocol no. 145/10.

In this study, we analyzed 41 questionnaires completed by two teachers and 26 by parents or legal guardians of children aged between five and nine years from a Center for Child Care and Education in Recife, Pernambuco state, totaling 67 completed questionnaires.

However, the questionnaires considered 56 children (25 boys and 31 girls) since the behavior and voice signals of 11 were observed both by their respective parent/ legal guardian and teacher.

Two questionnaires were used: one for the parents and the other for teachers (Attachment 1 and 2, respectively), modeled after other questionnaires applied in similar studies^{10,14,15,19}. Since this study is part of a larger project, whose aim was to characterize the vocal health of children in order

to develop vocal health promotion programs in institutional settings, the questions were related to vocal behavior with complementary questions regarding health, general behavior and signs of voice changes. In the present study, only questions on inadequate vocal habits were considered for analysis, given the aim proposed.

The questionnaire was applied to the parents in an interview to ensure they understood the questions. When complaints concerning oral and/or written communication of the children were detected, they were referred for assessment to the Speech Therapy Teaching Clinic of the institution responsible for this study.

The teachers received one questionnaire for each child in their charge, after the researcher had read all the questions and made all necessary changes.

The answers were tabulated according to the group of parents and teachers and analyzed by descriptive statistics, using relative frequency.

Results

The data obtained from analysis of the questionnaires applied to the parents and teachers were tabulated and distributed in percentage, according to the questions related to the inadequate vocal habits of the children (table 1).

Table 1 shows that, according to the parents, the most common habit of the children is “speaking too loudly”, while in the opinion of the teachers, it is “shouting”.

Table 2 demonstrates the occurrence of vocal signals in the children under study, as observed by the parents and teachers. A worse voice at the end of the day was noted by both parents and teachers, while constant hoarseness was observed only by the parents.

Table 3 shows the percentage of concurring responses between parents and teachers, regarding vocal behavior and signs of voice changes for the same child.

The most concurring responses are related to signs of worsened voice and constant hoarseness observed in the children under study.

Table 1. Occurrence (%) of inadequate vocal habits, observed by parents and teachers, in children aged 5 to 9 years from a Center for Child Care and Education (N=67).

	Speaks loudly (%)	Shouts (%)	Imitates voices (%)	Strained speech (%)
Parents (N=26)	57.7	46.2	46.2	26.9
Teachers (N=41)	22.0	63.4	00.0	19.5

N= number of questionnaires completed

Table 2. Occurrence (%) of vocal signals, perceived by parents and teachers, in children aged 5 to 9 years from a Center for Child Care and Education (N=67)

	Speaks very softly (%)	Worse voice at the end of the day (%)	Hoarseness (%)
Parents (N=26)	19.2	26.1	26.9
Teachers (N=41)	39.0	14.6	00.0

N= number of questionnaires completed

Table 3. Percentage of concurring and divergent answers between parents and teachers in terms of the inadequate habits and vocal signals of 11 children whose behaviors were observed by both their parents/legal guardians and their teacher (N=11).

	concurring (%)	divergent (%)	Total (%)
Speaks loudly	54.5	45.5	100
Shouts	54.5	45.5	100
Imitates voices	63.6	36.4	100
Strained speech	63.6	36.4	100
Speaks softly	45.5	54.5	100
Hoarseness	72.7	27.3	100
Worse voice at the end of the day	72.7	27.3	100

Discussion

In relation to the most frequent inadequate vocal habits, parents reported “speaking louder than other children”, followed by “shouting constantly” and imitating voices”, corroborating the findings of other studies^{5,10,14,18,19}.

The few occurrences of “speaking very softly”, observed by the parents, may be due to the fact that in a family setting, even timid children likely exhibit no difficulties in communication in relation to vocal self-image. In other words, they are not shy about using an intelligible voice volume, in contrast to other environments, such as school, where the more extrovert behavior of some children could interfere in the behavior of more reserved individuals, who lower the volume of their voices as a defense mechanism to avoid exposure.

As to the opinion of teachers, the most frequent vocal behavior was “shouting constantly”, corroborating literature data^{5,14,19}. “Speaking too much” did not appear on the questionnaire applied to parents, but on the teachers’ questionnaire it was reported as a frequent habit for 48.8% of the children^{10,15,18,19}.

Interestingly, “imitating voices” was not identified by teachers for any child. Thus, it seems to be a behavior more reserved for the family setting, suggesting a relationship with individual play that is not commonly observed in educational environments, where collective games and competition for attention occur.

Despite the different groups of children (only 16.4% of the children were assessed by both parents and teachers), table 1 shows a difference in opinion between the two groups, in terms of “speaking loudly”.

This analysis demonstrates the possibility that on leaving the institution - an environment where

competitive noise favors an increase in voice intensity – children may exhibit an altered voice for some time after arriving home²⁰, which would explain the parents’ perception of increased voice intensity in their children in relation to other family members.

In the institutional setting, in turn, increased vocal intensity is common in most children^{14,19} making it more difficult to identify who is speaking “loudly” (at a stronger intensity).

On the other hand, the item “shouting” was reported more by teachers than parents, reinforcing the idea of vocal abuse in educational environments^{5,19,21}.

With respect to vocal signals exhibited by the children, both parents and teachers felt that signs of a worse voice and constant hoarseness were absent in most of the children. Nevertheless, these signs are important and justify the assessment of the children indicated, given the presence of vocal cord nodules in the majority of children with hoarseness²².

Another relevant factor on the questionnaire applied to the teachers was that 95.1% of the children exhibited “tiredness when speaking”, which may indicate vocal abuse in this population.

Despite not being the object of this study, but rather that of a larger project, it is important to underscore that, in relation to the responses regarding the general health of the children, teachers stated that 43.9% require speech therapy, primarily due to problems with oral and written language, as observed in seven of the children.

It is noteworthy that, in the opinion of the parents, 19.2% of the sample displayed hearing disorders and 50% frequently use audiovisual devices at high volume. According to the teachers, however, hearing problems were not observed in

any of the children. Once again, we emphasize that the group analyzed by the parents was not identical to that evaluated by the teachers; however, one of the possible explanations for this conflicting finding is that when teachers observed the children in a group, they may not have identified their mild hearing difficulties.

Hearing health data are important for voice production, which depends on monitoring hearing to control vocal quality and intensity^{20,23}.

The complementary questions posed to the parents regarding health treatment showed the use of drugs against allergies and ear infection, confirming the increased prevalence of allergic disorders in recent decades and the use of antibiotics in general²⁴, in addition to the common occurrence of middle ear problems in preschoolers²⁵. The teachers also observed nasal congestion and hyponasality in 7.3% of the children studied, symptoms also found in another study²¹. It is important to underscore that the questionnaire applied to the teachers was in the form of an interview and that the researcher exemplified the characteristics of a child with nasal congestion and hyponasality.

These results should be considered in the voice analysis of these children and in the preparation of a vocal health promotion program for this group.

Despite obtaining data from only 19.6% of the same children, as observed by parents and teachers, the responses were compared, as depicted in table 3.

Opinions were more in agreement in relation to signs of vocal changes (hoarseness and worse voice at the end of the day). This finding is interesting, since it indicates that both parents and teachers apparently have the same analysis parameter when assessing vocal quality.

With respect to vocal behavior, differing answers indicate a possible difference in vocal habits in the two environments (home and institution)^{20,21}. This should be considered in a child vocal health program and when advising parents and teachers¹⁴.

It is important to emphasize that, according to the teachers, 31.7% of the children exhibited inadequate voices for their age. This result should be investigated more thoroughly in future studies.

It is suggested that the vocal quality of the children be compared with the vocal signals reported by the parents and teachers, which is the object of another investigation linked to the present study.

Conclusion

The results obtained demonstrate that 57.7% of parents and 63.4% of teachers observed the inadequate vocal habits of speaking loudly and shouting.

Given that these behaviors are considered abusive and risk factors for voice changes, the present study demonstrated the need to establish a vocal health program at the Center for Child Care and Education, including advice for parents and teachers.

The percentage of children with signs of voice changes (26 and 27%, in the opinion of parents and teachers, respectively) reinforces this point.

The divergence of opinions between parents and teachers, likely justified by the behavioral differences exhibited by some of the children in institutional/home environments, also demonstrates the importance of speech therapy in institutional settings in order to promote vocal health and prevent dysphonia.

It is suggested that the vocal quality of the children studied be compared with the vocal signals reported by parents, which is the object of another investigation linked to this study.

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Appendix 1. Questionário dirigido aos pais



UNIVERSIDADE FEDERAL DE PERNAMBUCO
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Projeto: Qualidade de vida em voz em ambiente institucional Questionário aplicado aos pais ou responsáveis pela criança

Nome do pai ou responsável: _____
Nome da criança: _____ sexo: M () F ()
Idade: _____ Data de Nascimento: ____/____/____ Classe: _____

I. SAÚDE GERAL DA CRIANÇA

1. Tratamentos

1.1. Com remédios:

() Já fez () Faz () Nunca fez

Qual ou quais? _____

1.2. Fonoaudiológico:

() Já fez () Faz () Nunca fez

Se faz ou fez, qual o motivo do tratamento? _____

1.3. Otorrinolaringológico (ouvido, nariz e garganta):

() Já fez () Faz () Nunca fez

1.4. Psiquiátrico e/ou psicológico:

() Já fez () Faz () Nunca fez

2. Doenças

2.1. A criança manifesta frequentemente:

() Rinite () Não sei responder

() Laringite/ inflamação na garganta () Não sei responder

() Asma () Não sei responder

() Doença gástrica/ estômago () Não sei responder

() Alergias () Não sei responder

() Outra(s): _____

2.2. A criança já apresentou laringite, gripe ou resfriado por mais de 15 dias?

() Sim () Não () Não sei responder

2.3. A criança apresenta:

Problemas neurológicos () Sim () Não () Não sei responder

Problemas de crescimento () Sim () Não () Não sei responder

II. AUDIÇÃO

1. A criança tem dificuldades em ouvir?

() Sim () Não () Não sei responder

2. A criança costuma assistir televisão e/ou ouvir música (rádio) em volume muito alto?

() Sim () Não () Não sei responder

3. A criança já fez algum exame auditivo?

() Sim* () Não () Não sei responder

*Se sim, o resultado do exame indicou algum tipo de perda auditiva?

() Sim () Não () Não sei responder

III. VOZ

1. A criança já apresentou ou apresenta problema na voz?

() Sim () Não () Não sei responder

Qual? _____

2. A criança já fez cirurgia na laringe? () Sim () Não () Não sei responder

3. A criança fala muito alto em relação a outras crianças? () Sim () Não () Não sei responder

4. A criança fala muito baixo? () Sim () Não () Não sei responder

5. A criança grita constantemente? () Sim () Não () Não sei responder

6. A criança faz imitação de vozes? (personagens, animais) () Sim () Não () Não sei responder

7. A criança canta em algum coral? () Sim () Não () Não sei responder

8. A criança apresenta piora na voz ao final do dia? () Sim () Não () Não sei responder

9. A criança tem rouquidão constante? () Sim () Não () Não sei responder

10. A criança fala com esforço? () Sim () Não () Não sei responder

11. Familiares, vizinhos ou amigos falam sobre a voz da criança? () Sim () Não () Não sei responder

Se sim, o que principalmente falam? _____

12. Você acha que seu(ua) filho(a) precisa de tratamento para a voz?

() Sim () Não () Não sei responder

Se sim, por quê?



Appendix 2. Questionário dirigido aos educadores

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DEPARTAMENTO DE FONOAUDIOLOGIA



Projeto: Qualidade de vida em voz em ambiente institucional
Questionário para avaliação da criança pelo educador

Nome do professor ou auxiliar: _____
Nome do aluno: _____ Sala: _____

DADOS DA SAÚDE GLOBAL DA CRIANÇA

1.1 Percebe que a criança precisa de tratamento fonoaudiológico? Sim () Não () Não sei responder ()

Se sim, qual?

- () Audiológico (problemas para ouvir)
() Vocal (alteração na voz: rouquidão, voz muito "fina" ou muito "grossa")
() Linguagem oral (problemas na fala)
() Linguagem escrita
() Não sei responder

1.2 Doenças

1.2.1 Apresenta frequentemente problemas respiratórios: Sim () Não () Não sei responder ()
Caso tenha respondido que sim, qual?

1.2.2 A criança já ficou sem ir à creche por que apresentou laringite, gripes ou resfriado por algum tempo? Sim () Não () Não sei responder ()

1.2.3 Tem Problemas neurológicos? Sim () Não () Não sei responder ()

1.2.4 Faz acompanhamento psicológico na creche? Sim () Não () Não sei responder ()

1.3 Audição da criança

1.3.1 Apresenta dificuldades em ouvir? Sim () Não () Não sei responder ()

1.3.2 Costuma queixar-se de dor no ouvido? Sim () Não () Não sei responder ()

1.4 Voz da criança

1.4.1 Fala muito alto em relação as outras crianças? Sim () Não () Não sei responder ()

1.4.2 Fala muito baixo? Sim () Não () Não sei responder ()

1.4.3 A criança grita constantemente? Sim () Não () Não sei responder ()

1.4.4 Faz imitação de vozes de animais, amigo(a) da turma, artistas ou desenhos animados? Sim () Não () Não sei responder ()

1.4.5 Percebe que a voz do aluno piora no final do dia? Sim () Não () Não sei responder ()

1.4.6 Tem rouquidão constante? Sim () Não () Não sei responder ()

1.4.7 Se esforça muito para falar? Sim () Não () Não sei responder ()

1.4.8 Fala rápido? Sim () Não () Não sei responder ()

1.4.9 Fala demais? Sim () Não () Não sei responder ()

1.4.10 Ela(e) se cansa quando fala? Sim () Não () Não sei responder ()

1.4.11 Já apresentou ou tem queixa de algum problema na voz?

Sim () /Qual? _____

Não () Não sei responder ()

1.4.12 A voz da criança é adequada à idade? Sim () Não () Não sei responder ()

1.4.13 Você sente dificuldades em alguns momentos para entendê-lo (a), por causa da voz?

Se sim, qual a principal causa: _____

2. ALIMENTAÇÃO DA CRIANÇA

2.1 Apresenta dificuldades na alimentação? Sim () Não () Não sei responder ()

Se sim, qual a dificuldade? _____

2.2 Prefere comidas líquidas () sólidas () pastosas () Não sei responder ()

2.3 Tem vômito após as refeições? Sim () Não () Não sei responder ()