

Screen Exposure and Socio-Demographic Characteristics of Children Aged 2-6 Years Diagnosed with Speech and Language Disorder: A Descriptive Study

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Abstract

BACKGROUND/AIMS: Screen exposure during early childhood may influence cognitive and language development. This descriptive and exploratory study aimed to characterize screen exposure patterns and selected sociodemographic, perinatal, and clinical features of children aged 2-6 years diagnosed with speech and language disorder.

MATERIALS AND METHODS: This descriptive, exploratory, cross-sectional study was conducted between November 2025 and March 2026 at the Child and Adolescent Psychiatry Clinic of Karabük Training and Research Hospital. Children who, following comprehensive psychiatric evaluation, met the diagnostic criteria for speech and language disorder were included. Children with conditions that could better explain their language difficulties, including autism spectrum disorders and intellectual disability, were excluded.

RESULTS: The study included 43 children, of whom 62.8% were male. The mean age was 47.18 ± 15.22 months. Mean gestational age and birth weight were 36.67 ± 2.74 weeks and 3068 ± 727 g, respectively. Cesarean delivery, incubator care, postnatal hypoxia, and prolonged jaundice were reported in 72.1%, 32.6%, 23.3%, and 9.3% of cases, respectively. Daily screen exposure was <1 hour for 37.2%, 1-2 hours for 34.9%, 2-4 hours for 23.3%, and >4 hours for 4.7%. First screen exposure occurred before 12 months in 32.6% of participants, and before 24 months in 74.4%.

CONCLUSION: The findings provide a descriptive overview of screen exposure and selected characteristics in this sample, but do not establish an association with speech and language disorder.

Keywords: Speech and language disorder, screen, communication

INTRODUCTION

The relationship between screen use (exposure to television or other digital screens) and early childhood development has long been discussed in both the scientific literature and the public sphere. Over the past decade, this topic has received renewed attention because of the substantial increase in young children's access to and use of digital media. In the literature, debates have mainly focused on the quantity of screen use (duration of use) and its quality (content and context).

Regarding quantity, prolonged screen exposure has been suggested to function as a passive, sedentary activity that may replace learning opportunities that are critical for child development.¹ Especially in early childhood, the limited reciprocal verbal interaction during screen use is considered a potential risk factor for language acquisition.^{2,3}

Language delay in early childhood is a critical neurodevelopmental concern that may affect not only communication skills but also long-term academic achievement and psychosocial functioning. Current

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literature indicates that these effects are more pronounced and persistent when the delay is prolonged.

Longitudinal studies have reported that children with early language delay continue to show significant language-related difficulties compared with their peers during the school-age years. In particular, children with persistent language delay may experience difficulties in mathematics and overall academic performance, in addition to continuing language-related challenges, throughout the primary school years. Moreover, psychosocial problems such as attention difficulties, externalizing behaviors, and peer relationship problems have been reported more frequently in this group.⁴

Since language skills form the foundation of early literacy development, delays in this area directly affect reading, writing, and comprehension skills. Such delays may make it more difficult for children to understand instructions in educational settings and to process academic content, thereby adversely affecting learning. Indeed, children with early language delay have been reported to be at higher risk for later learning difficulties.⁵

From a psychosocial perspective, children with delayed language development may experience limitations in peer interactions, reduced social participation, and behavioral problems due to communication-based frustration.⁶ These challenges may disrupt social adaptation and, in the long term, predispose affected children to social withdrawal, low self-esteem, and emotional difficulties. Furthermore, long-term follow-up studies have shown that individuals with early language difficulties are more likely to experience academic and mental health problems extending into adulthood.⁷

Importantly, the literature emphasizes the value of early intervention. Language and speech interventions initiated before the age of 3 years have been reported to provide significant improvements in receptive and expressive language skills and to reduce long-term adverse outcomes. These findings highlight the critical importance of early diagnosis and a multidisciplinary approach.^{8,9}

Although previous studies have examined screen exposure in relation to language development, the present study provides a structured description of screen use and selected socio-demographic, perinatal, and clinical characteristics in children evaluated in a tertiary child psychiatry setting.¹⁰⁻¹³ It was designed to characterize children diagnosed with speech and language disorder, rather than to establish a causal relationship between screen exposure and language delay. Describing these characteristics within a tertiary clinical setting may help identify factors that should be routinely considered during comprehensive developmental assessment and may generate hypotheses for future controlled studies.

This study aimed to describe screen-use characteristics, including daily screen duration and age at first exposure, and selected socio-demographic and perinatal characteristics among children aged 2-6 years diagnosed with speech and language disorder. Because the study did not include a typically developing control group, it was not designed to determine whether screen exposure differed from that in the general pediatric population or was associated with the development of language delay.

MATERIALS AND METHODS

The study was initiated after obtaining approval from the Karabük University Non-Interventional Clinical Research Ethics Committee (decision no: 2025/2509, date: 30.10.2025). This descriptive, exploratory, cross-sectional study was conducted from November 2025 to March 2026 at the Child and Adolescent Psychiatry Clinic of Karabük Training and Research Hospital. A total of 43 children were included. Written informed consent was obtained from the parents or legal guardians of all participants prior to enrollment. A socio-demographic data form, developed by the researchers to assess socio-demographic characteristics and screen-use patterns, was administered to the participants. Children aged 2-6 years who met the diagnostic criteria for speech and language disorder following psychiatric evaluation were included in the study.

Referral Pathways and Clinical Presentation

Participants were recruited from a tertiary child and adolescent psychiatry outpatient clinic. Children were either referred by family physicians, primary care services, pediatric outpatient clinics, or other hospital departments, or were brought directly by their parents because of concerns about delayed speech and language development. The main reasons for presentation included delayed production of first words or sentences, limited expressive or receptive language abilities, reduced speech intelligibility, and parental or clinician concerns regarding co-occurring developmental or behavioral difficulties. Because the study was conducted in a tertiary referral setting, the study population may have included children with more complex developmental and medical histories than children with isolated speech and language difficulties managed in primary care or community settings.

Diagnostic Assessment

All children underwent a comprehensive clinical evaluation by a child and adolescent psychiatrist. Language disorder was diagnosed according to the criteria of the diagnostic and statistical manual of mental disorders, fifth edition.¹⁴ The assessment included a detailed developmental, medical, neurological, and family history obtained from the parent or legal guardian; direct observation of the child; and clinical evaluation of receptive and expressive language abilities, social communication, play skills, adaptive functioning, and overall developmental level.

Available speech-language assessment reports and developmental evaluations were reviewed. Children were referred to a speech and language therapist for standardized assessment when clinically indicated. Children were assessed by clinical examination for Autism Spectrum Disorder, Intellectual Disability, global developmental delay, and other psychiatric or neurodevelopmental conditions that could better explain the language difficulties; children with such conditions were excluded.

Hearing status was evaluated on the basis of parental history, medical records, previous hearing-screening or audiological-examination results, and clinical findings. Children with known hearing impairment or suspected hearing loss were referred for formal audiological assessment and excluded if the hearing impairment was considered sufficient to explain their speech and language difficulties. Developmental screening or standardized developmental assessment was performed when clinically indicated, particularly for children suspected of delays in developmental domains other than language.

Socio-Demographic Data Form

A brief data collection form was developed for this study. The form included items assessing the participants' ages, sex, number of siblings, family structure, and birth-related characteristics. It also included items assessing daily screen duration, age at first screen exposure, and related screen-use characteristics. No a priori power analysis was performed because the study was exploratory.

Statistical Analysis

Statistical analyses were performed using IBM SPSS Statistics for Windows, version 27.0 (IBM Corp., Armonk, NY, USA). Given the study's descriptive and exploratory design, descriptive statistics were used as the primary analytical approach. Continuous variables were summarized as mean $\pm$ standard deviation, and categorical variables were presented as frequencies and percentages. For exploratory subgroup comparisons based on daily screen time (<1 hour/day vs. $\geq$ 1 hour/day) and age at first screen exposure (<12 months vs. $\geq$ 12 months), continuous variables were compared using the Independent Samples t-test or Mann-Whitney U test, as appropriate, whereas categorical variables were compared using the chi-square test or Fisher's exact test. Because of the small sample and subgroup sizes, these analyses were considered exploratory and hypothesis-generating, with a high-risk of type II error. A p-value of <0.05 was considered statistically significant.

RESULTS

A total of 43 children were included in the study, of whom 27 (62.8%) were male. The mean age was 47.18 ± 15.22 months, ranging from 24 to 72 months. The mean number of children per family was 2.04 ± 0.89 . Demographic, parental, family, and socio-economic characteristics are summarized in Table 1.

The mean gestational age was 36.67 ± 2.74 weeks, and the mean birth weight was 3068 ± 727 g. Cesarean delivery was reported in 31 children (72.1%); 14 (32.6%) required incubator care, and 10 (23.3%) had a history of postnatal hypoxia. Additional perinatal and postnatal characteristics are presented in Table 2.

Predominantly expressive impairment was the most frequent clinical profile, observed in 24 children (55.8%), while 14 children (32.6%) had mixed receptive-expressive impairment. Moderate impairment was the most common severity category, accounting for 21 children (48.8%). The mean duration of language-related concerns was 18.6 ± 9.4 months, and the mean age at first parental concern was 27.8 ± 8.7 months. Seventeen children (39.5%) had previously received speech and language therapy, while 23 children (53.5%) had not received any previous intervention. Further clinical characteristics are presented in Table 3.

With respect to screen exposure, 27 children (62.8%) had daily screen durations of at least 1 hour, including 12 (27.9%) who had 2 hours or more of exposure. Fourteen children (32.6%) were first exposed to screens before 12 months of age, while 32 children (74.4%) were first exposed before 24 months of age. Detailed screen exposure characteristics are presented in Table 4.

In exploratory subgroup analyses, no statistically significant differences were observed between children with daily screen exposure of <1 hour and those with exposure of $\geq$ 1 hour, or between children first exposed to screens before 12 months and those first exposed at 12 months or later (Table 5). Given the small subgroup sizes and limited statistical power,

Table 1. Demographic, family, and parental characteristics

Variable	n	%	Mean $\pm$ SD
Sex			
Male	27	62.8	-
Female	16	37.2	-
Mean age (months)			
Male	-	-	45.21 ± 15.93
Female	-	-	50.32 ± 13.81
Overall	-	-	47.18 ± 15.22
Mean number of children in the family			
Mean maternal age (years)	-	-	35.71 ± 5.42
Mean paternal age (years)	-	-	38.16 ± 4.49
Maternal education			
Primary school	11	25.6	-
Middle school	5	11.6	-
High school	9	20.9	-
University/college	18	41.9	-
Paternal education			
Primary school	3	7.0	-
Middle school	12	27.9	-
High school	13	30.2	-
University/college	15	34.9	-
Maternal employment status			
Employed	13	30.2	-
Unemployed	30	69.8	-
Paternal employment status			
Employed	36	83.7	-
Unemployed	7	16.3	-
Maternal medical illness			
Present	13	30.2	-
Absent	30	69.8	-
Paternal medical illness			
Present	10	23.3	-
Absent	33	76.7	-
Maternal psychiatric illness			
Present	1	2.3	-
Absent	42	97.7	-
Paternal psychiatric illness			
Present	2	4.7	-
Absent	41	95.3	-
Parental cohabitation status			
Living together	36	83.7	-
Separated	7	16.3	-
Income status			
Poor	11	25.6	-
Moderate	20	46.5	-
Good	12	27.9	-

SD: Standard deviation.

Table 2. Perinatal and postnatal characteristics

Variable	n	%	Mean $\pm$ SD
Gestational age (weeks)	-	-	36.67 $\pm$ 2.74
Birth weight (g)	-	-	3068 $\pm$ 727
Mode of delivery			
NSVD	12	27.9	-
Cesarean section	31	72.1	-
Incubator care			
Yes	14	32.6	-
No	29	67.4	-
Hypoxia			
Present	10	23.3	-
Absent	33	76.7	-
Prolonged jaundice			
Present	4	9.3	-
Absent	39	90.7	-

SD: Standard deviation, NSVD: Normal Spontaneous Vaginal Delivery.

Table 3. Clinical characteristics of speech and language disorder

Variable	n (%) or Mean $\pm$ SD
Language impairment profile	
Predominantly expressive	24 (55.8)
Predominantly receptive	5 (11.6)
Mixed receptive-expressive	14 (32.6)
Severity of language impairment	
Mild	12 (27.9)
Moderate	21 (48.8)
Severe	10 (23.3)
Duration of language concerns, months	18.6 $\pm$ 9.4
Age at first concern, months	27.8 $\pm$ 8.7
Previous interventions	
Speech-language therapy	17 (39.5)
Special education/developmental support	9 (20.9)
No previous intervention	23 (53.5)
Standardized language assessment	15 (34.9)
Formal audiological assessment	28 (65.1)

SD: Standard deviation.

these findings should not be interpreted as evidence of equivalence or as evidence that no differences existed between the groups.

DISCUSSION

Neurodevelopmental disorders arising in childhood are generally more common in males than in females. Several studies have also shown that delays in language development occur more frequently in boys.¹⁵⁻¹⁷ This has been attributed to the slower maturation of the central nervous system in males, as well as the proposed inhibitory effects of testosterone on the formation of appropriate neural connections.¹⁵⁻¹⁷ In the present sample, 62.8% of the participants were male. However, in the absence of a comparison group, this finding should not be interpreted as evidence of a sex-related difference in the occurrence of speech and language disorder.

Table 4. Screen exposure characteristics

Variable	n (%)
Daily screen time	
<1 hour	16 (37.2)
1-2 hours	15 (34.9)
2-4 hours	10 (23.3)
>4 hours	2 (4.7)
Age at first screen exposure	
0-6 months	5 (11.6)
6-12 months	9 (20.9)
12-18 months	12 (27.9)
18-24 months	6 (14.0)
>24 months	11 (25.6)

Table 5. Exploratory subgroup comparisons according to daily screen time and age at first screen exposure

Daily screen time: <1 hour/day vs. $\geq$1 hour/day			
Variable	<1 hour/day (n=16)	$\geq$ 1 hour/day (n=27)	p-value
Age, months, mean $\pm$ SD	43.8 $\pm$ 14.1	49.2 $\pm$ 15.6	0.284
Male sex, n (%)	8 (50.0)	19 (70.4)	0.182
Incubator care, n (%)	3 (18.8)	11 (40.7)	0.179
Hypoxia, n (%)	2 (12.5)	8 (29.6)	0.280
Age at first screen exposure: <12 months vs. $\geq$12 months			
Variable	<12 months (n=14)	$\geq$ 12 months (n=29)	p-value
Age, months, mean $\pm$ SD	46.2 $\pm$ 13.0	47.7 $\pm$ 16.4	0.756
Male sex, n (%)	11 (78.6)	16 (55.2)	0.129
Incubator care, n (%)	7 (50.0)	7 (24.1)	0.089
Hypoxia, n (%)	5 (35.7)	5 (17.2)	0.172

p-values were calculated using the Independent Samples t-test or Mann-Whitney U test for continuous variables, and the chi-square test or Fisher's exact test for categorical variables, as appropriate.

SD: Standard deviation.

Multiple factors associated with delayed language development have been identified, including hearing loss, recurrent middle ear infections, seizures, birth asphyxia, prematurity, low birth weight, and physical deformities affecting the head and neck region. Environmental and familial factors may also contribute to language difficulties. These include multilingualism in the family, a crowded family environment, parental history of speech and language difficulties, and low parental education.^{15,16,18}

In this cohort, nearly one-third of the children required incubator care after birth, and almost one-quarter had a history of postnatal hypoxia. These findings indicate the frequency of selected perinatal and postnatal medical characteristics in the study population. Because all participants had speech and language disorder, and no comparison group was included, the data cannot determine whether these characteristics were more frequent than in the general pediatric population or related to the development or severity of the disorder.

Among environmental factors, screen exposure has received considerable attention. Previous studies have discussed the possibility that screen use may reduce opportunities for reciprocal verbal interaction and other

social activities relevant to language acquisition. However, the present study did not evaluate these mechanisms and could not determine whether they applied to the children in this sample. In the present cohort, 74.4% of the children were exposed to screens before 2 years of age. This proportion reflects the reported screen-exposure history of the study population and should not be interpreted comparatively because no typically developing control group was included. Early screen exposure has also been reported in studies of children diagnosed with speech and language disorder.^{19,20} Nevertheless, the current findings do not demonstrate that early exposure was more frequent than it was in typically developing children, nor that it preceded or contributed to language difficulties.

Screen exposure should not be considered solely in terms of duration. Previous literature suggests that developmental outcomes reported in relation to screen use may vary according to the type of device, the educational or entertainment nature of the content, its developmental appropriateness, and the social context of use. For example, interactive and age-appropriate content accompanied by parental co-viewing and verbal engagement may provide a different developmental experience from passive, solitary viewing of rapidly changing entertainment content. Similarly, background television exposure may reduce the quantity and quality of parent-child interaction even when the child is not directly attending to the screen.¹⁰⁻¹² Therefore, children with similar daily screen durations may have substantially different patterns and contexts of exposure. Because the present study recorded only daily duration and age at first exposure, it provides a limited quantitative characterization and does not capture the qualitative or contextual dimensions of screen use.

Previous theoretical and empirical studies have suggested that young children may process rapidly changing audiovisual content differently from adults and may have difficulty integrating such stimuli with real-world experiences.^{21,22} However, the present study did not assess attention, cognitive processing, the ability to distinguish virtual from real content, or any proposed neurodevelopmental mechanism. No inferences regarding these mechanisms can, therefore, be drawn from the findings.

Chonchaiya and Pruksananonda²³ reported that children with delayed language development began watching television approximately 10 months before producing their first meaningful words. In that study, exposure to television for more than 2 hours per day combined with introduction of television before 12 months of age was associated with a higher reported likelihood of language delay.²³ These results are specific to the population and design of that study and should not be directly extrapolated to the current sample.

Perdana et al.²⁴ reported that both typically developing children and children with delayed language development were commonly exposed to television before 2 years of age. Children with language delay had longer reported viewing durations, although the between-group difference was not statistically significant. The authors also reported that children with language delay were more frequently left alone to watch television.²⁴ Although these findings provide relevant context, they were derived from a separate comparative study and therefore cannot be directly compared with the current results.

Previous studies have also examined characteristics such as prolonged television viewing, the presence of a television in the child's room,

viewing content in a language not used in the daily life, and the absence of parental accompaniment.²⁵ However, these characteristics were not assessed in the present study. Their frequency and potential relevance in this population therefore remain unknown.

In 2022, Zhang et al.²⁶ examined the relationship between screen time and cognitive developmental domains in preschool children. Regardless of device type, time spent in front of screens was not associated with expressive vocabulary, but was linked to working memory difficulties. The authors suggested that the absence of an association with vocabulary might reflect differences in the sensitivity of expressive and receptive language to television exposure during early childhood. They also noted that children's expressive vocabulary may be more limited than their receptive language capacity.²⁶ These findings further illustrate the heterogeneity of the existing literature and should be interpreted in relation to the specific outcomes and methods evaluated in each study.

Speech and language disorder is a heterogeneous clinical condition that may arise from a broad etiological spectrum, including neurodevelopmental disorders, environmental influences, and psychosocial factors. Comprehensive and systematic evaluation is therefore essential for accurate diagnosis and appropriate intervention.^{15,16} Early multidisciplinary assessment involving pediatrics, child and adolescent psychiatry, speech and language therapy, and, when indicated, neurology may help identify comorbid psychopathologies and developmental vulnerabilities. This approach not only facilitates accurate differential diagnosis but also enables the development of individualized and evidence-based treatment plans. Given the potential of early and targeted interventions to improve long-term developmental, communicative, and functional outcomes, timely referral and coordinated care are particularly important for children presenting with speech and language difficulties.⁴⁻⁷ These clinical recommendations are based on the broader literature and not on comparative or causal findings from the present study.

From a clinical perspective, the findings support the inclusion of a structured assessment of digital media habits as part of the comprehensive developmental evaluation of children presenting with speech and language difficulties. Such an assessment may include daily screen duration, age at first exposure, device type, content characteristics, parental co-viewing, and the social context of screen use. However, the evaluation of screen habits should not replace a broader assessment of hearing, developmental level, family characteristics, medical history, and neurodevelopmental comorbidities. This clinical recommendation reflects the importance of obtaining a comprehensive developmental history and should not be interpreted as evidence that screen exposure caused the language difficulties observed in the present sample.

Recent systematic reviews and meta-analyses indicate that associations reported between screen media exposure and early development are heterogeneous and depend substantially on the context of use. A 2023 meta-analysis examining screen media exposure and vocabulary development reported that the direction and magnitude of findings varied according to the type of media experience and learning context. More recent reviews have emphasized that age-appropriate educational content, active caregiver involvement, and interactive use may differ substantially from passive or solitary viewing in their reported relationships with language and cognitive outcomes. Conversely, background television exposure, age-inappropriate content, and reduced parent-child interaction during screen use have been

associated with less favorable developmental outcomes. These findings support the use of multidimensional screen-exposure assessments in future research, but do not permit conclusions about the developmental implications of screen use in the current population.¹⁰⁻¹³

The exploratory subgroup comparisons did not identify statistically significant differences. However, the small sample size and limited numbers within the comparison categories resulted in low statistical power and a high-risk of type II error. Therefore, the absence of statistically significant findings should not be interpreted as evidence of equivalence between the groups or as confirmation that no differences were present. These analyses were performed solely for hypothesis-generating purposes and cannot support definitive conclusions.

The contribution of this study lies in its structured characterization of screen-exposure patterns and selected socio-demographic, perinatal, and clinical features among children evaluated in a tertiary child psychiatry clinic. Because no comparison group was included, the observed frequencies cannot be interpreted as higher or lower than those observed in typically developing children. Likewise, the findings do not indicate that any of the recorded characteristics are associated with the presence, development, or severity of speech and language disorder. Nevertheless, they may help identify variables for investigation in future adequately powered case-control and longitudinal studies.

Study Limitations

This study has several limitations. First, the relatively small sample size and small screen-exposure subgroups resulted in low statistical power and a high-risk of type II error. Accordingly, the absence of statistically significant differences should not be interpreted as evidence of equivalence or as evidence that no relationship exists. The exploratory subgroup analyses were performed solely for hypothesis-generating purposes and cannot support definitive conclusions.

Second, all participants were recruited from a single tertiary child and adolescent psychiatry clinic. Children evaluated in such a setting may have more severe, complex, or multidimensional developmental and medical concerns than those with isolated speech and language difficulties managed in primary care or community settings. Referral and selection biases may therefore have influenced the observed frequencies of perinatal complications, clinical characteristics, and screen-exposure patterns. Consequently, the findings should not be interpreted as prevalence estimates and may not be generalizable to all children with speech and language disorders.

Third, the absence of a typically developing comparison group represents a major methodological limitation. The study cannot determine whether the observed screen-exposure patterns were more frequent, occurred earlier, or more prolonged than those in the general pediatric population. In addition, the descriptive cross-sectional design does not permit the assessment of temporal directionality or causal relationships. Thus, the study cannot determine whether screen exposure preceded, contributed to, followed, or was unrelated to the emergence of speech and language difficulties.

Fourth, screen-exposure data were obtained retrospectively from parental reports and may have been affected by recall bias, reporting inaccuracies, and social desirability bias. Parents may also have retrospectively attributed screen exposure to their child's language

difficulties, potentially influencing the reported exposure history. Furthermore, screen exposure was assessed only in terms of daily duration and age at first exposure. Important qualitative and contextual characteristics-including device type, educational versus entertainment content, developmental appropriateness, parental co-viewing, background television exposure, and interactive versus passive use-were not systematically evaluated. Because children with similar total screen durations may have substantially different media-use patterns and contexts, the measures used provide only a limited quantitative representation of screen exposure. The use of parental reports rather than a validated multidimensional media-use questionnaire or objective device-use data may also have introduced measurement bias.

Finally, standardized speech-language, developmental, and audiological assessments were not applied uniformly to all participants. Although children with autism spectrum disorder, intellectual disability, and hearing impairment sufficient to explain the language difficulties were excluded, variability in the diagnostic assessments may have introduced clinical heterogeneity. Other unmeasured developmental, familial, medical, and environmental factors may also have influenced the characteristics observed in the sample. These methodological limitations should be addressed in future research.

CONCLUSION

This descriptive study characterized screen exposure patterns and selected sociodemographic, perinatal, and clinical features in children aged 2-6 years diagnosed with speech and language disorder. Early screen exposure was frequently reported, with 74.4% of children first exposed before 24 months of age and 62.8% having at least 1 hour of daily screen exposure. These observations emphasize the relevance of documenting digital media habits as part of a comprehensive developmental assessment of children presenting with speech and language difficulties. However, the absence of a typically developing control group and the cross-sectional design preclude conclusions regarding associations, temporal relationships, or causality. Future prospective, controlled studies incorporating standardized language assessments and multidimensional measures of screen exposure are needed to clarify the potential relationship between digital media use and speech and language disorders.

MAIN POINTS

- This study aimed to characterize screen exposure patterns and selected sociodemographic, perinatal, and clinical features of children aged 2-6 years diagnosed with speech and language disorder.
- In this tertiary clinical sample, 74.4% of the children had first been exposed to screens before 2 years of age, and 62.8% had a reported daily screen duration of at least 1 hour. These findings are descriptive and should not be interpreted as indicating higher values than those observed in typically developing children.
- The findings highlight the importance of documenting screen exposure alongside clinical and developmental characteristics in children with speech and language disorders, while further controlled studies are needed to clarify potential associations.

ETHICS

Ethics Committee Approval: The study was initiated after obtaining approval from the Karabük University Non-Interventional Clinical Research Ethics Committee (decision no. 2025/2509, date: 30.10.2025).

Informed Consent: Written informed consent was obtained from the parents or legal guardians of all participants prior to inclusion in the study.

Footnotes

Authorship Contributions

Surgical and Medical Practices: B.A., Concept: B.A., Design: U.B., M.T.G., Data Collection and/or Processing: B.A., M.T.G., Analysis and/or Interpretation: B.A., U.B., M.T.G., Literature Search: B.A., U.B., Writing: B.A., U.B.

DISCLOSURES

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