Speech Clinicians' and the General Public's Perceptions of Self and Stutterers

La perception de soi des orthophonistes cliniciens et du grand public et la perception qu'ils ont des personnes bègues

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Abstract

Similarities and differences between perceptions of self and perceptions of stutterers held by speech-language clinicians and members of the general public were examined with a modified version of a 25-item semantic differential test instrument. Results showed that clinicians and the general public held similar perceptions of self and negative perceptions of a hypothetical adult male stutterer relative to self. For example, when compared to themselves, members of both groups perceived stutterers as being guarded, withdrawn, tense, shy, anxious, afraid, reticent, and introverted. It is hypothesized that the negative stuttering stereotype may reflect an individual's cognitive and affective reactions to the physical act of stuttering. In addition, for the speech-language clinicians, it is suggested that the negative stereotype is related to stutterers' difficulty in maintaining long-term amelioration of the disorder following symptomatic therapy.

Résumé

Les ressemblances et les différences entre la perception de soi des personnes bègues et la perception qu'ont d'elles les orthophonistes cliniciens et le grand public ont été étudiées au moyen d'un instrument de différenciation sémantique. Les résultats ont révélé que les cliniciens et le grand public ont une perception de soi semblable et une perception négative d'une personne bègue typique de sexe masculin par rapport à eux-mêmes. Par exemple, les membres de ces deux groupes ont jugé que, comparativement à eux, les personnes bègues étaient réservées, renfermées, tendues, timides, angoissées, craintives, réticentes et introverties. On suppose que ce stéréotype négatif à l'égard du bégaiement peut témoigner des réactions cognitives et affectives de la personne à l'acte du bégaiement. En outre, dans le cas des orthophonistes cliniciens, on suggère que ce stéréotype négatif est relié au fait que les personnes bègues ont de la difficulté à maintenir pendant une longue période les effets bénéfiques d'une thérapie symptomatique.

Woods and Williams (1976), in an attempt to investigate various groups' perceptions of stutterers and nonstutterers, developed a 25-item bipolar semantic differential test instrument. Using this test instrument, they examined adult stutterers', parents' of stuttering children, parents' of children with speech pathologies unrelated to fluency, parents' of normally speaking children, elementary classroom teachers', public school speech clinicians', and college students' perceptions of a hypothetical stutterer and nonstutterer. The results showed that all groups shared a similar negative stereotype of stutterers as compared to nonstutterers. That is, stutterers were perceived to be anxious, tense, nervous, afraid, quiet, reticent, guarded, avoiding, introverted, passive, self-derogatory, and more sensitive. Follow-up studies examining the perceptions of stutterers by parents (Crowe & Cooper, 1977; Fowlie & Cooper, 1978), teachers (Crowe & Cooper, 1977; Crowe & Walton, 1981; Lass, Ruscello, Schmitt, Pannbacker, Orlando, Dean, Ruziska, & Bradshaw, 1992), employers (Hurst & Cooper, 1983a), and vocational rehabilitation counselors (Hurst & Cooper, 1983b) confirmed the existence of a pervasive negative stereotype.

With respect to speech-language clinicians, numerous studies have confirmed similar attitudes and perceptions towards stutterers. For example, Cooper and colleagues (Cooper, 1975; Cooper & Cooper, 1982, 1985; Cooper & Rustin, 1985) have revealed many consistent misbeliefs among clinicians with regard to the etiology of stuttering, appropriate therapeutic intervention, and the stuttering personality.

The robustness of the stuttering stereotype, as evidenced in the aforementioned studies examining clinicians and nonclinical groups, stands in contrast to studies which have examined stutterers' personalities. In his review of over 40 years of personality research, Bloodstein (1987) emphatically stated that "there is little conclusive evidence of any specific kind of character structure or broad set of basic personality traits that is typical of stutterers as a group" (p. 208), and that stutterers perform much like nonstutterers in studies which have used adjustment inventories. In other words,

stutterers are perceived to be different from nonstutterers in various character traits when compared to nonstutterers, although there is little empirical support for this position.

Woods and Williams (1976) suggested that the negative stereotype of stutterers held by speech-language clinicians may have an adverse influence on the therapeutic process. They suggested that speech-language clinicians may need to identify and discuss inaccurate perceptions of stutterers during the therapeutic process. The notion that clinicians need to recognize clinical biases through self-inspection was expressed by Van Riper (1975) when he wrote, "All clinicians need to examine their clinical behaviors and impressions" (p. 474).

Earlier works (e.g., St. Louis & Lass, 1981; Turnbaugh, Guitar, & Hoffman, 1979) have examined speech-language clinicians' and various other groups' perceptions of two hypothetical individuals. That is, a hypothetical stutterer was compared to a hypothetical normal speaker. There have been, to the best of our knowledge, no investigations concerning speech-language clinicians' and the general public's perception of self (i.e., an actual person) compared to their perception of a hypothetical stutterer. In terms of the clinical process, it appears more germane to examine how clinicians view the stutterer in relationship to themselves than to examine how they perceive two hypothetical individuals. In addition, past researchers have typically examined how stutterers are perceived by specific nonstuttering samples and not by a more representative sample of the general public with no known clinical education, training, and experience. Therefore, the purpose of this study was to compare speech-language clinicians' and the general public's perception of stutterers to their perception of self.

Method

Subjects

One hundred (100) questionnaires were distributed to speech-language clinicians attending the 1986 Annual Connecticut State Speech-Language and Hearing Conference. Results are based on returned questionnaires from 58 clinicians whose mean age was 37.8 years with a range from 22 to 58 years of age. The mean clinical experience was 11.1 years with a range from less than 1 year up to 34 years. The amount of clinical experience in treating stutterers was not ascertained.

The members of the general public were drawn from a list of computer generated random telephone numbers for all telephone prefixes for the State of Connecticut. These telephone numbers were called by research assistants. Appropriate subjects were residential customers of Southern New England Telephone who were either the male or female head of the household. Callers asked for the male or the female head of the household on alternate calls to maintain a 50 percent gender division. Each telephone number for which there was no initial answer was recalled four times before being discarded as a non-operating number. Of the 310 people contacted by telephone, 275 agreed to participate which resulted in 138 usable questionnaires. The mean age of this group was 39.5 with a range from 17 to 81 years of age[1].

Test Instrument

The instrument employed in this study to evaluate stuttering stereotypes was a modified version of the 25-item semantic differential test instrument developed by Woods and Williams[2] (1976) (see Tables). The semantic differential format has often been used to examine character features of groups. This particular instrument has been previously employed to investigate stuttering stereotypes (Turnbaugh, Guitar, & Hoffman, 1981; White & Collins, 1984). Each bipolar adjective pair was presented with a 9 point Likert scale (Kalinowski, Lerman, & Watt, 1987).

Procedure

Questionnaires for the speech-language clinicians were circulated as conference attendees were registering for the morning sessions. Those clinicians who took a questionnaire were asked to complete and return them before the end of the day. Questionnaires for the general public were mailed to the prospective participants. These subjects were requested to complete the questionnaire and return it in an enclosed self-addressed stamped envelope. Instructions for completing the questionnaire which were derived from those described by White and Collins (1984) were printed at the top of each scale (see Appendix).

Results

Mean and standard deviation values for speech-language clinicians' and the general public's perceptions of self are shown in Table 1. The mean values are illustrated in Figure 1. Independent two-tailed *t*-tests investigating mean differences among each of the rating scales, with the level of significance set at $p = 0.001$ to correct for the compounding error

[1]The data from the general public was previously reported by Kalinowski, Lerman, & Watt, 1987.

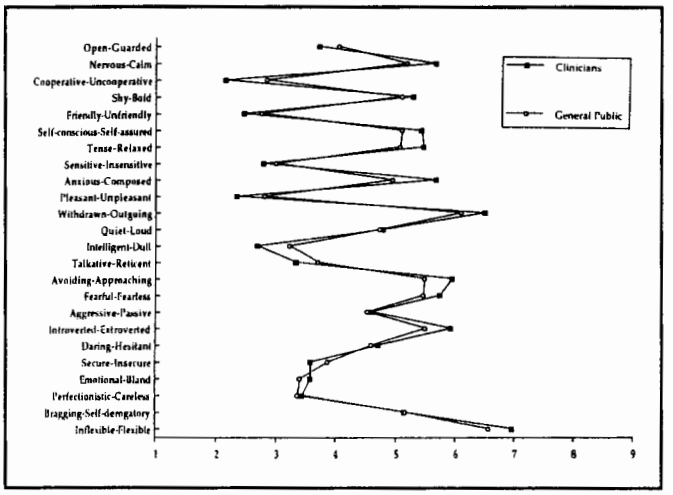
[2]The scales used in this study differed from the original Woods and Williams (1976) scale in two ways. First, we used a 9 point scale, while Woods and Williams used a 7 point scale. Second, one scale, *afraid-confident*, was mistakenly printed as *afraid-content* and therefore was not used in our data analyses.

Table 1. Means, standard deviations, and results of independent two-tailed *t*-tests between each scale for speech-language clinicians' and the general public's perception of self

Scale	*t*-test Result	Clinicians' Perception of Self	Public's Perception of Self
Open-Guarded	NS	3.7 (1.8)	4.0 (1.8)
Nervous-Calm	NS	5.7 (1.9)	5.2 (2.1)
Cooperative-Uncooperative	*	2.1 (1.1)	2.8 (1.6)
Shy-Bold	NS	5.3 (1.8)	5.1 (1.8)
Friendly-Unfriendly	NS	2.4 (1.4)	2.7 (1.7)
Self-conscious-Self-assured	NS	5.4 (2.2)	5.1 (2.2)
Tense-Relaxed	NS	5.4 (1.8)	5.1 (2.0)
Sensitive-Insensitive	NS	2.8 (1.4)	3.0 (1.7)
Anxious-Composed	NS	5.7 (1.8)	4.9 (2.1)
Pleasant-Unpleasant	NS	2.3 (1.2)	2.8 (1.4)
Withdrawn-Outgoing	NS	6.5 (1.6)	6.1 (1.6)
Quiet-Loud	NS	4.8 (1.7)	4.7 (1.8)
Intelligent-Dull	NS	2.7 (1.0)	3.2 (1.4)
Talkative-Reticent	NS	3.3 (1.5)	3.7 (1.6)
Avoiding-Approaching	NS	5.9 (1.5)	5.5 (1.5)
Fearful-Fearless	NS	5.7 (1.5)	5.5 (1.5)
Aggressive-Passive	NS	4.6 (1.4)	4.5 (1.7)
Introverted-Extroverted	NS	5.9 (1.6)	5.5 (1.7)
Daring-Hesitant	NS	4.7 (1.6)	4.6 (1.7)
Secure-Insecure	NS	3.6 (1.5)	3.9 (1.9)
Emotional-Bland	NS	3.6 (1.3)	3.4 (1.6)
Perfectionistic-Careless	NS	3.4 (1.5)	3.4 (1.7)
Bragging-Self-derogatory	NS	5.1 (0.9)	5.2 (1.4)
Inflexible-Flexible	NS	6.9 (1.2)	6.6 (1.5)

Note: * significant at $p < 0.001$, nonsignificant (NS).

Figure 1. Mean values of speech clinicians' and the general public's perceptions of self.



attendant with multiple *t*-tests, showed that clinicians were significantly different from the general public for 1 of the 24 scales examined. That is, clinicians viewed themselves as more cooperative.

Table 2 shows mean and standard deviation values for clinicians' and the general public's perceptions of a hypo-

Table 2. Means, standard deviations, and results of independent two-tailed *t*-tests between each scale for speech-language clinicians' and the general public's perception of a hypothetical stutterer.

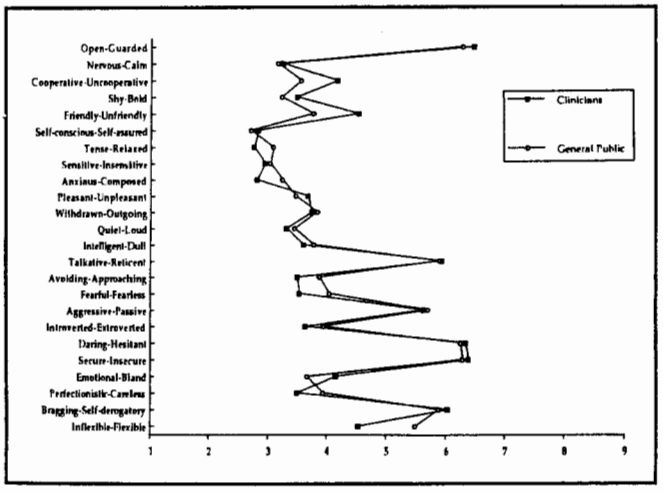
Scale	*t*-test Result	Clinicians' Perception of Stutterer	Public's Perception of Stutterer
Open-Guarded	NS	6.5 (1.4)	6.3 (1.7)
Nervous-Calm	NS	3.2 (1.5)	3.2 (1.6)
Cooperative-Uncooperative	NS	4.2 (1.3)	3.6 (1.6)
Shy-Bold	NS	3.5 (1.3)	3.2 (1.6)
Friendly-Unfriendly	*	4.5 (1.3)	3.8 (1.7)
Self-conscious-Self-assured	NS	2.8 (1.4)	2.7 (1.7)
Tense-Relaxed	NS	2.8 (1.3)	3.1 (1.6)
Sensitive-Insensitive	NS	2.9 (1.3)	3.0 (1.6)
Anxious-Composed	NS	2.8 (1.4)	3.2 (1.7)
Pleasant-Unpleasant	NS	3.7 (1.3)	3.5 (1.7)

Table 2 - continued

Scale	t-test Result	Clinicians' Perception of Stutterer	Public's Perception of Stutterer
Withdrawn-Outgoing	NS	3.7 (1.4)	3.8 (1.7)
Quiet-Loud	NS	3.3 (1.3)	3.4 (1.7)
Intelligent-Dull	NS	3.6 (1.4)	3.8 (1.6)
Talkative-Reticent	NS	5.9 (1.6)	5.9 (1.8)
Avoiding-Approaching	NS	3.5 (1.6)	3.9 (1.6)
Fearful-Fearless	NS	3.5 (1.3)	4.0 (1.5)
Aggressive-Passive	NS	5.6 (1.6)	5.7 (1.7)
Introverted-Extroverted	NS	3.6 (1.4)	3.9 (1.6)
Daring-Hesitant	NS	6.3 (1.3)	6.3 (1.6)
Secure-Insecure	NS	6.4 (1.4)	6.3 (1.6)
Emotional-Bland	NS	4.2 (1.6)	3.7 (1.7)
Perfectionistic-Careless	NS	3.5 (1.4)	3.9 (1.9)
Bragging-Self-derogatory	NS	6.0 (1.4)	5.9 (1.4)
Inflexible-Flexible	*	4.5 (1.4)	5.5 (1.5)

Note: * significant at $p < 0.001$, nonsignificant (NS).

Figure 2. Mean values of speech clinicians' and the general public's perceptions of a typical stutterer.



thetical adult male stutterer. Figure 2 displays these mean values. Independent two-tailed *t*-tests, evaluating mean differences for each of the rating scales, revealed that clinicians and the general public were only significantly different on two scales: friendliness and flexibility ($p < 0.001$). That is, the general public viewed stutterers as more friendly and flexible than did the clinicians.

Table 3 and Figure 3 illustrate clinicians' perceptions of self contrasted with their perceptions of a hypothetical stutterer. Comparison of differences between mean ratings with dependent two-tailed *t*-tests showed that clinicians' self-perceptions were significantly different from their perceptions of stutterers on 21 of 24 scales ($p < 0.001$). That

Table 3. Means, standard deviations, and results of independent two-tailed *t*-tests between each scale for speech-language clinicians' perception of self and a hypothetical stutterer.

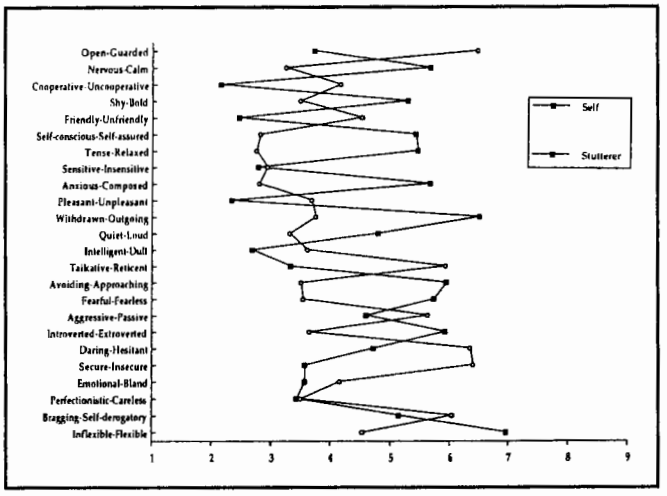
Scale	t-test Result	Clinicians' Perception of Self	Clinicians' Perception of Stutterer
Open-Guarded	*	3.7 (1.8)	6.5 (1.4)
Nervous-Calm	*	5.7 (1.9)	3.2 (1.5)
Cooperative-Uncooperative	*	2.1 (1.1)	4.2 (1.3)
Shy-Bold	*	5.3 (1.8)	3.5 (1.3)
Friendly-Unfriendly	*	2.4 (1.4)	4.5 (1.3)
Self-conscious-Self-assured	*	5.4 (2.2)	2.8 (1.4)
Tense-Relaxed	*	5.4 (1.8)	2.8 (1.3)
Sensitive-Insensitive	NS	2.8 (1.4)	2.9 (1.3)
Anxious-Composed	*	5.7 (1.8)	2.8 (1.4)
Pleasant-Unpleasant	*	2.3 (1.2)	3.7 (1.3)
Withdrawn-Outgoing	*	6.5 (1.6)	3.7 (1.4)
Quiet-Loud	*	4.8 (1.7)	3.3 (1.3)
Intelligent-Dull	*	2.7 (1.0)	3.6 (1.4)
Talkative-Reticent	*	3.3 (1.5)	5.9 (1.6)
Avoiding-Approaching	*	5.9 (1.5)	3.5 (1.6)
Fearful-Fearless	*	5.7 (1.5)	3.5 (1.3)

Table 3 - continued

Scale	*t*-test Result	Clinicians' Perception of Self	Clinicians' Perception of Stutterer
Aggressive-Passive	*	4.6 (1.4)	5.6 (1.6)
Introverted-Extroverted	*	5.9 (1.6)	3.6 (1.4)
Daring-Hesitant	*	4.7 (1.6)	6.3 (1.3)
Secure-Insecure	*	3.6 (1.5)	6.4 (1.4)
Emotional-Bland	NS	3.6 (1.3)	4.2 (1.6)
Perfectionistic-Careless	NS	3.4 (1.5)	3.5 (1.4)
Bragging-Self-derogatory	*	5.1 (0.9)	6.0 (1.4)
Inflexible-Flexible	*	6.9 (1.2)	4.5 (1.4)

Note: * significant at $p < 0.001$, nonsignificant (NS).

Figure 3. Mean values of speech clinicians' perceptions of self and of a typical stutterer.



is, clinicians saw a hypothetical stutterer as being more guarded, uncooperative, nervous, shy, unfriendly, self-conscious, tense, anxious, unpleasant, withdrawn, quiet, dull, reticent, avoiding, fearful, passive, introverted, daring, insecure, self-derogatory, and inflexible.

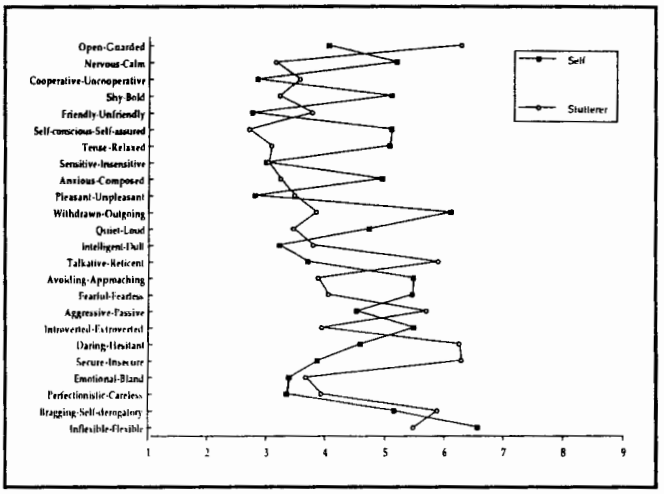
Table 4 and Figure 4 contrast the general public's self-perceptions with their perceptions of a hypothetical stutterer. Dependent two-tailed *t*-tests revealed statistically significant differences between 22 of 24 rating scales ($p < 0.001$). Like speech-language clinicians, the general public attributed

Table 4. Means, standard deviations, and results of independent two-tailed *t*-tests for the general public's perception of self and a hypothetical stutterer.

Scale	*t*-test Result	Clinicians' Perception of Self	Public's Perception of Stutterer
Open-Guarded	*	4.0 (1.8)	6.3 (1.7)
Nervous-Calm	*	5.2 (2.1)	3.2 (1.6)
Cooperative-Uncooperative	*	2.8 (1.6)	3.6 (1.6)
Shy-Bold	*	5.1 (1.8)	3.2 (1.6)
Friendly-Unfriendly	*	2.7 (1.7)	3.8 (1.7)
Self-conscious-Self-assured	*	5.1 (2.2)	2.7 (1.7)
Tense-Relaxed	*	5.1 (2.0)	3.1 (1.6)
Sensitive-Insensitive	NS	3.0 (1.7)	3.0 (1.6)
Anxious-Composed	*	4.9 (2.1)	3.2 (1.7)
Pleasant-Unpleasant	*	2.8 (1.4)	3.5 (1.7)
Withdrawn-Outgoing	*	6.1 (1.6)	3.8 (1.7)
Quiet-Loud	*	4.7 (1.8)	3.4 (1.7)
Intelligent-Dull	*	3.2 (1.4)	3.8 (1.6)
Talkative-Reticent	*	3.7 (1.6)	5.9 (1.8)
Avoiding-Approaching	*	5.5 (1.5)	3.9 (1.6)
Fearful-Fearless	*	5.5 (1.5)	4.0 (1.5)
Aggressive-Passive	*	4.5 (1.7)	5.7 (1.7)
Introverted-Extroverted	*	5.5 (1.7)	3.9 (1.6)
Daring-Hesitant	*	4.6 (1.7)	6.3 (1.6)
Secure-Insecure	*	3.9 (1.9)	6.3 (1.6)
Emotional-Bland	NS	3.4 (1.6)	3.7 (1.7)
Perfectionistic-Careless	*	3.4 (1.7)	3.9 (1.9)
Bragging-Self-derogatory	*	5.2 (1.4)	5.9 (1.4)
Inflexible-Flexible	*	6.6 (1.5)	5.5 (1.5)

Note: * significant at $p <. 001$, nonsignificant (NS)

Figure 4. Mean values of the general public's perceptions of self and of a typical stutterer.



more negative attributes to the hypothetical stutterer than themselves (e.g., nervous, tense, sensitive, anxious, withdrawn, fearful, passive, introverted).

Discussion

The most important finding of the study is that speech-language clinicians' perceptions of self and their perceptions of a hypothetical adult male stutterer were markedly dissimilar. That is, their perceptions of a stutterer were significantly more negative than their perceptions of self (see Figure 3). Clinicians attributed numerous negative adjectives to stutterers, which included: guarded, nervous, tense, reticent, insecure, and hesitant. Further, despite more than 10 years of clinical experience, they did not differ significantly from the untrained general public on 22 of 24 scales assessing perceptions of a typical stutterer (see Figure 2). Further, the self-perceptions of clinicians differed minimally from the members of the general public. Specifically, no significant differences were found on 23 of 24 scales (see Figure 1). These results show that speech-language clinicians and the general public possess a strong negative stereotype of a typical stutterer relative to self. These findings are consistent with previous studies that have examined speech-language clinicians' perceptions of a hypothetical stutterer and a hypothetical normal speaker (e.g., Woods & Williams, 1976).

It is speculated that the existence of the negative stuttering stereotype is due to two factors: the aberrant nature of stuttering behavior in terms of its intermittent overt physical manifestations and stuttering's resistance to successful long-term amelioration. With regard to the former, it is undeniable that stuttering is characterized by physical effort, strain, struggle, and tension. As such, these motor behaviors are likely to have a powerful impact upon the listener. According to Nisbett and Ross (1980), people assign cognitive/affective weight to physical and social data in proportion to its salience and vividness. It follows that people who exhibit intermittent stuttering behavior are more likely to be categorized/stereotyped as being unlike the normal population because of the saliency and vividness of such behavior. In other words, there is a visceral response to the stuttering moment.

According to White and Collins (1984), the negative stuttering stereotype, especially for those who have limited exposure to stutterers (i.e., general public), is formed by making inferences about variables that accompany disfluencies or stuttering-like behaviors in normal speakers. In other words, based on their own internal feelings of anxiety, tension, and nervousness during normal disfluencies or stuttering-like moments, nonstutterers generalize state anxiety to trait anxiety. The observer of stuttering behavior may be theorizing, "If I feel tense and show signs of anxiety when I'm disfluent then you, as a stutterer, must be tense and anxious all of the time."

A second probable factor contributing to the stuttering stereotype may be stuttering's resistance to successful long-term amelioration. In other words, the negative perceptions held by speech clinicians may reflect their inclination to blame stutterers rather than themselves for outcomes which may be less than optimal. Thus, the consistency of the stereotype might be, in fact, an admission on the part of the speech clinicians of the difficulty in treating the disorder. This would be especially true for those clinicians who have not received specialized training in fluency disorders, which is most likely the case for the majority of clinicians sampled in this study.

One distinctive property of stereotypes is their persistence over time and their resistance to vary, even when the holder of the stereotype is exposed to information that fails to justify his/her stereotypic expectations (Brigham, 1971). If this is true, the stuttering stereotype may even be more difficult to discard because the stutterer continues to intermittently display behaviors which solidify the stereotype. That is, there are behavioral manifestations of the disorder that differentiate stutterers from nonstutterers. Speech-language clinicians may observe these signs of internal stress and are possibly unable to separate the behavior from the person. Thus, clinicians are conceding to the aberrant nature of the disorder. They may be saying, " I know what research says about the character of stutterers but my emotional response to the moment of stuttering and the person who stutters is very powerful." In light of this, Van Riper's (1975) postulation seems appropriate:

> Competent clinicians also know that all observing is selective. No one can attend to all the behaviors being emitted by the stutterer even in a single minute of therapy, and there are always the dangers that this selectivity may distort the picture. Wise clinicians ... search for rejecting evidence even more than for corroboration before coming to any conclusions. It is not easy to operate in this way but we can and must. (p. 462)

Based on their investigation of stuttering stereotypes, Woods and Williams (1976) concluded, "Initially, people do react unfavorably to stutterers" (p. 277). It might be more appropriate to say that initially people, including the speech-language clinician who treats the stutterer, hold a pervasive and tenacious negative stereotype of the stutterer. The speech clinician's attitudes towards the stutterer differ little from the general population despite years of higher education and clinical experience. It is hypothesized that the physical act of stuttering, and the speech clinician's difficulty in maintaining long-term amelioration of the disorder following symptomatic therapy, sustain the negative stuttering stereotype. Future studies which examine the possible consequences of the negative stereotype held by speech clinicians on the success or failure of the therapeutic process are warranted.

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Appendix

Instruction set #1:

Below you will see some rating scales each with 9 points. I would like you to evaluate YOURSELF, as you typically are, on each of these scales. Please circle the number on the scale that best describes yourself, on each scale.

Instruction set #2:

Below you will see some rating scales each with 9 points. I would like you to evaluate a typical ADULT MALE STUTTERER, someone who has difficulty when trying to speak. On the scales provided below circle the number on the scale which identifies what YOU THINK are the traits of a STUTTERER.