

## Research Article

# Speech-Language Pathologists' Comfort Level With Use of Term "Stuttering" During Evaluations

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**Purpose:** Speech-language pathologists (SLPs) anecdotally report concern that their interactions with a child who stutters, including even the use of the term "stuttering," might contribute to negative affective, behavioral, and cognitive consequences. This study investigated SLPs' comfort in providing a diagnosis of "stuttering" to children's parents/caregivers, as compared to other commonly diagnosed developmental communication disorders.

**Method:** One hundred forty-one school-based SLPs participated in this study. Participants were randomly assigned to one of two vignettes detailing an evaluation feedback session. Then, participants rated their level of comfort disclosing diagnostic terms to parents/caregivers. Participants provided rationale for their ratings and answered various questions regarding academic and clinical experiences to identify factors that may have influenced ratings.

**Results:** SLPs were significantly less likely to feel comfortable using the term "stuttering" compared to other communication disorders. Thematic responses revealed increased experience with a specific speech-language population was related to higher comfort levels with using its diagnostic term. Additionally, knowing a person who stutters predicted greater comfort levels as compared to other clinical and academic experiences.

**Conclusions:** SLPs were significantly less comfortable relaying the diagnosis "stuttering" to families compared to other speech-language diagnoses. Given the potential deleterious effects of avoidance of this term for both parents and children who stutter, future research should explore whether increased exposure to persons who stutter of all ages systematically improves comfort level with the use of this term.

Imagine a scenario where a speech-language pathologist (SLP) has completed an evaluation of a preschool child. The results confirm the referring concern, stuttering. The child is playing with toys and is within hearing distance of the SLP as they convey the diagnosis of stuttering to the child's parent(s). Would the SLP feel comfortable directly stating to the parent(s) that their child presents with "stuttering?" If not, why? Imagine the same scenario; the only difference is that the referring concern is articulation, not stuttering. Would the same SLP now feel more or less comfortable stating the diagnostic term of word articulation within earshot of the child? Why or why not?

At present, any predicted answers to these questions are largely anecdotal in nature, with the first and third authors' decades of interactions with both parents and SLPs commonly including a discussion as to whether using the word "stuttering" when speaking with their child about their speech might somehow have a deleterious effect. This frequent clinical exchange is juxtaposed with the documented reflection of adults who stutter; the lack of any pointed discussion of stuttering when they were a child significantly contributed to their fear, avoidance, anger, frustration, and shame (Daniels et al., 2012).

Theoretical support for choosing not to say the word "stuttering" is found in the early etiological perspective of stuttering beginning in the ear of the listener, not the mouth of the speaker. Johnson's diagnosogenic theory of stuttering's etiology suggested that any direct discussion of the behavior, certainly any labeling, may lead the child to shift from being typically fluent to being atypically disfluent (e.g., W. Johnson, 1942, 1946; W. Johnson et al., 1946). Advice given to parents was to ignore the stuttering and make no issue of it to any degree, certainly no direct discussion.

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Editor-in-Chief: Julie Barkmeier-Kraemer

Editor: Shelley B. Brundage

Received September 5, 2019

Revision received December 13, 2019

Accepted January 23, 2020

[https://doi.org/10.1044/2020\\_AJSLP-19-00081](https://doi.org/10.1044/2020_AJSLP-19-00081)

**Disclosure:** The authors have declared that no competing interests existed at the time of publication.

Although evidence for the diagnosogenic theory is generally lacking (Manning & DiLollo, 2017), the theory still permeates professional views. For example, Yairi and Carrico (1992) surveyed pediatricians and reported that they advise parents that their child may begin to stutter during the age of 2–3 years, but that the parents should ignore it and their children will grow out of it, a central tenet of the theory. Implicit within this suggestion is that choosing not to ignore beginning stuttering and, instead, discussing it directly to any degree is not the correct course of action. Thus, many parents report anecdotally that not only they have never used the term “stuttering” with their child but also they have never talked to their child about the observable differences in their speech, even if the parent is also a person who stutters.

It could be assumed that SLPs, compared to parents, would be well informed that the diagnosogenic theory is considered no longer tenable. However, although there may have been some improvements (Yaruss et al. 2017), there are significant data to demonstrate that, across the areas that are core to our scope of practice, stuttering continues to be the area for which SLPs report receiving the least academic and clinical training in their undergraduate and graduate studies. As a result, stuttering also continues to also be the one of the communication disorders about which SLPs consistently report feeling the least competent and confident to assess and/or treat (e.g., Brisk et al., 1997; Coalson et al., 2016; Cooper & Cooper, 1985; Crichton-Smith et al., 2003; Gabel, 2014; Kelly et al., 1997; St. Louis, 1997; St. Louis & Durrenberger, 1993). Given research to suggest that communication of formal diagnostic terms of other diagnostic constructs (e.g., mild cognitive impairment) is avoided when the clinician does not feel knowledgeable about the diagnosis (T. Mitchell et al., 2008), it seems plausible that the use of the term “stuttering” may be more likely to be avoided than use of the diagnostic terms for other communication disorders.

It is also possible that SLPs who have been adequately trained may still be hesitant to use the label “stuttering” for another reason. SLPs are trained to be in tune with parental concerns. During their initial exchanges with parents of children who stutter, they may sense parents’ discomfort, anxiety, and/or fear surrounding the disorder and, as a result, choose to avoid saying it. Nevertheless, by choosing not to say the word “stuttering,” any past or future avoidance of parental use of this term is affirmed unintentionally. Such avoidance of terminology that they may not initially feel comfortable using can yield short-term relief for the parent(s) as a more difficult dialogue is, at least, temporarily evaded. Nevertheless, it deters the long-term relief of the increased competence and confidence the parent will experience when they are objectively informed of their child’s diagnosis, even if the term is one they have never encountered or one they have feared.

In fact, there are significant data to suggest that parents/caregivers prefer to be verbally informed of formal diagnosis as opposed to engaging a discussion wherein the clinician is talking around the name (e.g., Hasnat &

Graves, 2000; Schofield et al., 2001; Sloper & Turner, 1993). Research has demonstrated that use of the direct diagnostic term, regardless of the severity of the diagnosis, significantly reduces parental anxiety and depression (Schofield et al., 2001). Research has also demonstrated that the decision to avoid sharing a diagnosis with a child can have deleterious effects. For example, Instone (2000) studied a cohort of children with HIV who were not told of their formal diagnosis by their parents for a considerable amount of time. Their parents’ decision to avoid discussion of their diagnosis reportedly contributed to poor psychosocial adjustment resulting in severe emotional distress, disturbed self-image, and social isolation.

In summary, pediatricians have reported that they typically advise parents to ignore their child’s stuttering, guidance that resonates from the no longer supported diagnosogenic theory (Yairi & Carrico, 1992). This guidance may lead the parent to be more hesitant to directly label their child’s speech. SLPs who meet with these parents may either sense their hesitation or may be hesitant themselves because of their insufficient academic and clinical training. Given evidence that clinicians are more likely to avoid direct term use when they do not feel confident in their knowledge, the use of the term “stuttering” would presumably be a diagnostic term that would be more likely to be avoided. This study aims to assess whether SLPs feel distinctly less comfortable using the term “stuttering” as compared to other developmental communication disorders, and what qualitative factors influence their comfort level with these distinct diagnostic terms.

## Method

### *Participants*

Participants were recruited via a two-pronged approach. Public school districts were identified across the country and e-mailed according to contact information available to the public. Lead SLPs, or the contact for the speech-language pathology team, were e-mailed at 158 primary and secondary schools across the country. Additionally, e-mails were sent to the special education contacts and/or speech-language pathology contacts for 13 distinct districts across the country. Schools and districts were identified in 16 different states that represented distinct geographical regions of the United States. States and school districts were targeted first by geographical location such that states were identified in each region (i.e., east and west coasts, northern and southern, and midwest/mid-America states), and similarly, school districts were searched for to represent cities from across the state’s geography. E-mails were not sent to school contacts more than once, unless the contact requested the researchers reach out to a different contact or supply further research information ( $n = 3$ ). Recruitment also simultaneously included posts to five social media outlets specified for school-based SLPs (Facebook groups: “School-Based SLPs for Professionals Only!,” “School SLP Jubilee,” “School-Based SLP,” “PRESCHOOL Speech

Language Pathologists,” and “Speechies in Schools”). These posts were reposted to each outlet monthly for 4 months. Participants were eligible for this study if they reported they worked as a state-licensed SLPs and that their primary work environment was in the United States school systems. Accordingly, survey responses were omitted from analysis if participants responded with any of the following exclusionary criteria: (a) status as a preservice clinician or graduate student, (b) having less than 6 months of work experience as an SLP, (c) primary work environment outside of a school system (e.g., hospital, private practice), (d) primary work environment to be outside of the United States, and (e) incomplete submission of the entire survey. School-based clinicians were recruited due to the wide variety of diagnoses with which they routinely work, thus creating a cohort of clinicians who were likely to have worked with both high and low incidence populations, compared to individuals who identify as or gain certification as specialists for any one area of practice.

A total of 145 participants responded to the survey. Four were excluded due to status as being a graduate student ( $n = 1$ ) or less than 6 months experience ( $n = 3$ ), resulting in 141 participants included for analysis. Years of working experience ranged from 6 months to 42 years ( $M = 16.13$  years). Participants reported working in 37 different states and in the District of Columbia. Participants were asked to report whether they had specialized knowledge or training in any specific area of practice. Each of the four diagnostic terms was listed as multiselect options, and as an ability to select “other” and write-in an unlisted specialty. Of the 141 participants, 101 responded. However, the majority of these participants indicated either through explicit statement that they viewed themselves more as a generalist or by selecting or writing in three or more populations they felt they had specialized knowledge or training of. Forty participants indicated specialization in one or two areas of practice. Articulation was the most frequently reported area of specialty ( $n = 17$ ), followed by language ( $n = 16$ ), phonological disorders ( $n = 5$ ), assistive and augmentative communication, voice and autism spectrum disorder ( $n = 2$  each), dysphagia, fluency, social communication, bilingualism, and traumatic brain injury ( $n = 1$  each). It is important to note that, of all of these specialties, the following were the only that were never reported as the sole specialty (i.e., they were always accompanied with another reported area): fluency and social communication.

### **Procedure**

The institutional review board of the first and second author approved this study. Participants were first presented with a cover letter with instructions for affirming informed consent. Participants were then presented with one short vignette of a clinical scenario in which they were to imagine themselves having just completed a diagnostic evaluation with a 4-year-old male client, a typical age at which children may begin the diagnostic process to receive school-based services. They were then asked to rate their comfort level on

a visual analog scale with relaying four different diagnostic terms to parents in a feedback conference, assuming the child had presented with each diagnosis, namely, mixed receptive-expressive language disorder, articulation disorder, stuttering, and phonological disorder. The scale was bipolar in structure such that a score of 0 indicated “extremely uncomfortable,” and a score of 100 indicated “extremely comfortable.” A rating of 50 indicated that the respondent was neutral about the diagnosis.

Participants were randomly presented with one vignette that either described the 4-year-old client was present in the room during the feedback conference, or the child was absent (see the Appendix). Following the ratings of the four diagnoses, all participants were presented with an essay text box and asked to describe what factors informed their comfort level ratings for each diagnosis type.

The survey then presented participants with questions relative to the frequency of experiences with feedback conferences related to each vignette, as well as overall frequency of feedback conferences provided for each diagnosis. Additionally, the survey posed questions related to the participant’s undergraduate and graduate academic and clinical experiences with fluency disorders. Finally, participants were asked to report their current level of involvement with stuttering support groups, and the frequency with which they produce a voluntary stutter.

### **Analyses**

A two-way repeated-measures analysis of variance was employed to determine if the comfort level of school-based SLPs with stating diagnosis terms to parents was significantly different for each diagnosis type (within-group factor), or whether the child was also present in the room (between-group factor). Significant main effects were then deconstructed via pairwise comparisons.

To assess qualitative reasonings for comfort levels, thematic analysis of participant responses was conducted by the second author and a research assistant. Coding focused exclusively on responses to the question, “Please describe what influenced your rating of how comfortable you were with saying each diagnosis to the parent. Be sure to comment on your rating for each of the four diagnoses.” Themes of responses were first identified by the second author. Responses were coded for themes such that each response could contain multiple themes (e.g., if a clinician provided rationale for comfort with articulation and an additional, separate rationale for comfort or discomfort with stuttering). The second author, a certified SLP, first identified responses that provided rationale for specific diagnoses, compared to those that only provided a general rationale for all four diagnoses. These responses were analyzed for valence, in which reported comfort (overall or with a specific diagnosis) was attributed a positive valence and discomfort a negative valence. Rationales for specific diagnoses were then grouped into themes based upon overt explanations and those inferred, but not explicitly stated. For example, with respect to the theme “emotional component of

stuttering,” an overt response coded for this theme included “Fluency is an area that I am less comfortable with because parents often want to place blame and I am less comfortable discussing it in front of the student because of the emotional ties to fluency” (Participant 29), whereas an inferred response coded for this theme included, “Stuttering typically goes one way or the other. Either the family is comfortable and objective about the student’s needs or they appear fearful or ashamed” (Participant 37). All responses were then reanalyzed for the presence of themes related broadly to comfort level or any diagnosis. Following the establishment and coding of themes for each response, a research assistant was trained on the themes and coding and independently repeated the coding process. Interrater agreement of coding responses was calculated for the themes related to stuttering (92%). To investigate which clinical or academic experiences quantitatively influenced comfort ratings with stuttering, a multivariate regression model was utilized for clinical experiences.

## Results

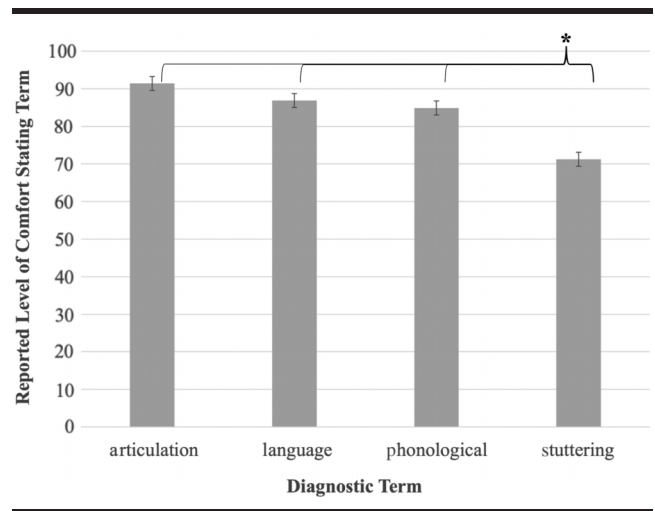
### Comfort Level Conveying Diagnostic Terms

Initial results of the two-way, repeated-measures analysis of variance revealed a violation of sphericity, and a Greenhouse–Geisser correction was applied. A significant main effect for diagnosis type,  $F(1.90, 264.03) = 46.550$ ,  $p < .001$ , was observed, but not presence of child,  $F(1, 139) = 1.360$ ,  $p = .250$ , or interaction between diagnosis type and presence of child,  $F(1.90, 264.03) = 1.280$ ,  $p = .280$ .

To further investigate the main effect for diagnosis type, pairwise comparisons via the emmeans package in Rstudio were completed for all four diagnoses. Results of these comparisons revealed stuttering to be significantly lower in confidence rating than each of the other three diagnoses, language versus stuttering:  $t(417) = 8.682$ ,  $p < .001$ ; articulation versus stuttering:  $t(417) = 11.209$ ,  $p < .001$ ; and phonological versus stuttering:  $t(417) = -7.586$ ,  $p < .001$ . Only one other pair was observed to be significantly different in confidence ratings. Relaying the phonological diagnosis was rated significantly lower than the articulation diagnosis,  $t(417) = 3.623$ ,  $p = .001$  (see Figure 1).

Inspection of residuals revealed a lack of normality in the data. For each diagnosis type, data were negatively skewed. Inspection of outliers revealed two patterns of responses from outliers. One pattern was related to the construct of the visual analogue scale. Given the scale was bipolar in nature, a score of 50 would indicate neutrality in relaying each diagnosis. However, the most frequent response were very high ratings (i.e., between 90 and 100), which is not an unexpected result given that relaying common diagnoses to parents is a frequent task of SLPs. Some participants rated primarily around the 50, or neutral, mark for all diagnoses, contributing to the lack of normality in the data. Other outlier participants simply rated very low scores for one or multiple diagnoses, indicating extreme lack of comfort. Given the lack of normality, though ecologically

**Figure 1.** Mean reported levels of comfort stating each term by speech-language pathologists. Asterisk indicates stuttering was reported significantly less comfortable than each of the three other terms.



valid, follow-up nonparametric analyses were completed. A Friedman test revealed a significant effect of diagnosis type on participant,  $\chi^2(3) = 126.47$ ,  $p < .001$ . Median scores for all diagnoses were 100, except stuttering, which were 76. The significant effect for diagnosis type on participant remained when Friedman test was completed with child present,  $\chi^2(3) = 64.487$ ,  $p < .001$ ; median scores: language = 90, articulation = 100, phonological = 96, stuttering = 74, and child absent,  $\chi^2(3) = 65.808$ ,  $p < .001$ ; all median scores = 100 except stuttering = 80. Wilcoxon signed-ranks tests were utilized to compare each diagnosis rating with and without the child present. Results of these tests showed that, for language, but no other diagnosis, the confidence rating was significantly higher when the child was absent ( $W = 2939$ ,  $p = .043$ ; articulation:  $W = 2783.5$ ,  $p = .148$ ; stuttering:  $W = 2869.5$ ,  $p = .108$ ; phonological:  $W = 2595.5$ ,  $p = .626$ ).

### Clinical and Academic Experiences

Clinical and academic experiences during preservice training and professional careers were analyzed to determine whether or not undergraduate and graduate experiences could predict later comfort level with saying the word “stuttering” to families. Upon review of academic coursework, 121 participants (86%) reported receiving information about fluency disorders as either part of a required course, or as an entire required course dedicated to fluency disorders during their undergraduate program. Similarly, 124 participants (88%) reported receiving this same level of academic coursework during their graduate program. It should be noted that nine participants (6%) reported no academic exposure during their undergraduate program and seven (5%) participants for their graduate program. Due to the majority of participants reporting high levels of academic exposure at



both the undergraduate and graduate level, this variable was not used as a predictor of comfort level.

With respect to clinical experiences, a multivariate regression model was utilized with the following predictor variables: undergraduate clinical experience with a client who stutters, graduate clinical experience with a client who stutters, experience with voluntary stuttering, attendance at a stuttering support group, knowing a person who stutters, and years of professional work experience. All of these variables, with the exception of years of professional work experience, were dichotomous in nature. Attendance at stuttering support groups was originally categorized by frequency: never ( $n = 93$ ), once ( $n = 31$ ), occasionally ( $n = 14$ ), yearly ( $n = 2$ ), monthly ( $n = 1$ ), or more ( $n = 0$ ); however, due to limited responses across the positive attendance choices, these categories were collapsed such that attendance was binary (i.e., never or at least once). Controlling for all of these variables, knowing a person who stutters was observed to be the only significant predictor variable for comfort level stating the word “stuttering” (see Table 1).

### Qualitative Analysis

Participants’ comments were analyzed to further understand the reasons for their ratings. Of the 141 participants, 127 (90%) provided free text responses. Sixteen individual themes were identified across responses along with the frequency of each, as listed in Table 2. Seven, or nearly half, were related specifically to stuttering. Of those, only one was positive (i.e., having a positive experience or knowledge base with stuttering). Six themes were related to negative aspects related to stuttering (e.g., dealing with emotional components of stuttering, believing that stuttering is difficult to explain, choosing an alternative word for “stuttering,” having limited experience with stuttering, having limited knowledge of stuttering, and having difficulty assessing stuttering). Of the remaining themes, three were neutral in nature (i.e., having no issue in relaying diagnostic terms and depending on the degree to which a diagnosis is obvious, possessing knowledge or experience to provide adequate skills or comfort). Two themes were related to negative aspects specific to phonology (i.e., believing that phonology is difficult to explain and having limited experience with phonology), and two to negative relationships to language (i.e., having limited knowledge of language and believing that “language” is vague). No themes describing negative aspects relating to articulation were reported. Two negative

themes that were not specific to any diagnosis related to considering whether or not the child was present in the room and recognizing the long-term consequences of a diagnosis. The most frequently occurring theme in all the responses was a high level of comfort resulting from either an extensive knowledge of a diagnoses or an abundance of experience with a diagnosis (44.8%). The second most frequent theme in free text responses was related to limited experience with stuttering (25.2%).

### Discussion

Given that medical research has demonstrated that clinicians are more likely to use formal diagnostic terms when they feel confident in their knowledge and skills, coupled with the studies that have demonstrated that parents experience reduced anxiety and emotionality when the clinician directly labels and discusses the diagnosis as opposed to using evasive, nondescript, informal language, the purpose of this study was to examine SLPs’ comfort using the term “stuttering” as compared to other developmental communication disorders when relaying a formal diagnosis to parent(s). Results confirm the anecdotal reports that SLPs feel significantly more uncomfortable using the diagnostic term “stuttering.” These results are consistent regardless of whether or not the child is present in the room during the feedback conference. Our preliminary findings suggest that there are at least a few reasons why SLPs report significantly higher rates of discomfort using this term.

First, they may not have had sufficient academic and/or clinical training. A 2013–2014 review by Yaruss et al. (2017) shows there has been some improvements, but there are still other reports that stuttering remains the area for which most SLPs report they feel they did not receive as much exposure academically or clinically. In this study, 86% of the participants reported to having some exposure at the undergraduate level and 88% also reported having graduate coursework in stuttering. This percentage is indicative of improvement in academic training, at least on the surface. However, it does not support the assumption that clinicians who have the knowledge are more likely to use the formal diagnostic term. Perhaps, the participants in this study completed courses, but the courses were not taught by people who were experts in the area. Support for this possibility is found in Coalson et al. (2016). Specifically, they found that, across most of the accredited programs where stuttering is part of the required academic coursework, the

**Table 1.** Results of multivariate regression model with included predictor factors for comfort stating the term “stuttering.”

Predictor	Estimate	SE	t value	Significance ( $p$ )
Undergraduate clinical experience	2.29	6.21	0.37	.71
Graduate clinical experience	3.58	5.47	0.65	.51
Experience voluntary stuttering	-4.83	5.07	-0.95	.34
Attendance at stuttering support group	6.48	5.29	1.22	.22
Years of working experience	-0.06	0.20	-0.30	.76
Knowing a person who stutters	15.96	5.99	2.66	< .01

**Table 2.** Frequency and valence of themes in response to qualitative responses to comfort level ratings for each diagnosis.

Response theme	Example	Frequency	Valence
Language			
Less knowledge of language	<i>"I'm continuing to learn about language and stuttering and don't feel I have as much knowledge about them."</i>	1/127	Negative
"Language" vague	<i>"...It's hard to explain because language is so abstract."</i>	8/127	Negative
Stuttering			
Stuttering difficult to explain	<i>"...stuttering and phonological are tougher terms to explain"</i>	6/127	Negative
Choosing an alternative word for "stuttering"	<i>"I generally don't use the word 'stutter' even during therapy at the younger ages (age varies by child)."</i>	6/127	Negative
Less experience with stuttering	<i>"I have slightly less experience with fluency than with the other three domains."</i>	32/127	Negative
Less knowledge about stuttering	<i>"I'm continuing to learn about language and stuttering and don't feel have as much knowledge about them."</i>	6/127	Negative
Difficulty assessing stuttering	<i>"Stuttering is hard to diagnose as true stuttering, especially if it's actually impacting them within their classroom and home environments. I feel less comfortable deciphering a few stumbles from a stutter sometimes if I don't really know the child."</i>	4/127	Negative
Positive experience with stuttering	<i>"I had a wonderful experience working as a GA for a professor who was a board-certified specialist in stuttering."</i>	1/127	Positive
Emotional component of stuttering	<i>"Fluency is an area that I am less comfortable with because parents often want to place blame and I am less comfortable discussing it in front of the student because of the emotional ties to fluency."</i>	18/127	Negative
Phonology			
Phonology difficult to explain	<i>"Phonology is a less commonly understood word (when considering parents) and often feels more abstract."</i>	11/127	Negative
Less experience with phonology (negative)	<i>"I have not worked too much with phonological disorders, so I am not as comfortable explaining them."</i>	12/127	Negative
Any diagnosis			
Knowledge/experience dictating comfort	<i>"My comfort level in discussing the diagnoses is directly related to my experience with each of them."</i>	57/127	Neutral
Presence of child in room	<i>"I'm uncomfortable with the child in the room. The parent isn't free to express their concerns as readily as they would without the child present."</i>	8/127	Neutral
Whether diagnosis is obvious	<i>"General perception of the disorder and how obvious it is to parents. Articulation, phonology and to a certain extent stuttering diagnoses are most often not a surprise."</i>	10/127	Neutral
No issue relaying terms	<i>"With standardized data collection and professional experience I feel most comfortable sharing any substantiated diagnosis with parents."</i>	17/127	Neutral
Long-term consequences of diagnosis	<i>"Language is often a disorder that could indicate lower cognitive skills, learning disability or deficits that will impact the child for years, whereas artic and phonological are very treatable and children typically can attain age appropriate levels with therapy. Fluency is can be difficult to remediate."</i>	1/127	Negative

person responsible for teaching the course was someone (i.e., adjunct faculty, lecturer) for whom stuttering was not their area of expertise. If that was the case, it is possible that the participants in this study were inaccurately taught that calling any attention to stuttering may be detrimental to the child, and as a result, they felt less comfortable using the term. Support for this possibility is highlighted in the open-ended comments by the present participants where they expressed that they had limited knowledge of stuttering.

That being said, we did not ask the participants to provide information about their previous instructor's knowledge of stuttering. Thus, it is possible that the SLPs who participated in this study were well trained academically, but were still hesitant to use the term "stuttering" because they had minimal to no clinical experience. However, similar to the academic training, this assumption also does not align with the data for our present participants as the

majority did report having had experience at both the undergraduate and graduate level. Specifically, 26% reported having clinical experience as an undergraduate and 68% reported having clinical experience at the undergraduate level, and clinical experience did not influence comfort level with use of the term. It could be that the nature of the experience precluded the ability to feel comfortable. The qualitative commentary from the present participants appear to support this possibility; however, additional data are needed. Future research should explore whether working with children versus working with adults yields differences in comfort level in use of the term "stuttering" during diagnostic evaluations.

A next logical hypothesis would be that attending stuttering support groups might increase their comfort using the term "stuttering." Of the 141 participants, 34% reported having attended a support group at least once. However,

attendance at these groups did not increase comfort. Perhaps, attending multiple times would have yielded a positive result. That is, with regular attendance, the SLP may gain more insight that would in turn provide more comfort with use of the term. Future studies should explore this possibility.

Interestingly, although having clinical experience and/or attending a stuttering support group did not increase comfort level with use of the term, knowing a person who stutters did. Recall that the question posed to participants was “Do you personally know a person who stutters?” For those who responded yes, they were more significantly more comfortable using the term “stuttering.” In hindsight, the manner in which this question was worded may have resulted in the participant reflecting on an adult, and thus, logically, someone who they may have been more likely to directly discuss stuttering. Furthermore, given that both anecdotal and empirical data show that the majority of adults who stutter share that they wish someone would have told them what was happening with their speech when they were a child, as opposed to ignoring their stuttering, those participants in this study who reported they knew a person who stutters may be more personally motivated to not avoid use of the term “stuttering.”

Along those same lines, another plausible explanation is that, as a result of having more intimate as opposed to clinical exchanges with people who stutter, their comfort with the use of the term increased as a natural byproduct. This explanation addresses the possibility that SLPs avoid the use of the term because of concerns that they might invoke the stigma associated with it (Boyle & Blood, 2015). Research shows the more intimately you know a person who has a specific diagnosis, the more comfortable you may feel talking about their diagnosis, not just with the person but with other people (Gronholm et al., 2017). It is interesting that, at least for the participants in this study, knowing someone who stutters positively increased comfort level with use of the term. It is also interesting that this relationship was not demonstrated or, rather not needed, to increase comfort level with use of the other diagnostic terms in this study, further suggesting that the stigma that is unique to stuttering may drive the comfort level with use of the term.

That is, SLPs may be concerned that using the term could result in parents viewing their child’s communication difference through a stereotype threat that directly conflicts with the message the clinician is attempting to convey to the parent(s). Thus, to avoid the parent having concerns that are influenced by the inaccurate portrayal of stuttering in the popular media, an inaccurate portrayal that is not observed as it relates to the other disorders included in this study (Boyle et al., 2009; G. F. Johnson, 1987; J. K. Johnson, 2008), SLPs may choose to discuss the behaviors that the child is demonstrating rather than use the specific diagnostic term.

A related, but distinct, finding from this study is the breadth of reasons SLPs reported for feeling negative toward disclosing stuttering to families. Of all of the diagnoses investigated, negative relationships with stuttering accounted for almost half of all of the rationales for comfort levels.

Participants reported six distinct negative relationships with stuttering, ranging from feeling apprehensive about increasing negative emotions, and ill prepared to adequately explain the diagnosis to parents, to several themes related to the clinicians’ own understanding of the nature, assessment, and treatment of the disorder. Several participants also reported purposely choosing alternative terms to “stuttering” to attempt to lessen negative perceptions of the disorder.

Additionally, given that voluntary stuttering is thought to be desensitizing (Byrd et al., 2016), we assumed that participants who had experience with stuttering on purpose would be more comfortable using the term “stuttering.” Seventy-five participants reported having used voluntary stuttering, but this use did not increase the comfort level of the use of the term “stuttering.” Thus, it appears that this strategy may yield comfort with behavior itself as opposed to the formal description of the behavior.

Yet, another possibility that we were not able to capture via our survey but is important to consider for future research is that SLPs may have optimal academic and clinical training, but may still be hesitant to use the term “stuttering” given that they were sensitive to the parents’ level of comfort using the word. That is, participant responses in this study may have been reflective of how the participants internalized that the parents may feel about their use of the term “stuttering.” As a result, they may have been reticent to use it in the initial diagnosis as they did not want to inadvertently cause any additional stress.

Perhaps, SLPs would be less hesitant to use the word, if they were aware of the research related to use of diagnostic terms outside of our field. Continuing education should include review of studies that demonstrate preferences for open, direct, and educational discussions during diagnosis disclosure that have been documented in other developmental disabilities (e.g., Baird, 2000; Hasnat & Graves, 2000; Nissenbaum et al., 2002; Sheet et al., 2011; Sloper & Turner, 1993). For example, parents receiving diagnoses of developmental disabilities, such as autism spectrum disorder, report they are more satisfied with the disclosure process when professionals are direct, demonstrate an understanding of their concerns, and provide ample information (Hasnat & Graves, 2000; Sloper & Turner, 1993).

Preference for use of formal diagnosis is present even in the presence of grief, feelings of overwhelming amounts of information, and regardless of whether the child is present in the room when the diagnosis is conveyed (Hasnat & Graves, 2000). This is important as clinicians often do not provide complete disclosure but, instead, avoid openly labeling a diagnosis for fear of creating negative feelings in the family, or giving more information than the family can handle (Nissenbaum et al., 2002). In fact, research that has examined the relaying of diagnoses directly to patients has demonstrated that there is a significant reduction in their anxiety and depression when using the direct term, even when the term is of life-altering consequence, “cancer,” as opposed to avoiding using the term and instead describing the term more generally or talking around it (Schofield et al., 2001).

Furthermore, the impact on the child of the parents' experience with the manner in which their child's diagnosis is communicated to them has also been investigated. Research demonstrates that, if the parent has a negative experience during the initial exchange with the diagnostician, their child is also more likely to have a negative experience during initial discussions with their parents regarding their diagnosis (Goodwin et al., 2015). Thus, SLPs must be informed that avoidance of use of the formal diagnostic term during the initial exchange regarding the child's diagnosis may contribute to parent perception of that initial exchange being negative.

Together, these data demonstrate that, no matter their perception of the potential negative impact, use of the formal diagnostic terms is preferred and should be encouraged. A. J. Mitchell (2007) has proposed that both undergraduate and graduate programs should provide opportunities for students to practice sharing formal diagnoses in hopes that this will reduce their hesitancy to have direct doctor-patient discussions in their eventual work settings. Results from this study also suggest that having the opportunity to personally know a person who presents with the diagnosis may contribute to increased comfort with use of the diagnostic term.

## Conclusions

Anecdotally, SLPs report concern that their interactions with a child may have harmful effects. Results from this study demonstrate that this concern, at least, in part, manifests as a general hesitation to use the term "stuttering" when relaying this diagnosis parents/caregivers. In fact, the SLPs who participated in this study were significantly less likely to feel comfortable using the term "stuttering" compared to other communication disorders. Thematic responses revealed increased experience with a specific speech-language population was related to higher comfort levels with using its diagnostic term with the parents and/or within hearing range of the child. Additionally, knowing a person who stutters predicted greater comfort levels, but clinical and academic experiences, as defined in this study, did not. That being said, the qualitative commentary suggests that the quality of the clinical and academic training received may not have been lacking specifically in increasing confidence with use of the term "stuttering." Given the negative consequences of avoidance of this term for both parents and children who stutter, continuing education should include reference to the value of using formal diagnostic terms and future research should explore whether increased exposure to persons who stutter of all ages systematically improves comfort level with term use.

## Acknowledgments

Funding for this study has been provided in part by the Michael and Tami Lang Stuttering Institute research endowment.

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## Appendix

### Vignettes Presented to Participants.

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#### Vignette A

You have just completed a comprehensive evaluation of a 4-year-old male client. Results reveal that he conclusively presents with one of the disorders listed below. You are now reviewing the results of your evaluation, including your diagnosis, with the parent. **The child is not present in the room during this exchange.** Please rate the following:

Your comfort level stating each diagnostic term when describing which disorder the child presents with.

0 = Extreme discomfort.

50 = Neutral, neither comfortable nor uncomfortable.

100 = No discomfort, extremely comfortable.

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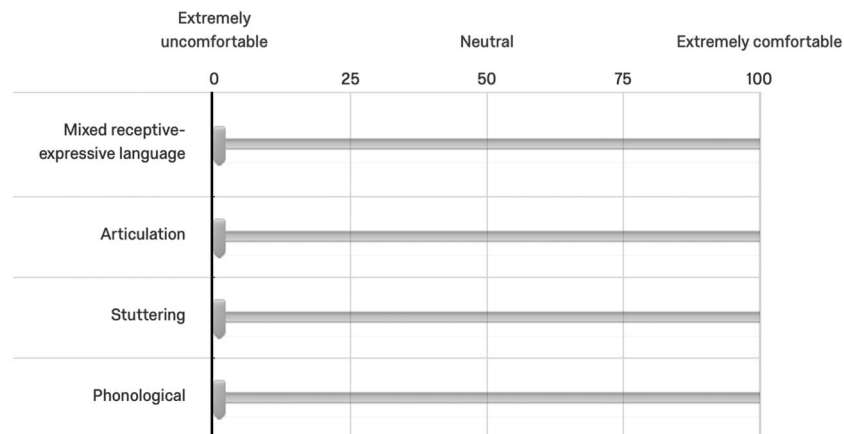
#### Vignette B

You have just completed a comprehensive evaluation of a 4-year-old male client. Results reveal that he conclusively presents with one of the disorders listed below. You are now reviewing the results of your evaluation, including your diagnosis, with the parent.

**The child is present in the room during this exchange.** Please rate the following:

rate the following:

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*Note.* Participants viewed one of the following vignettes, and all rated the same rating scale pictured below. During rating, participants received visual feedback of their numerical rating.

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