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## Enacted Stigma and Felt Stigma Experienced by Adults Who Stutter

Michael Boyle

Montclair State University, boylemi@mail.montclair.edu

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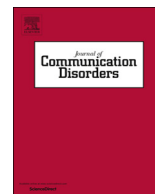
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## Enacted stigma and felt stigma experienced by adults who stutter

Michael P. Boyle\*

Department of Communication Sciences and Disorders, Montclair State University, 1515 Broad St. Building B – 2nd Floor, Bloomfield, NJ, 07003, United States



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## ABSTRACT

**Purpose:** The aim of this study was to (1) document the experiences of enacted stigma (external stigma, experienced discrimination) and felt stigma (anticipation and expectation of discrimination or negative treatment by others) in adults who stutter, (2) investigate their relationships to each other, and (3) investigate their relationships to global mental health.

**Method:** Participants were 324 adults who stutter recruited from clinicians and self-help group leaders in the United States. Participants completed an anonymous web survey consisting of measures of enacted stigma, felt stigma, and global mental health. Data analysis focused on obtaining descriptive statistics for enacted stigma and felt stigma, and performing correlational analysis between these variables, and also between these variables and global mental health.

**Results:** Most participants reported experiencing several different forms of social devaluation and negative treatment from other people at some point in their lives (i.e., enacted stigma), although they rarely experienced these events during the past year. Most participants agreed that they anticipate future stigmatizing experiences (i.e., felt stigma). Enacted stigma in the past year demonstrated a significant positive relationship to felt stigma. Both enacted stigma in the past year and felt stigma demonstrated significant negative relationships with global mental health. Enacted stigma in the past year and felt stigma were unique predictors of participants' global mental health.

**Conclusions:** People who stutter experience discrimination and social devaluation, and they anticipate future stigmatizing experiences. Both of these types of stigma, enacted and felt, are associated with reduced mental health in adults who stutter. Assessment and therapy with adults who stutter should address these aspects of stuttering.

## 1. Introduction

The experience of stigma is a major problem encountered by people who stutter (PWS) (St. Louis, 2015). The experience of stigma includes instances in which PWS are reacted to or treated negatively. In addition, stigma can be perceived or felt by PWS in the anticipation or fear of being treated negatively (Corcoran & Stewart, 1998; Plexico, Manning, & Levitt, 2009). These experiences and feelings of being stigmatized may be related to the psychological distress, such as anxiety, that is often documented in adults who stutter (Iverach & Rapee, 2014). Although previous research has indicated that PWS experience negative reactions from others (Blood et al., 2011; Gabel, Blood, Tellis, & Althouse, 2004), and that they can come to fear or anticipate these reactions (Iverach & Rapee, 2014), studies that have compared enacted stigma and felt stigma within the same participants using focused measures are lacking. Furthermore, it has not yet been determined how these different components of stigma are related to global mental health. The purpose of this study was to document the enacted stigma and felt stigma experienced by adults who

\* Corresponding author.

E-mail address: [boylemi@montclair.edu](mailto:boylemi@montclair.edu).<https://doi.org/10.1016/j.jcomdis.2018.03.004>

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stutter, investigate the relationship between these two aspects of stigma, and determine whether relationships exist between them and global mental health.

### 1.1. Background on stigma

One of the most cited definitions of stigma comes from Goffman's (1963) seminal book. In his book, Goffman wrote that stigma is an "attribute that is deeply discrediting" and that it diminishes a person in the eyes of others "from a whole and usual person to a tainted, discounted one" (p. 3). Jones et al. (1984) added to this definition by highlighting how stigma can be both a trait (e.g., symptoms, skill deficits, appearances, or labels) and an outcome of possessing that trait (e.g., discrimination, avoidance, segregation). Link and Phelan (2006) described the process through which a stigmatized characteristic can lead to negative consequences for the individual possessing that characteristic. Those authors described how labeling a difference that is perceived as undesirable leads to generation of stereotypes of individuals with those characteristics. These stereotypes can lead to negative emotional reactions and ultimately discrimination from the public. As a result of this separation from others, individuals with stigmatized conditions experience a status loss in society in addition to decrements in physical and psychological well-being.

Corrigan, Rafacz, and Rüsich (2011) proposed a progressive model of stigma which separated public stigma from self-stigma. Public stigma represents the beliefs and actions of members of the public toward the stigmatized group, and self-stigma refers to the internalization of public stigma among individuals with stigmatized conditions. Importantly, this model of self-stigma was conceptualized to be trickle-down, or progressive, in nature such that stigma awareness precedes agreement with those negative views, and agreement precedes application of negative societal attitudes to the self. The application of stigmatizing attitudes to the self would then lead to reductions in self-efficacy and self-esteem and finally limitations in societal participation. Despite the popularity of this model in the area of mental illness, other researchers have disputed the notion that feelings of stigma must necessarily be preceded by instances of public stigma (Livingston & Boyd, 2010). Another conceptualization of stigma that is widely used in the psychology literature separates enacted stigma from felt stigma and this model will be the focus of this paper.

#### 1.1.1. Enacted stigma

Scambler (2009) stated that *enacted stigma* referred to episodes of discrimination against individuals with a societally or culturally stigmatized condition solely on the ground of being imperfect. Enacted stigma can therefore be thought about as external stigma which is expressed by the public toward individuals with devalued characteristics (Molina, Choi, Cella, & Rao, 2013). Enacted stigma includes discrimination (e.g. being denied a job) as well as more subtle forms of social devaluation such as being stared at, being patronized or treated unkindly, being taken less seriously, or being avoided (Quinn & Earnshaw, 2013). Therefore enacted stigma is a general term that encompasses any externally stigmatizing reaction that would result in the stigmatized individual being treated unfairly or negatively (Gray, 2002). Essentially, enacted stigma is what the public actually does to the person with a stigmatized condition.

#### 1.1.2. Felt stigma

*Felt stigma* on the other hand, has been defined as knowledge and expectations about the probability that enacted stigma could occur under certain circumstances (Herek, Gillis, and Cogan, 2009), and the possibility of accompanying feelings of dread and fear in anticipation of social rejection (Jacoby, 1994; Livingston & Boyd, 2010; Scambler, 2009). Felt, or anticipated stigma, is people's belief that they might encounter negative treatment from others if their stigmatized condition is exposed (Quinn & Earnshaw, 2013). Even though felt stigma can certainly result in anxiety in certain social situations (Gray, 2002), felt stigma is not synonymous with an anxiety disorder. Anxiety disorders are diagnosed when fear or anxiety is out of proportion to the situation and normal functioning is inhibited (American Psychiatric Association, 2017). Felt stigma on the other hand is a more general term that indicates an awareness and expectation of enacted stigma, and even though fear or anxiety may be experienced, they are not necessarily present to a degree that is out of proportion to the situation. It is also conceivable for an individual to feel or anticipate being stigmatized without experiencing the physical tension and situational avoidance that is typically associated with anxiety. Therefore, although the terms are related, anxiety and felt stigma are not one in the same. Whereas enacted stigma relates to what the public does to a person with a stigmatized condition, felt stigma is an internal experience for the individual with that condition. If people with a stigmatized condition are aware of negative societal stereotypes about people with their condition, they may expect social devaluation even if they have never experienced overt discrimination (Jacoby, 1994; Quinn & Earnshaw, 2013).

### 1.2. Enacted stigma experienced by people who stutter

Enacted stigma experienced by PWS is clearly seen in studies documenting job discrimination and bullying. It is important to point out that although the definition of enacted stigma involves expression of discrimination or devaluation, research with adults who stutter has not observed actual instances of public stigma because of the obvious difficulties researchers would have in obtaining those data in real life situations. Despite this, several studies have sought to document these phenomena through perceptions of members of the public, as well as reports from PWS regarding their experiences of enacted stigma through self-report. In a study of the perceptions of 644 employers, Hurst & Cooper (1983a) found that about 50% of participants believed that stuttering decreased employability, and many believed that PWS should seek jobs requiring little oral communication. Hurst & Cooper (1983b) also studied 152 vocational rehabilitation counselors' perceptions and found that over 75% believed that stuttering would be vocationally handicapping. Silverman and Paynter (1990) found that college students viewed a factory worker and lawyer who stuttered more

negatively (including being less employable and competent) than a fluent worker. Silverman and Boney (1997) also reported that nurses viewed a doctor who stutters more negatively than a fluent doctor (e.g., less educated, competent, reputable). Other studies have found that university students (Gabel et al., 2004), teachers (Irani, Gabel, Hughes, Swartz, & Palasik, 2009), and speech-language pathologists (Swartz, Gabel, Hughes, & Irani, 2009) perceive certain careers to be less appropriate for PWS, especially those that require frequent oral communication (e.g., attorney, judge, speech-language pathologist, counselor, physician). There have also been a few studies that have documented accounts of workplace discrimination directly from PWS. PWS have reported that employers had misjudged their abilities and that stuttering damaged their chances of being hired or promoted (Klein & Hood, 2004). Qualitative research with PWS also supports the notion that stuttering is perceived to limit occupational success and progress (Bricker-Katz, Lincoln, & Cumming, 2013).

In addition to workplace discrimination, bullying (physical, verbal, relational, and cyberbullying) can also be experienced by PWS, and these experiences can be quite common (Hugh-Jones & Smith, 1999). Studies have shown that PWS are about three times more likely to be bullied than fluent controls (Blood & Blood, 2004; Blood & Blood, 2007; Blood et al., 2011). Children who stutter are also more likely to be perceived as a bully-victim, more likely to be perceived as withdrawn, and to be socially rejected (Davis, Howell, & Cooke, 2002). Many PWS have reported being bullied during school-age years and adolescence (Erickson & Block, 2013) and these experiences can create lasting memories that persist into adulthood (Blood & Blood, 2016; Daniels, Gabel, & Hughes, 2012). Although bullying and job discrimination can be considered aspects of enacted stigma, as mentioned previously the construct of enacted stigma is much broader and can include more subtle responses including being treated unkindly, being avoided, stared at, being taken less seriously, or being patronized (St. Louis, 2015). These aspects of stuttering have not been extensively detailed to date in a large sample of adults who stutter. Still, the findings reviewed above indicate that the public can indeed treat PWS negatively.

### 1.3. Felt stigma experienced by people who stutter

Several qualitative research studies have illustrated that many PWS anticipate and are concerned about being perceived negatively by others solely due to their stuttering. Specifically, PWS have stated they believe they will be perceived by others as “mentally defective,” “strange,” “not good enough,” “a fool,” “incompetent,” “freak of nature,” “not a whole person,” “mentally retarded,” “inferior,” “socially crippled,” “not normal,” “an imbecile,” “an idiot,” or “crazy” because of their stuttering (Bricker-Katz, Lincoln, & McCabe, 2010; Corcoran & Stewart, 1998; Klompass & Ross, 2004; Plexico et al., 2009; Whaley & Parker, 2000). The fear of being perceived negatively could perpetuate avoidance of speaking or social situations among PWS. For example, Blood, Blood, Tellis, and Gabel (2003) found that most PWS avoid talking about stuttering or discuss it very rarely. Furthermore, some PWS attempt to pass as a fluent speaker and hide their stuttering from communication partners altogether (Butler, 2013). When concealing stuttering is not possible, PWS have reported attempting to minimize their stuttering to reduce listener discomfort (Plexico et al., 2009). Scales such as the Overall Assessment of the Speaker’s Experience of Stuttering (OASES, Yaruss & Quesal, 2006), and the Unhelpful Thoughts and Beliefs about Stuttering (UTBAS) scale (St. Clare et al., 2009) include certain items that assess felt stigma. In addition to those more general scales, Boyle (2013) developed the Self-Stigma of Stuttering Scale (4S) to measure self-stigma according to the specific model of Corrigan et al. (2011) which included a subscale of ‘stigma awareness.’ That portion of the scale measured how aware PWS are of negative reactions of others, including stereotypes, prejudiced emotional reactions, and discrimination. In a sample of 291 adults who stutter, Boyle (2013) found that 86% of the sample demonstrated moderate to high levels of awareness of public stigma (i.e., on average, they agreed that members of the public respond to them negatively in domains of attitudes, emotions, and actions). Boyle (2015) conducted a follow-up study with 354 adults who stutter and found that 84% of the sample demonstrated moderate to high levels awareness of public stigma.

Despite the finding that a vast majority of adults who stutter are aware of public stigma regarding stuttering, the 4S did not directly measure the anticipation, worry, and fear of experiencing future stigmatizing experiences (e.g., discrimination, devaluation) among PWS in those studies (Boyle, 2013; Boyle, 2015). This is the case because the 4S was designed according to Corrigan et al.’s (2011) model of self-stigma, and not from the more general model of stigma which highlights enacted stigma and felt stigma as the major constructs (Jacoby, 1994; Quinn & Earnshaw, 2013). Self-stigma, or internalized stigma (i.e., agreement with negative stereotypes and application of negative societal attitudes to the self), can be conceptually distinguished from felt stigma (i.e., anticipation of future stigmatizing events). Because of this, the construct of felt stigma, as described in this paper, has only partially been examined by the 4S. That is, the 4S has measured awareness of negative societal attitudes, but not level of anticipation of experiencing public stigma among PWS and this is a limitation of previous research that is addressed in this study. Despite these limitations, when examining the research presented above, it is clear that many PWS are aware of being viewed negatively and this awareness may lead to fear and avoidance of speaking.

### 1.4. Stigma and its associations with well-being

The experience of stigma has been shown to have negative implications for mental and physical health in a variety of populations including individuals with AIDS, mental illness, physical deformities, epilepsy, drug addiction, and LGBT individuals (Birtel, Wood, & Kempa, 2017; Denton, Rostovsky, & Danner, 2014; Earnshaw, Lang, Lippitt, Jin, & Chaudoir, 2015; Jacoby, 1994; Kusch, Wilentz, & Kleinman, 2006; Miller et al., 2016). In the area of stuttering, it was found that increased awareness and internalization of public stigma among adults who stutter, measured with the 4S, are related to reduced self-efficacy, self-esteem, life satisfaction, hope, empowerment, quality of life, social support, overall physical health, and health care satisfaction (Boyle, 2013; Boyle, 2015; Boyle & Fearon, 2017) and increased anxiety, depression, stress, and severity of physical speech disruption (Boyle, 2015; Boyle & Fearon,

2017). It has also been proposed that the increased risk for anxiety disorders often found in PWS is related to the negative reactions that PWS have received from others throughout the course of their lives (Iverach & Rapee, 2014; Iverach et al., 2009). In addition, reduced quality of life (Craig, Blumgart, & Tran, 2009) and increased negative affect (Iverach et al., 2010) in some PWS may also be related to negative experiences with enacted stigma and its resulting fear of negative evaluation and perceived social threat (Brundage, Winters, & Beilby, 2017). It should be noted that Manning and Beck (2011) warned against the possibilities of further stigmatizing people who stutter by attaching diagnoses of psychological disorders to PWS, including personality disorders, and in their own research found that the prevalence of personality disorders in people who stutter was no different from the general population (Manning & Beck, 2013). However, Manning and Beck (2013) did discuss that anxiety and negative emotions can be seen as a natural reaction to stuttering. Iverach et al. (2011) described that it would make sense to investigate the mental health of PWS because they experience negative consequences that include "...negative listener reactions and stereotypes, bullying and teasing, social isolation and rejection... expectancies of social harm and fear of speaking in social situations" (p. 66). These responses represent key elements in the constructs of enacted and felt stigma described above. Hopefully it has been shown in this literature review how the terms enacted stigma and felt stigma can be helpful to describe many of the difficulties experienced by PWS. Although the terms of enacted stigma and felt stigma may not be as familiar to the lay public compared to terms such as stereotypes or discrimination, they are used frequently in the psychology literature (Gray, 2002; Herek et al., 2009; Jacoby, 1994; Livingston & Boyd, 2010) to aid in describing, summarizing, and quantifying different components of stigma in various populations.

To summarize, from the evidence presented above it could be the case that the instances of public stigma faced by PWS (i.e., enacted stigma) lead to an internalization of those negative societal views. PWS become aware that they are stigmatized, agree with those negative views, and incorporate them into their own self-constructs. Once this happens, PWS may experience decrements in self-esteem and self-efficacy and could limit their communication with others. PWS can also begin to anticipate receiving negative reactions from the public (i.e., felt stigma) which could contribute to fear, anxiety, and avoidance. Experiences of public stigma and the anticipation of experiencing public stigma may therefore be precursors to reduced well-being among PWS. It is therefore worthwhile to investigate the links between enacted stigma, felt stigma, and mental health in adults who stutter.

### 1.5. Rationale and purpose of the current study

The review of literature above suggests that PWS can experience both enacted stigma, as well as felt stigma, and that both of these aspects of stigma could possibly be related to mental health. In the stuttering literature to date however, the constructs of enacted stigma and felt stigma linked specifically to stuttering have not been assessed with focused measures. The 4S has not measured all aspects of felt stigma as defined in this paper because it does not directly measure fear and anticipation of enacted stigma. Also, because the 4S was focused on assessing self-stigma, it did not address enacted stigma at all. The relationship between enacted and felt stigma experienced by adults who stutter is also currently unknown because studies are lacking that have analyzed both of these variables with concrete measures within the same sample of PWS. Therefore it is not known whether enacted stigma and felt stigma overlap considerably, or whether they are discrete and therefore worthy of measuring separately. Furthermore, research studies attempting to identify associations between stuttering-specific enacted stigma and felt stigma and mental health are lacking.

The aim of this study therefore was to document the enacted stigma (both lifetime, and within the past year) and felt stigma experienced by adults who stutter and their associations. Specifically, the purposes of the study were to: (1) determine percentages of adults who stutter who had reported ever experiencing different types of stigmatizing episodes from the public over the course of their lives, and how frequently these episodes have been experienced in the past year; (2) identify percentages of adults who stutter who experience felt stigma; (3) assess the relationship between felt stigma and enacted stigma in the past year; and (4) analyze relationships between enacted stigma in the past year and global mental health, as well as between felt stigma and global mental health. Because the first two aims were exploratory and descriptive in nature, no a priori hypotheses were made for either of them. Regarding the third aim, based on the literature reviewed in this paper suggesting that enacted and felt stigma are different but related aspects of stigma (Herek et al., 2009; Jacoby, 1994; Livingston & Boyd, 2010; Scambler, 2009), it was predicted that these two variables would be positively related. Regarding the fourth aim, in accordance with prior research reviewed above, it was hypothesized that both increased enacted stigma in the past year and increased felt stigma would be negatively related to global mental health. Furthermore, it was hypothesized that enacted stigma in the past year and felt stigma would each separately and significantly predict global mental health after the shared variance between the two variables was partialled out of the analysis.

## 2. Methods

### 2.1. Participants

In order for participants to be included in this study, they needed to indicate that they were PWS, and age 18 or above. Although there were 533 responses to the survey, 209 of the responses could not be used because of failure to meet the inclusion criteria above, or failing to complete the portions of the survey focusing on enacted and felt stigma. This resulted in a sample size of 324 adults who stutter for the current project. Participants were recruited from speech-language pathologists, and self-help support group leaders of national chapters of the National Stuttering Association in the United States, in addition to websites and social media. Participants included 218 males (67%), and 102 females (32%), one individual reported being non-binary/third gender, another preferred not to say, and two participants did not provide any answer. The age of the participants ranged from 18 to 87 years ( $M = 38$ ,  $SD = 15.6$ ). The sample was comprised of 16 African Americans (5%), 21 Asian Americans (7%), 240 Caucasian, non-Hispanic Americans (74%),

24 Hispanic Americans (7%), 17 participants (5%) selected “other” ethnicity, 4 participants (1%) preferred not to say, and 2 participants did not answer the question. Three-hundred and seven participants (95%) reported having previous therapy for stuttering, 15 participants (5%) reported having no prior treatment history for stuttering, and two participants did not answer. Participants in this research study were a part of a larger project analyzing the link between self-stigma and physical health of adults who stutter (Boyle & Fearon, 2017). The previous project had different research aims, variables of interest, and hypotheses than the current study.

## 2.2. Procedure

A web survey was created using Qualtrics Survey Software. This survey was sent to Board Certified Specialists in Fluency Disorders, other clinical speech-language pathologists who were listed in the referrals section of the Stuttering Foundation website, and adult chapter leaders of chapters of the National Stuttering Association in the United States. These individuals were sent a personalized e-mail with a short description of the study, an anonymous link to the survey, and a request to forward the message to former or current clients who stutter, acquaintances who stutter, or self-help/support group members. It was made clear in the descriptions of the study and informed consent form that participation was voluntary, and the e-mail contacts did not have to forward the survey if they did not wish to. Individuals were contacted through e-mail three separate times with one week separating each contact. An anonymous link to the survey was also posted on various websites and social media including several community sites of the American Speech-Language-Hearing Association. Before data were collected, the project received IRB approval from the author’s institution, as well as the National Stuttering Association Research Committee. If participants were interested in completing the survey after reading the brief description of the survey and the informed consent form, they proceeded to answer several scales described in the next section.

## 2.3. Measures

*Enacted stigma* was measured with 15 items that described various stigmatizing experiences relevant to stuttering. The items were adapted from scales analyzing experiences of enacted stigma in individuals with epilepsy (Jacoby, 1994), physical scars from burns (Lawrence, Fauerbach, Heinberg, Doctor, & Thombs, 2006), chronic illness (Molina et al., 2013), and mental illness (Ritsher, Otilingam, & Grajales, 2003; King et al., 2007), but tailored to situations which were likely to be experienced by PWS based on a thorough review of literature (St. Louis, 2015). Examples include “People have avoided looking at me,” or “People have taken me less seriously.” All items in the enacted stigma scale are shown in Table 2 in the Results section. First, participants were asked about lifetime enacted stigma with the question “Have you ever in your life experienced these things because of your stuttering?” and answered either “yes” or “no.” Then, participants were asked about enacted stigma they experienced in the past year with the question “Lately (in the past year), because of your stuttering, how often have you experienced these things?” with five different response options (1 = never, 2 = rarely, 3 = sometimes, 4 = often, 5 = always). Regarding enacted stigma experienced in the past year, responses from the 15 items were averaged, with higher scores representing more enacted stigma experienced. Importantly, the responses to lifetime enacted stigma questions were included for exploratory and descriptive purposes, however these were not included in any of the correlational analyses in the study. No summative scores were generated based on the responses to dichotomous yes/no responses questions. Only the enacted stigma in the past year questions were used in correlational analyses because they were measured with rating scales that created increased variability in responses. It is also important to note that the questions asked whether participants experienced certain things “because of your stuttering” to make it clear that these things were only of interest regarding responses to stuttering specifically.

*Felt stigma* was measured with four items created by the author after reviewing several scales focusing on stigma related to epilepsy (Bielen et al., 2014; Jacoby, 1994; Leaffer et al., 2011), chronic illness (Molina et al., 2013), and mental illness (King et al., 2007). The author also used Livingston and Boyd’s (2010) definition of felt stigma to generate items. An example item is, “I am fearful that others will reject me if they hear me stutter.” All four items can be seen in Table 4 of the Results section. Response options ranged from 1 (strongly disagree) to 5 (strongly agree). Item responses were averaged and higher scores represented increased felt stigma. Similar to the enacted stigma items, the felt stigma questions asked whether participants experienced certain things “because of your stuttering” to make it clear that feelings related to stuttering were of interest.

*Global mental health* was measured using questions from the Patient-Reported Outcomes Measurement Information System (PROMIS) Global Health–Short Form (Hays, Bjorner, Revicki, Spritzer, & Cella, 2009). The PROMIS short-form is comprised of 10 items obtained from the PROMIS project, which are a summary of the PROMIS physical function, pain, fatigue, emotional distress, and social health domain scores. There are two dimensions to the scale: global physical health, and global mental health, which each include four items. The items utilized in this study were those pertaining to global mental health. An example item is, “In general, how would you rate your mental health, including your mood and your ability to think?” Response options vary from 1 (Poor) to 5 (Excellent) for most items, and 1 (Always) to 5 (Never) for one item measuring frequency of emotional problems. Raw scores range from 4 to 20 based on the sum of the responses. Raw scores are then converted to T-scores (ranging from 21.2 to 67.6) with a mean of 50 and standard deviation of 10 based on standardization from the U.S. general population. Higher scores represent increased mental health.

**Table 1**

Descriptive statistics for enacted stigma in past year, felt stigma, and global mental health for 324 adults who stutter.

	<i>M</i> or T-score	<i>SD</i>	Range observed	Range possible	Interpretation
Enacted stigma (in past year)	1.78	0.65	1.0–4.40	1.0–5.0	Higher scores represent more enacted stigma
Felt stigma	3.67	0.99	1.0–5.0	1.0–5.0	Higher scores represent more felt stigma
Global mental health <sup>a</sup>	47.50	8.51	28.4–67.6	21.2–67.6	Higher scores represent better mental health

<sup>a</sup>Note. T-scores were calculated for Global Mental Health.

## 2.4. Data analysis

Preliminary analysis included determining the reliability of all sets of items intending to measure unidimensional constructs using Cronbach's coefficient alpha. Descriptive statistics including means or T-scores, standard deviations, and ranges for variables of enacted stigma in the past year, felt stigma, and global mental health were obtained. The primary analyses included calculating percentages of respondents who reported experiencing various episodes of enacted stigma throughout the lifetime, and in the past year. Percentages of respondents who agreed and disagreed with items pertaining to felt stigma were also calculated. Spearman's rho correlation coefficients were calculated to assess potential relationships between enacted stigma in the past year and felt stigma. Correlation coefficients were also calculated for relationships between enacted stigma in the past year and global mental health, as well as between felt stigma and global mental health. Finally, exploratory multiple linear regression was used to determine if enacted stigma in the past year and felt stigma were unique predictors of global mental health. In these analyses, the predictor variables were enacted stigma in the past year and felt stigma, and the outcome variable of interest was global mental health.

## 3. Results

### 3.1. Preliminary analysis

All scales intending to measure unidimensional constructs were assessed for their reliability using Cronbach's coefficient alpha. Good to excellent levels of internal consistency were demonstrated for items intending to measure enacted stigma ( $\alpha = 0.94$ ), felt stigma ( $\alpha = 0.86$ ), and global mental health ( $\alpha = 0.83$ ). Because items from each scale were sufficiently interrelated, averages for items in these scales were computed. Descriptive statistics were calculated for each variable of interest, and can be seen in Table 1.

### 3.2. Primary analysis

Percentages of adult participants who had reported experiencing enacted stigma over the lifetime were obtained, and can be seen in Table 2. For all but two items, a majority of participants reported experiencing each type of negative reaction listed. Particularly striking is the fact that 80% or above of the sample reported having been made fun of and picked on, being laughed at, being taken less seriously, experiencing listeners avoiding eye contact, and being treated unkindly. The only items in which lower than 50% of the sample agreed were not getting a job applied for, and being treated unfairly at work (although a considerable percentage of participants had experienced those things as well). The frequency of participants' experiencing these events within the past year can be seen in Table 3. Note that although a majority of participants reported experiencing these events in their lifetimes, on average, most participants reported experiencing them never or rarely in the past year. A minority of participants (less than 50%) reported experiencing these negative social responses sometimes, often, or always. In addition, percentages of participants agreeing with items

**Table 2**

Percentages of participants experiencing enacted stigma during the lifetime.

	Yes	No
1. People have been unkind to me.	84.6	15.4
2. People have avoided looking at me.	80.1	19.9
3. People made fun of me or picked on me.	84.6	15.4
4. Strangers stared at me.	72.9	27.1
5. I was being treated unfairly by others.	66.1	33.9
6. People have treated me as inferior.	71.4	28.6
7. People have discriminated against me.	58.2	41.8
8. People have taken me less seriously.	80.6	19.4
9. People have patronized me, or treated me like a child.	70.5	29.5
10. People have avoided me.	54.9	45.1
11. People have called me names.	61.3	38.7
12. People have laughed at me.	82.3	17.7
13. People have bullied me.	57.4	42.6
14. I did not get a job I applied for.	48.4	51.6
15. I have been treated unfairly at work.	36.9	63.1

**Table 3**  
Percentages of participants reporting enacted stigma within the past year.

	Never	Rarely	Sometimes	Often	Always
1. People have been unkind to me.	32.9	49.4	14.2	3.5	0
2. People have avoided looking at me.	26.9	33.9	27.6	11.0	0.7
3. People made fun of me or picked on me.	49.0	34.6	13.7	2.3	0.3
4. Strangers stared at me.	33.6	31.6	26.6	8.3	0
5. I was being treated unfairly by others.	49.5	30.8	14.6	4.4	0.7
6. People have treated me as inferior.	43.7	30.1	17.2	7.3	1.7
7. People have discriminated against me.	58.0	24.2	12.6	4.1	1.0
8. People have taken me less seriously.	31.7	27.7	28.4	10.2	2.0
9. People have patronized me, or treated me like a child.	45.3	28.2	20.5	5.0	1.0
10. People have avoided me.	51.7	28.5	14.2	4.9	0.7
11. People have called me names.	75.3	17.2	5.5	1.7	0.3
12. People have laughed at me.	40.7	32.1	20.9	4.6	1.7
13. People have bullied me.	76.8	14.3	6.8	1.4	0.7
14. I did not get a job I applied for.	68.6	16.7	9.2	4.4	1.0
15. I have been treated unfairly at work.	70.1	17.1	8.5	3.2	1.1

**Table 4**  
Percentages of participants agreeing or disagreeing with felt stigma items.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
1. I believe that people look down on me because I stutter.	15.5	18.9	20.1	37.5	8.0
2. Because of my stuttering, I have worried about other people's attitudes toward me.	7.4	5.6	5.9	44.0	37.2
3. I am fearful that others will reject me if they hear me stutter.	11.5	14.9	9.6	41.2	22.9
4. Because of my stuttering, I have felt embarrassed in social situations.	4.3	4.3	3.7	43.0	44.6

representing felt stigma are presented in Table 4. It can be seen that most of the participants agreed either strongly or somewhat that they have worried about the reactions of other people, are fearful of rejection, and have felt embarrassed about stuttering in social situations. As a whole, these data demonstrate that although most participants have rarely or never experienced overt social devaluation (i.e., enacted stigma) during the past year, they have experienced these negative reactions at some point during their lives and most report that they anticipate negative treatment from others if their stuttering is exposed.

There was a significant positive correlation between enacted stigma in the past year and felt stigma,  $r = +0.49$ ,  $p < .001$ , indicating that these variables increase together. The effect size of this correlation was considered to be moderate (Cohen, 1992). The coefficient of determination ( $R^2$ ) was 0.237, representing 23.7% shared variance between the two variables which indicates that felt stigma and enacted stigma in the past year are positively related but also measure different aspects of stigma.

It was also of interest to determine correlation coefficients between enacted stigma in the past year and global mental health, and

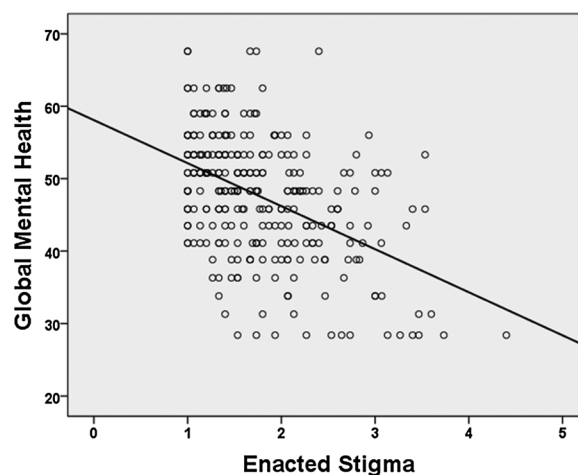


Fig. 1. Scatterplot of relationship between enacted stigma and global mental health. A linear regression line is shown.



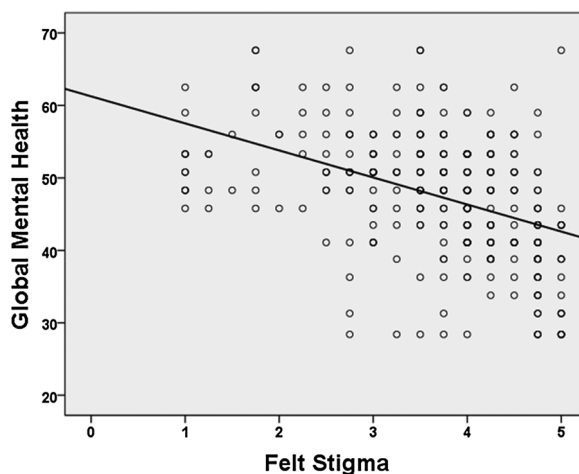


Fig. 2. Scatterplot of relationship between felt stigma and global mental health. A linear regression line is shown.

between felt stigma and global mental health. Figs. 1 and 2 show a significant negative relationship between enacted stigma in the past year and global mental health,  $r = -0.47$ ,  $p < .001$  (medium effect size), and between felt stigma and global mental health,  $r = -0.43$ ,  $p < .001$  (medium effect size), respectively. This indicates that as felt stigma and enacted stigma in the past year increase, global mental health decreases. A multiple regression analysis was also conducted to determine if felt and enacted stigma were unique predictors of global mental health. Felt stigma and enacted stigma were simultaneously entered as predictor variables and global mental health served as the outcome variable. Results, shown in Table 5 demonstrated that both enacted stigma and felt stigma were unique predictors of global mental health. That is, each predictor variable accounted for a significant and separate amount of variance in global mental health, with the other predictor already in the model. This indicates that just taking one of these variables into account is not sufficient for predicting mental health, and that both variables are valuable to measure. The overall model with enacted stigma and felt stigma as predictors accounted for 27% of the variance in global mental health.

#### 4. Discussion

The purpose of this study was to document the enacted and felt stigma experienced by PWS, determine the extent to which enacted and felt stigma were related, and identify potential relationships between those variables and mental health. It was hypothesized that enacted stigma in the past year and felt stigma would be positively related to each other. This hypothesis was supported in this study reflected by the significant correlation observed between the two variables. It was also hypothesized that both enacted stigma in the past year and felt stigma would be inversely related to mental health, and furthermore that both of these variables would be unique predictors of global mental health with the other variable in the model. These hypotheses were also supported in the current study, as demonstrated by the significant and moderate negative correlations found between enacted stigma in the past year and mental health, as well as between felt stigma and mental health. Furthermore, enacted stigma in the past year and felt stigma were unique predictors of global mental health. Other key findings were that although most participants had experienced several forms of enacted stigma throughout their lives, most of them rarely if ever experienced them in the past year. In addition, felt stigma was quite common, with a majority of participants agreeing that they anticipate, fear, and worry about potential future instances of negative treatment from others regarding to their stuttering.

The results support previous research in the area of stuttering that suggests that adults who stutter experience negative public responses such as devaluation and social distancing due to stuttering (St. Louis, 2015), that they are subjectively aware of public stigma related to their stuttering (Boyle, 2013, 2015; Bricker-Katz et al., 2010; Corcoran & Stewart, 1998; Klompass & Ross, 2004; Plexico et al., 2009), and can anticipate negative responses to it (Iverach & Rapee, 2014). However, the current study adds to the knowledge in this area by operationalizing the constructs of enacted and felt stigma, as defined in the psychology literature, with reliable sets of items that were specifically tailored to stuttering. Because of this, the results of this study provide a clear picture of the percentages of PWS who experience enacted stigma (both lifetime and within the past year) and felt stigma. The findings of this study also support previous theories of stigma that proposed that enacted stigma and felt stigma were distinct elements of stigma, and that

Table 5  
Multiple regression analysis with felt stigma and enacted stigma predicting global mental health.

	<i>B</i>	<i>SE</i>	$\beta$	<i>t</i>	<i>p</i>	<i>R</i> <sup>2</sup>
Enacted stigma (in the past year)	−4.14	0.75	−0.32	−5.53	< 0.001	0.27
Felt stigma	−2.34	0.05	−0.28	−4.83	< 0.001	

Note. The *R*<sup>2</sup> value represents the variance of global mental health accounted for with felt stigma and enacted stigma in the model.

these variables can predict mental health (Herek et al., 2009; Jacoby, 1994; Livingston & Boyd, 2010; Scambler, 2009). This study adds to knowledge in this area by parsing out the relationships of these different facets of stigma and their associations with mental health.

It is interesting to note that although most participants rarely if ever experienced enacted stigma during the past year, an overwhelming majority of them still agreed that they anticipated these negative responses from others. In other words, PWS were concerned about encountering future instances of enacted stigma related to their stuttering even though they had experienced very little, if any, of these instances in the recent past. There are a few different explanations for this finding. First, it could be the case, as recent research has suggested, that adults who stutter experience heightened anxiety which is associated with hypervigilance toward potential social threat information (e.g., negative facial expressions), representing an attentional bias for negative information (Lowe et al., 2016). It could also mean that even though adults who stutter rarely experience instances of enacted stigma, the instances in which they do experience these negative reactions are powerful enough to create long lasting fears of encountering subsequent similar events. This possibility makes sense, especially when considering the fact that a large majority of participants in the current study reported experiencing various instances of enacted stigma at some point throughout the course of their lives. It is possible, for example, that a few salient experiences during childhood in which negative responses from key individuals such as parents generated a sense of felt stigma even in the absence of overt instances of obvious discrimination or negative societal responses. This possibility highlights the importance of clinicians working with parents to make sure they are modeling helpful responses to stuttering that will not increase shame. There is indeed evidence in our field suggesting that negative experiences related to stuttering in childhood can have lasting impact into adulthood for PWS (Blood & Blood, 2016; Daniels et al., 2012).

The finding that there was 23.7% shared variance between enacted stigma in the past year and felt stigma also supports the view that frequency of enacted stigma in the recent past is not largely predictive of the felt stigma that PWS feel currently. In addition, the present findings that increased enacted stigma in the past year and felt stigma are associated with lower global mental health support claims of other researchers who have highlighted the potential grievous effects of social penalties for stuttering on the well-being of PWS, specifically by increasing risk for development of anxiety disorders (Iverach et al., 2009; Iverach et al., 2011; Iverach & Rapee, 2014). It is certainly possible that many individuals who reported felt stigma are also at risk for more serious psychological problems including social anxiety disorders. However, this is speculative because this study did not intend to diagnose the presence of anxiety disorders. It is interesting to note that although the mean for global mental health in this study was lower than the U.S. general average, it was only one quarter of a standard deviation lower, which is a small difference. Therefore, it is important to highlight that although stigma can predict lower mental health in adults who stutter, PWS as a group did not score much differently than the general population on global mental health.

From the current results it seems that if PWS have experienced discrimination or other devaluing behavior based on their stuttering, they are more likely to anticipate future negative experiences. It could also be possible that those feelings of anticipated stigma may actually reduce opportunities for enacted stigma in the future. This is because if PWS feel stigmatized by their condition, they may attempt to avoid situations in which they would be stigmatized (e.g., concealing their stuttering from others). Therefore, it would not be expected that felt stigma could be explained purely by the frequency of experiences of public stigma. Although there are different interpretations possible for the current results, it seems plausible to suggest that although children who stutter do not possess constitutional traits of anxiety (Alm, 2014), a great majority of PWS experience a variety of harmful instances of enacted stigma at some point in their lives. These experiences may contribute to reduced mental health over the lifespan for some PWS.

#### 4.1. Clinical implications

The results indicate that enacted stigma over the past year and felt stigma measure different aspects of stigma related to stuttering. Therefore, clinicians should not rely on one of these variables to predict the other. That is, knowing the frequency of negative social responses clients who stutter have encountered over the past year is not sufficient for understanding their current level of anticipation and fear of experiencing these events in the future. The reverse is also true in that knowing how much stigma clients feel does not adequately represent the frequency of negative social responses they have experienced over the past year. Therefore, in order to understand the depth of the experience of stuttering, researchers and clinicians should attempt to measure multiple aspects of stigma, including enacted stigma and felt stigma, during assessment and if necessary, as a treatment outcome. The results of this study also add increased urgency to this recommendation as it was shown that enacted stigma in the past year and felt stigma significantly and separately predict global mental health in adults who stutter. Although the experiences of enacted and felt stigma are obviously difficult for PWS, there are reasons to be hopeful as it has been demonstrated that many types of treatments that focus on cognitive restructuring, and enhancing personal empowerment can reduce the negative life impact of stuttering (Beilby, Byrnes, & Yaruss, 2012; Menzies et al., 2008). Also, recent research has begun systematically studying the positive effects of public anti-stigma campaigns (i.e., interpersonal contact, education, and protest) for stuttering (Boyle, Dioguardi, & Pate, 2016). Therefore, clinicians working with clients who stutter who are exhibiting problems with stigma should target both personal and environmental aspects of stuttering to reduce stigma.

Clinicians and researchers who wish to reliably document the many aspects of stigma experienced by PWS could use dedicated scales such as the 4S (Boyle, 2013), in combination with the newer items presented in this study for measuring enacted stigma and felt stigma. In addition, there are several other more general scales, such as the Overall Assessment of the Speaker's Experience of Stuttering – OASES (Yaruss & Quesal, 2006) or the Unhelpful Thoughts and Beliefs about Stuttering – UTBAS scale (St. Clare et al., 2009) available for adults who stutter that include items representing some of the aspects of felt stigma described in this paper. Even though scales such as the OASES and UTBAS do not intend to focus purely on stigma, some of their items would be helpful in identifying the experience of stigma in PWS.

#### 4.2. Limitations and future research needs

The current study had some methodological limitations. The correlational nature of the study precludes causal determinations from being made. Despite the interpretations and hypotheses made above, it is not possible to determine the directionality of the associations between enacted stigma, felt stigma, and global mental health with the current data. In addition, there are other unmeasured variables that could predict global mental health. Future studies should seek to identify a variety of other predictors that could explain more of the variance in global mental health among PWS. For example, social anxiety could be measured in future studies so that it could be determined if enacted stigma and felt-stigma explained mental health beyond what social anxiety contributes. Another limitation is that the participants were recruited through speech-language pathologists and self-help/support group chapter leaders. Therefore, most of the participants had experience with either therapy for stuttering, or self-help support groups which may make them distinct from individuals who have not sought therapy or support for their stuttering. It is possible that individuals who have not received help for stuttering could feel more stigmatized because of their stuttering. Also, it should be mentioned that average scores were obtained for enacted stigma in the past year and felt stigma although these groups of items were measured with ordinal response options. Although it has been common for researchers to use parametric analyses for ordinal responses, future research should consider using nonparametric methods or score conversion to better approximate equal intervals for various mathematical operations. Finally, due to the nature of the study, experiences of stigma were determined by self-report only. It is possible that participants' memories of enacted stigma are different from what actually occurred. It would be difficult to actually observe real instances of discrimination as part of a research study, however it is conceivable that experiments could be designed to observe instances of enacted stigma experienced by PWS in real life situations.

Beyond the methodological limitations to this study, several unanswered questions could be investigated in future research. Studies examining enacted and felt stigma in adolescents and school-age children who stutter would be helpful in determining whether instances of enacted stigma are more frequently experienced during younger ages. Because bullying is quite common during school-age and adolescent years (Blood et al., 2011), it is reasonable to speculate that enacted stigma is more commonly experienced during these ages, as opposed to adulthood when most interactions occur with other adults. It seems important that future studies continue to explore educational methods and anti-stigma programs and strategies that can be used to improve children's attitudes about stuttering and children who stutter. Furthermore, if enacted stigma contributes to reduced mental health in PWS, it is critical that future research investigates and documents the effects of various anti-stigma strategies. For example, strategies of education, protest, and interpersonal contact have been shown to be effective for reducing negative attitudes and increasing affirming attitudes in adults who stutter (Boyle et al., 2016).

In addition, future research should attempt to clearly define the various aspects of stigma that have been described in the literature. Some researchers have called for increased clarity in the definitions of various aspects of stigma (Livingston & Boyd, 2010). Because of this, measures of stigma should be made in accordance with agreed on theoretical definitions of constructs. Measures could attempt to be exhaustive, or focus on specific aspects of stigma. For example, the 4S (Boyle, 2013) was intended to be a measure of self-stigma following the self-stigma model of Corrigan et al. (2011). However, as this study demonstrated there are other aspects of stigma that are relevant to consider and possibly include in a more general scale of stigma. As an example, the 4S does not measure the frequency of enacted stigma (lifetime or in the past year), or the fear or anticipation of experiencing enacted stigma. It may be desirable moving forward to determine the most pertinent aspects of stigma experienced by PWS for predicting well-being and communicative participation (e.g., self-stigma, felt stigma, and enacted stigma), and combine them into a scale with various sub-components. More work also needs to be done in identifying the ways in which felt stigma is similar and distinct from anxiety. For example, it would be interesting to determine to what degree these constructs overlap statistically. Although more work clearly needs to be done regarding the measurement of stigma, the current study adds to our knowledge about the experiences of enacted stigma and felt stigma, and their relations to global mental health among adults who stutter.

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