



# PERSON-FIRST LABELING AND STUTTERING

KENNETH O. ST. LOUIS

*Department of Speech Pathology and Audiology, West Virginia University,  
Morgantown, West Virginia*

---

Four groups of subjects, speech-language-hearing impaired clients, parents of clients, speech-language pathology students, and the general public, reacted to 28 words used to label individuals. Twelve words were either person-first (e.g., "Stutterer") or direct labels (e.g., "Person who stutters") and 16 were identical anchor labels in alternate forms of questionnaires. Nine labels identified speech, language, or hearing disorders. Highly variable subjects groups were surprisingly similar in judgments about their own personal impressions and experiences as well as the appropriateness of use by others for all the labels. Person-first labeling was regarded as significantly more positive in only 2% of the comparisons, and all of these in favor of "Person with leprosy" or "Person with psychosis" over "Leper" or "Psychotic." Person-first labeling did not make a difference in any of the speech-language terms, including variants for "stuttering" or "stammering." Overall, person-first terminology did little to lessen negative beliefs and attitudes for the speech-language pathology labels assessed. This study draws into question recent policies promoting person-first labeling. © 1998 Elsevier Science Inc.

**Key Words:** Stuttering; Disfluency; Terminology; Person-first labels; Stereotypes

---

## INTRODUCTION

Person-first labeling refers to identifying someone first, and most importantly, as a person and second, and less importantly, by a descriptive word or phrase. The rationale for such labeling is to make it clear that the individual is being labeled is regarded primarily as a "person" and secondarily as a member of some descriptive class. It is often used for the purpose of showing as much sensitivity as possible to a person who has an identifiable condition or characteristic that is deemed by most people to be undesirable. Such conditions or characteristics are known to result sometimes in behavior or attitudes of others toward the person that are belittling, unfavorable, derogatory, or even stigmatizing. For example, the term "person who stutters" is purported to communicate less implicit negative judgment, prejudice, or disrespect to a person who manifests the disorder of stuttering than the direct label "stutterer."

---

Address correspondence to the author at Department of Speech Pathology and Audiology, West Virginia University, Morgantown, West Virginia 26506-6122. e-mail: kstlouis@wvu.edu

---

J. FLUENCY DISORD. 24 (1999), 1-24

© 1999 Elsevier Science Inc. All rights reserved.  
655 Avenue of the Americas, New York, NY 10010

0094-730X/99/\$-see front matter  
PII S0094-730X(98)00024-2

Advocating person-first labeling began in the field of special education in the 1980s, an area that has struggled to use labels that do not carry unintended negative meanings. For example, the terms “idiot” and “moron” were originally descriptive terms referring to various levels of intelligence similar to severe or moderate “mental retardation,” “mental impairment,” “cognitive impairment,” and so on. As terms have acquired unintended negative meanings beyond the original usage, professionals in this area have tended to suggest less pejorative alternatives. Person-first labeling is one form of linguistic “deperjoration” and in the past several years has spread to other areas, including speech-language pathology in general and stuttering in particular. Following the lead of some in the stuttering self-help movement, the American Speech-Language-Hearing Association (ASHA) began to advocate the use of first-person labeling. Since 1991, ASHA has recommended that authors use person-first terminology in all ASHA publications for the purpose of demonstrating that speech-, language-, or hearing-disordered individuals are recognized as persons first and communicatively disordered second. In 1993, ASHA adopted this as a policy for all documents and publications (Executive Board Meeting Minutes, 1993). But the recommended changes did not stop there. A short article, presumably written by those in charge of editorial policy appeared in ASHA’s house organ, *Asha*, entitled, “Person First, Please” (ASHA News, 1994). In addition to recommending person-first language, the article suggested that authors use terms such as “disability” or “disorder” but avoid terms like “impairment” and “handicap.” It also recommended using the term, “disfluent” but avoiding “dysfluent,” presumably because the prefix “dys” connotes abnormality and “dis” connotes difference. “Older” was recommended, but “old,” “aging,” and “elderly” were not.<sup>1</sup>

There has been very little public debate—and indeed little research (but see Robinson & Robinson, 1996 below)—to justify the adoption of such a policy by professional associations or individuals. For these reasons, this study was undertaken to determine the extent to which person-first versus direct-label terminology affects beliefs and attitudes associated with fluency disorders and selected other speech-language disorders.

---

<sup>1</sup>As of this writing, the policy of the *Journal of Fluency Disorders* is ambiguous relative to person-first language. The editor has maintained an author preference policy with respect to using person-first terminology (Gene J. Brutton, personal communication, April 23, 1998). Authors may use the term “stutterer” or “person (child) who stutters” at their own discretion. Nevertheless, beginning with the last issue of Volume 20 in 1995, the “Information for Authors” section references the Fourth Edition of the *Publication Manual of the American Psychological Association* (American Psychological Association, 1994) as guidelines for authors. The manual directs authors to do the following: “1. Put people first, not their disability” (e.g., preferring “person with [who has] a disability” to “disabled person”) and “2. Do not label people by their disability or overextend its severity” (e.g., preferring “individuals with epilepsy” to “epileptics”) (pp. 59–60). Although many articles now are written with person-first labels, and whereas some editorial consultants firmly believe the *Journal* should insist on such nomenclature, the policy is currently unclear.

## METHOD

Four related investigations were carried out with speech and/or language-disordered clients, parents of clients, speech-language pathology students, and the general public. All four investigations utilized questionnaires with the same 28 labels, listed in Table 1. Half of 12 pairs of person-first and direct labels appeared on alternate versions of questionnaires, each containing an equal number of person-first and direct labels. For example, one version contained “*Person who stutters*” and “*Smoker*”; the alternate version contained “*Stutterer*” and “*Person who smokes*” (Table 2). Additionally, all questionnaires had the same 16 “anchor labels” to disguise the purpose of the study and provide anchor points for comparing the person-first versus direct labels (e.g., “*Crazy*”; “*Disfluent*”). Identical anchor labels in alternate versions of the

**Table 1.** Twelve Person-first versus Direct Labels and 16 Anchor Labels Presented to Subjects

---

### Person-First and Direct Labels

“*Person who composes*”/“*Composer*”  
 “*Person who gambles*”/“*Gambler*”  
 “*Person with leprosy*”/“*Leper*”  
 “*Person who murders*”/“*Murderer*”  
 “*Person who smokes*”/“*Smoker*”  
 “*Person who wets the bed*”/“*Bed wetter*”  
 “*Person with psychosis*”/“*Psychotic*”  
 “*Person with aphasia*”/“*Aphasic*”<sup>a</sup>  
 “*Person who lisps*”/“*Lisper*”<sup>a</sup>  
 “*Person who clutters*”/“*Clutterer*”<sup>a</sup>  
 “*Person who stammers*”/“*Stammerer*”<sup>a</sup>  
 “*Person who stutters*”/“*Stutterer*”<sup>a</sup>

### Anchor Labels

“*Disfluent*”<sup>a</sup>  
 “*Hoarse*”<sup>a</sup>  
 “*Cleft palate*”<sup>a</sup>  
 “*Deaf mute*”<sup>a</sup>  
 “*Mentally retarded*”  
 “*Overweight*”  
 “*Obese*”  
 “*Person with cancer*”  
 “*White*”  
 “*Black*”  
 “*African American*”  
 “*Crazy*”  
 “*Moron*”  
 “*Articulate*”  
 “*Trustworthy*”  
 “*Genius*”

---

<sup>a</sup> Speech-language-hearing labels.

questionnaires were also included to allow estimates of normal variability among subject groups as well as to provide benchmarks from which to evaluate differences between the responses for direct versus person-first labels. Of the 28 total labels, nine identified speech-language-hearing disorders, including five pairs with person-first versus direct labels and four as anchor labels. Subjects in each study were assigned at random to one of two components (see below) and to the alternate versions and word orders of questionnaires. College senior and graduate students enrolled in courses in stuttering were trained to administer the questionnaire and were assigned to locate from one to five respondents (or to take it themselves), depending on the subject group being tested. Past and current clients or parents of young clients were solicited as part of a client audit at West Virginia University Speech Clinic or at other locations. Public respondents were required not to be speech-language-hearing professionals but were recruited by, and generally well acquainted with, the students soliciting questionnaires.

Each of the four investigations actually contained two separate but related components, one dealing with respondent's own impressions and experiences regarding the labels ("I/E" Component) and the other, their views of appropriate use of the same labels by others ("A" Component). Following each label in the questionnaires were five different dependent variables. Examples of each are shown in Table 2. The I/E Component variables asked subjects to scale their first impressions of each label, their desire to be like a person named by the label, the semantic intent of the label from ridicule or oppression on the negative side to praise or empowerment on the positive side, their own personal experience with the labeled condition or characteristic, and their degree of knowledge of the label. These variables assessed what the respondents, themselves, believed or felt. The A Component variables were assumed to be related to the I/E Component variables but asked respondents to make judgments about the appropriateness of others' use of the labels in certain situations. The variables included use of the label: by professionals such as doctors, teachers, therapists, and researchers; by family members and close friends of the person labeled; by persons who have illnesses, handicaps, or disabilities; by those who have been victims of discrimination; and in joking, even when the intent of the humor was not to hurt, offend, or oppress. Importantly, for both components, respondents were instructed to assume that the label fits the person being described, e.g., that if the label were "liar," the respondent should assume that the person being described had a reputation for not telling the truth.

For the I/E Component, respondents rated labels on equal-appearing interval scales. The first four ratings were made by circling a number from a negative (-5) to neutral (0) to positive (+5) scale where 0 = "neutral," 1 = "slight," 3 = "moderate," and 5 = "maximum imaginable." These data were later converted to a 1-11 scale with 6 being neutral. The fifth variable, i.e., "What I know about [the] name," used a scale from 1 to 5 in which 1 = "nothing" and

**Table 2.** Samples From Questionnaires Showing, First, the I/E Component Instructions and Variables and, Second, the A Component Instructions and Variables. Alternate Versions of the Questionnaires Reflecting Person-first versus Direct Labels are Also Shown

Please use this rating scale for the first four judgments under each name															
Negative (-)				Neutral			Positive (+)								
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5					
Maximum imaginable	Moderate		Slight			Slight	Moderate		Maximum imaginable						
<u>“Crazy”</u>															
My first impression: ( <i>Negative</i> → <i>Positive</i> )						-5	-4	-3	-1	0	+1	+2	+3	+4	+5
My reaction: ( <i>I don't want to be</i> → <i>I want to be</i> )						-5	-4	-3	-1	0	+1	+2	+3	+4	+5
Intent: ( <i>Ridicule/Oppress</i> → <i>Praise/Empower</i> )						-5	-4	-3	-1	0	+1	+2	+3	+4	+5
My personal experience: ( <i>Negative</i> → <i>Positive</i> )						-5	-4	-3	-1	0	+1	+2	+3	+4	+5
What I know about name: ( <i>Nothing</i> → <i>Very much</i> )											1	2	3	4	5
<u>“Stutterer”</u>															
My first impression: ( <i>Negative</i> → <i>Positive</i> ) etc.															
<u>“Person who smokes”</u>															
My first impression: ( <i>Negative</i> → <i>Positive</i> ) etc.															
Please use the rating scale below for the five judgments under each name															
Circle (+), (-), or (0) after each situation.															
Appropriate:						+									
Don't know or unsure:						0									
Inappropriate:						-									
<u>“Crazy”</u>															
Discussions by doctors, lawyers, teachers, therapists, scientists, or researchers								+	0	-					
Conversations about the named person by his/her close friends and family members								+	0	-					
Conversations with persons who have illnesses, handicaps, or disabilities								+	0	-					
Conversations with persons who have been victims of discrimination								+	0	-					
Joking with others when the humor is <u>not intended</u> to hurt, offend, or oppress								+	0	-					
<u>“Person who stutters”</u>															
Discussions by doctors, etc.															
<u>“Smoker”</u>															
Discussions by doctors, etc.															

5 = “very much.” Respondents to the A Component were asked to rate the same labels according to their appropriateness of use as “inappropriate” (-), “neutral” (0), or “appropriate” (+). These categorical judgments were converted to a 1–3 scale in which 1 = inappropriate, 2 = neutral, 3 = appropriate.

Person-first scores were compared with direct label scores in the two versions of each questionnaire. Similarly, identical anchor labels were compared for the two versions. For all comparisons, *t* tests using the Bonferroni correction were applied.

### Respondent Profile

Respective biographical data for subjects in the I/E and A Components (divided by a diagonal slash) of each investigation are shown in Table 3. The client, parent, and student groups each contained 60 subjects, 30 in each of the two components. The public group was much larger, with 109 respondents in the I/E Component and 117 in the A Component. The majority of subjects lived in West Virginia, but subjects were obtained from surrounding states, e.g., Pennsylvania, Ohio, Maryland, New York, New Jersey, and Washington, D.C. A few subjects lived as far away as Florida. The gender profile was markedly different: both sexes were represented in substantial proportions among the public and client groups, but nearly all of the parent and student re-

**Table 3.** Description of Respondents in Each of the Two Components (I/E Component/A Component)

Descriptor	Clients	Parents	Students	Public
Number of subjects	30/30	30/30	30/30	109/117
Gender (%)				
Female	43/33	93/87	93/97	56/63
Male	57/67	7/13	7/3	44/37
Age (years)				
Mean	33/37	40/37	23/22	36/32
Range	15–72/18–80	23–76/22–57	21–40/21–33	18–61/18–74
Education (mean years)	15/15	15/15	16/16	15/16
English as first language (%)	93/100	100/96	100/100	100/99
Speech/language/hearing impaired (%)	79/100	9/18	2/16	11/11
Victim of discrimination (%)				
Have been	27/24	14/30	26/27	26/30
May have been	12/36	10/11	10/24	16/23
Occupation (%)				
Student	11/7	0/13	100/100	15/7
Teaching/helping	11/19	22/17	0/0	39/35
Medical and related	7/15	17/33	0/0	7/12
Homemaker	0/0	21/13	0/0	2/2
Other profession	64/50	35/25	0/0	28/43
Retired	7/8	4/0	0/0	9/1

spondents were women. The means ages for the client, parent, and public groups varied from 32 to 40 years; mean ages of the student groups were 22 and 23 years. As can be seen from the table, the range of ages represented varied widely, from teenagers to older adults, among clients, parents, and public groups; however, nearly all of the students were in their early 20s. Nearly all of the subjects reported English as their first language. From 2% to 18% of the parent, student, and public groups reported a history of a speech, language, or hearing impairment. All of the A Component client respondents reported a communicative disorder, but only 79% of the I/E Component clients did so, no doubt due to the fact that 21% no longer regarded themselves as having a disorder. Roughly one-fourth of the clients considered that they had been victims of discrimination (unspecified), but so did the student and public groups. The parent groups in the two components for this appraisal were variable, 14% and 30%, respectively. In addition, 10 to 36% of the subjects indicated that they may have been a victim of discrimination. Predictably, the profiles for occupations showed considerable diversity.

Disorders represented in the client and parent groups are provided in Table 4. Efforts were made to ensure that stutterers were represented; about one-fourth (23%) of the I/E Component clients and more than half (53%) of the clients in the A Component clients were stutterers. Ten to 20% of the parents had stuttering children. Most of the rest of the client group had either articulation or hearing disorders. About 40% of all the parents had an articulation-disordered child and 20%–27%, a child with a language disorder.

### Reliability

About 1/5 (46 or 20.3%) of the public and 1/6 (10 or 16.7%) of the student respondents re-rated an identical questionnaire at least 24 h later for test-retest reliability. The results are shown in Table 5. For the I/E Component, 79%–

**Table 4.** Disorder Categories of Clients and the Children of Parents for the I/E and A Components

Disorder	Clients		Parents (Children's disorders)	
	I/E Component	A Component	I/E Component	A Component
Stuttering (%)	23	53	20	10
Articulation (%)	27	30	40	43
Voice (%)	13	3	3	0
Language (%)	3	3	20	27
Hearing (%)	23	10	7	7
Other (%)	10	0	10	13

**Table 5.** Test-retest Reliability for Public and Student Groups

	Public	Students
I/E Component (four 11-point scales and one 5-point scale)		
2nd ratings identical to original	59%	65%
2nd ratings within 1 scale value	79%	86%
2nd ratings within 2 scale values	90%	95%
2nd ratings within 4 scale values	100%	100%
A Component (five 3-point categories)		
2nd ratings identical	80%	89%
2nd ratings within 1 judgement	92%	95%
2nd ratings within 2 judgements	100%	100%

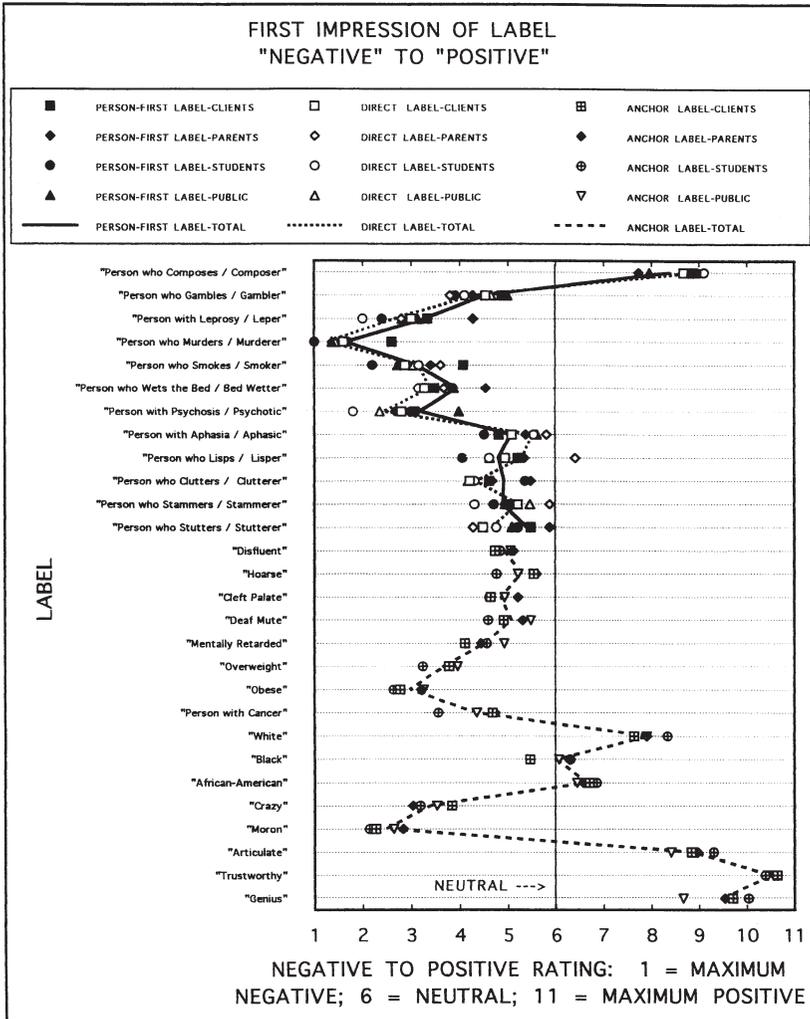
86% of the subjects re-rated labels within 1 scale value of the original rating. For the A Component, 80%–89% of the re-rated labels were identical. These results suggest that subjects were reasonably consistent in rating names.

## RESULTS

### All Studies

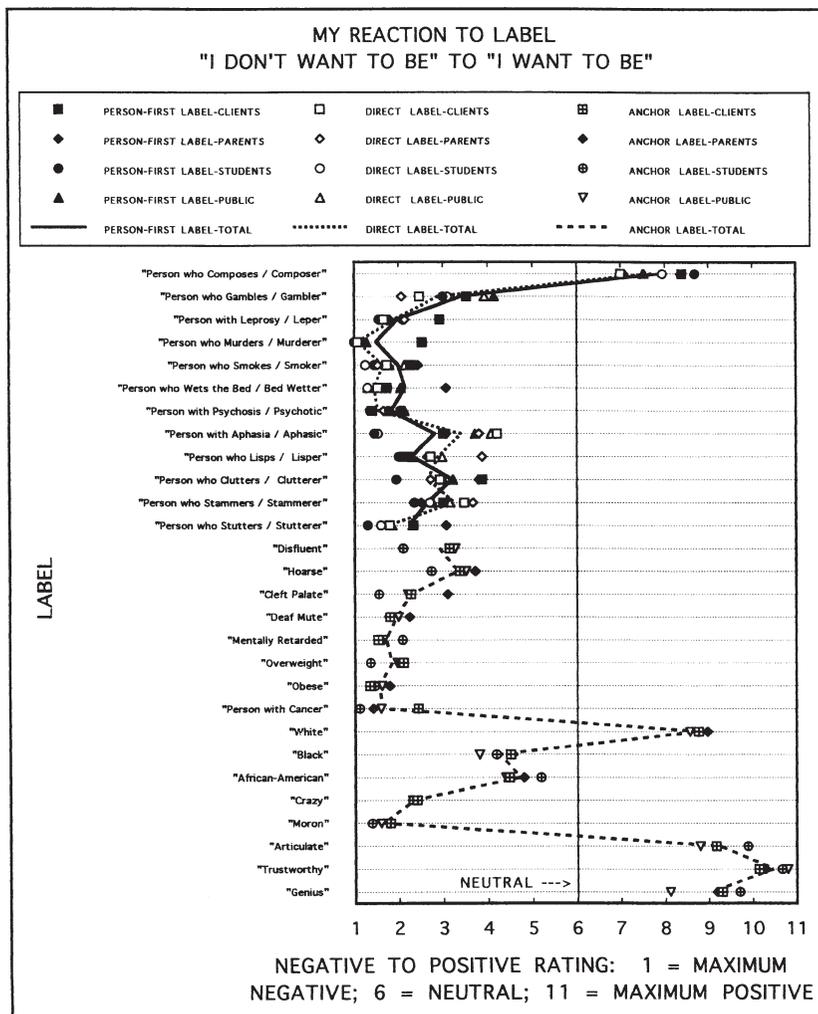
Mean results for the I/E and A components are shown in 10 graphs, Figures 1–10. Each graph plots individual mean values for the variable in question for each of the subject groups (clients, parents, students, and public) as well as for person-first, direct, and anchor labels. To provide an overall impression of the findings, mean values across all four subject groups for person-first versus direct label comparisons are plotted at the top of each graph in solid versus closely spaced dashed lines. Similarly, means for the anchor labels are plotted at the bottom of each graph in wider-spaced dashed lines. Importantly, anchor label means for the two versions of each questionnaire are combined into one overall mean in the graphs (for the sake of visual clarity), even though data on the same anchor words from the two versions of each questionnaire were compared statistically.

The unmistakable impression from all of the graphs (except Figure 5 referring to “What I know about the name”) is that the means from the four pairs of entirely different groups of subjects were very similar. As predicted, “*Person who composes*”/“*Composer*,” “*Trustworthy*,” and “*Genius*” were uniformly rated positively. Similarly, “*Person with leprosy*”/“*Leper*” and “*Moron*” were uniformly rated negatively. Moreover, differences between person-first and direct labels were small and did not appear to be nearly as great as differences among labels. The latter impression is buttressed by the fact that of 480 person-first versus direct label comparisons (12 labels  $\times$  4 subject groups  $\times$  5 variables  $\times$  2 components), only 10 *t* tests (2.1%) were significantly different



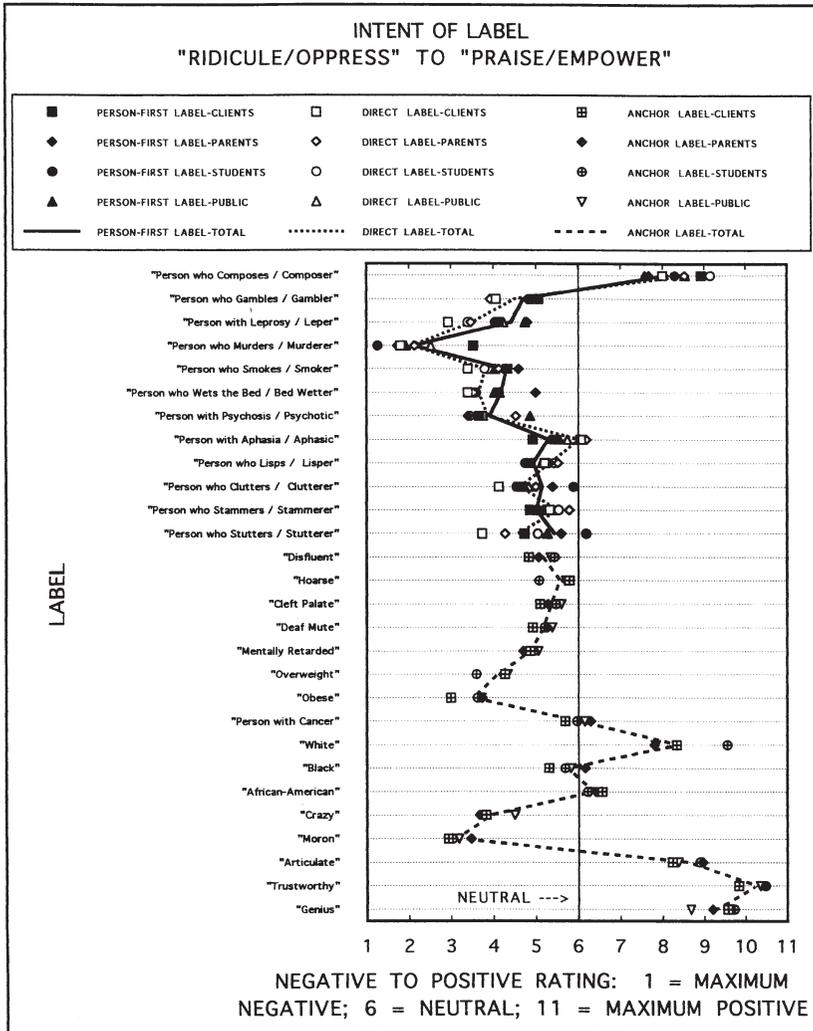
**Figure 1.** Summary of mean ratings for person-first labels, direct labels, and anchor labels for the I/E Component variable, "First Impression."

at the family-wise alpha of  $p < .0018$  (using the Bonferroni correction in which the alpha level of .05 was divided by the number of words being compared, 28). For all of the remaining comparisons (97.9%), person-first versus direct labels were *not* significantly different. And of 640 anchor label comparisons (16 labels  $\times$  4 subject groups  $\times$  5 variables  $\times$  2 components), no  $t$  tests (0%) were statistically significant.



**Figure 2.** Summary of mean ratings for person-first labels, direct labels, and anchor labels for the I/E Component variable, “My Reaction.”

All of the significant differences did favor person-first over direct labeling: seven comparisons for “*Person with leprosy*” versus “*Leper*” and three for “*Person with psychosis*” versus “*Psychotic*.” Student and public groups each accounted for half (five) of the comparisons, providing oblique but important evidence that the much larger sample size for the public groups was *not* the critical factor in determining the significance of differences. There were no

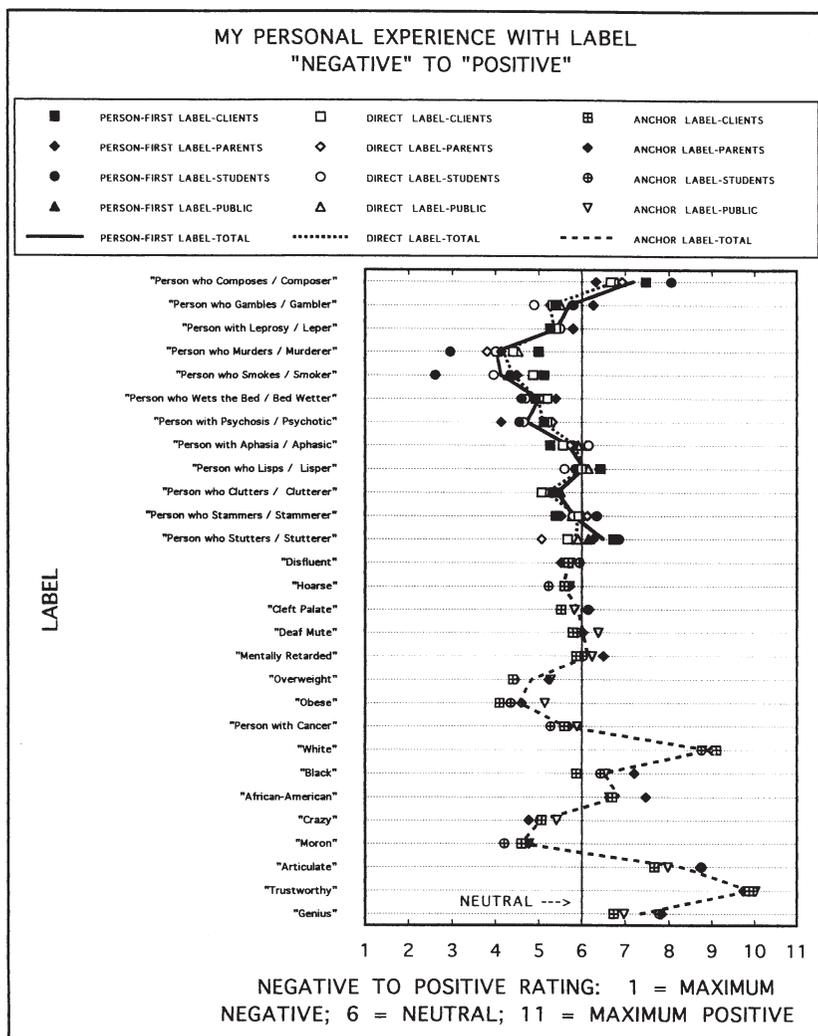


**Figure 3.** Summary of mean ratings for person-first labels, direct labels, and anchor labels for the I/E Component variable, "Intent."

person-first versus direct label differences in comparisons for the client or parent groups.

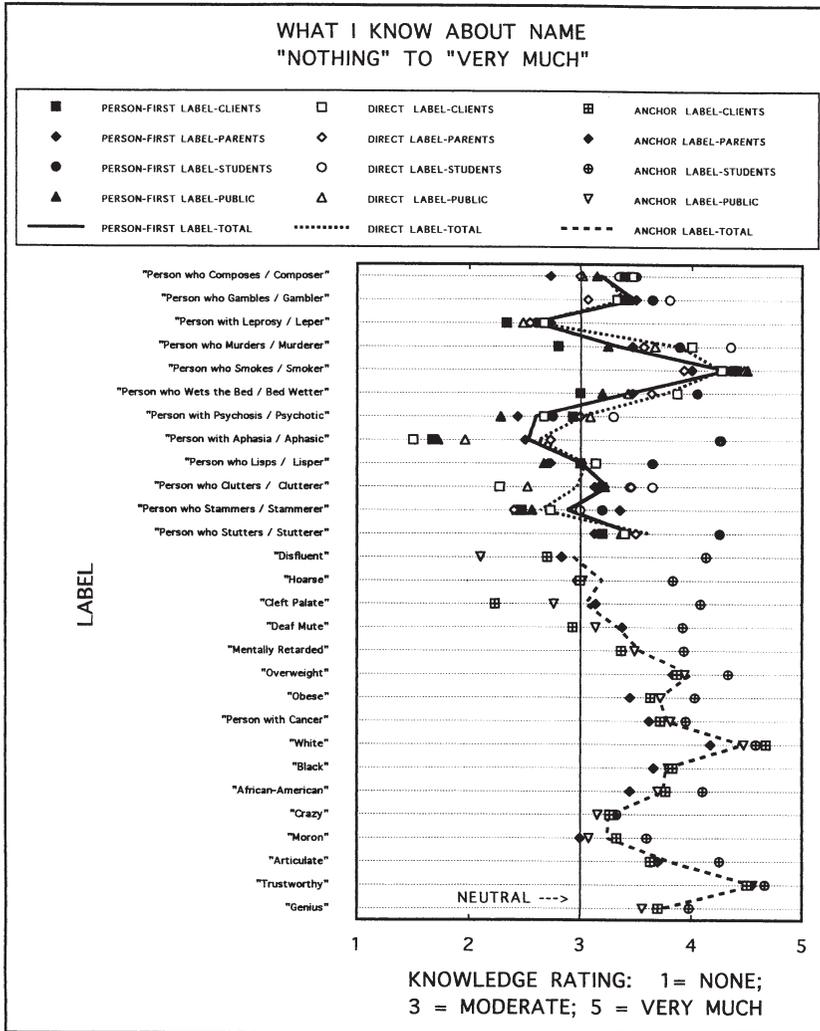
**Individual Variables**

One way to understand the various ways subjects rated the labels in this study is to compare individual variables within each of the two components. Mean



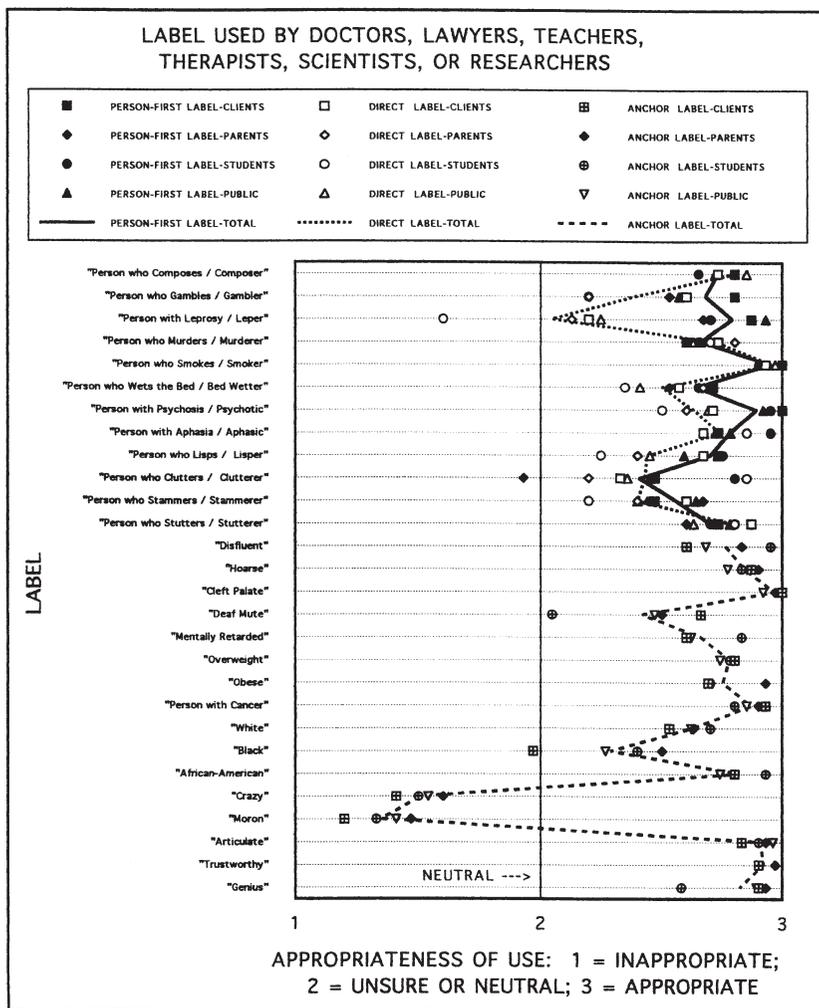
**Figure 4.** Summary of mean ratings for person-first labels, direct labels, and anchor labels for the I/E Component variable, “My Personal Experience.”

ratings of the four variables in the I Component that could vary from -5 to +5 are comparable. The most positive ratings were given for “Personal experience” with the label (negative to positive) (Mean = 5.97 [Clients = 5.88; Parents = 6.07; Students = 5.89; Public = 6.04]) (Figure 4). For this variable, mean values for most speech-language-hearing terms were near neutral, and the lowest ratings occurred for student ratings of *Person who smokes*. The



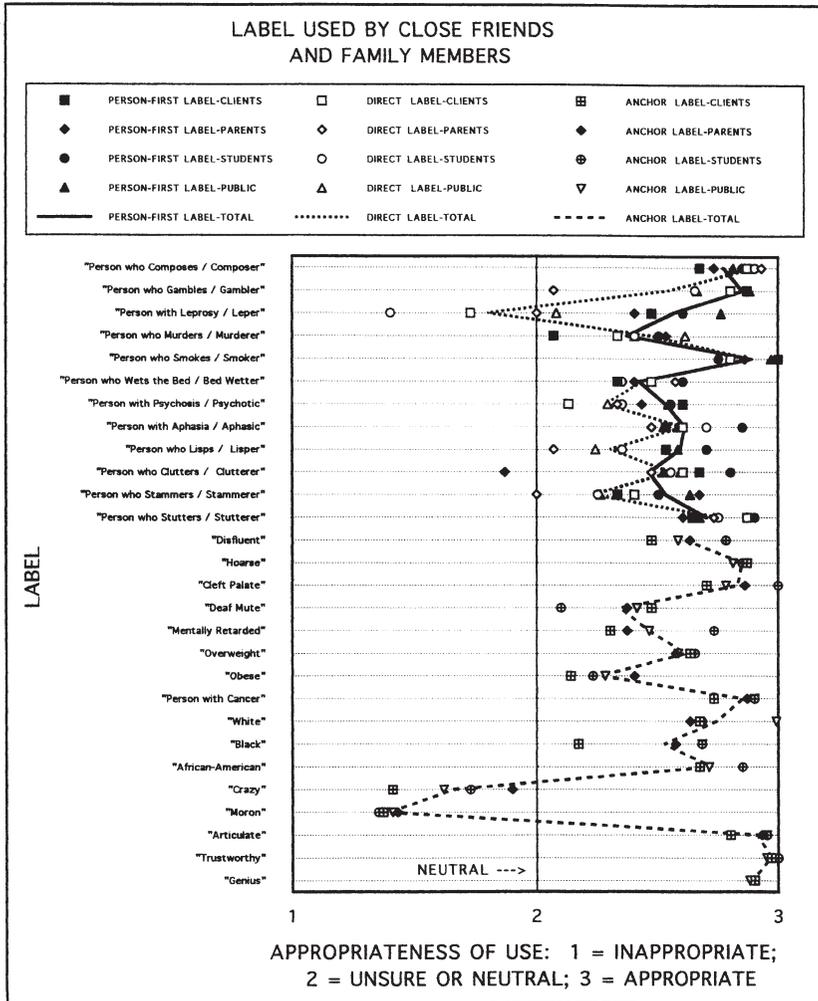
**Figure 5.** Summary of mean ratings for person-first labels, direct labels, and anchor labels for the I/E Component variable, “What I Know About [the] Name.”

variable, “Intent” of the label (from ridicule or oppression to praise or empowerment), was next most positive (Mean = 5.45 [Clients = 5.28; Parents = 5.50; Students = 5.49; Public = 5.51]) (Figure 3). In this case, the lowest ratings occurred for “*Person who murders*”/“*Murderer*,” “*Obese*,” and “*Moron*.” “First impression” ratings (negative to positive) were next (Mean = 5.10 [Clients = 5.11; Parents = 5.26; Students = 4.93; Public = 5.12]) (Figure 1).



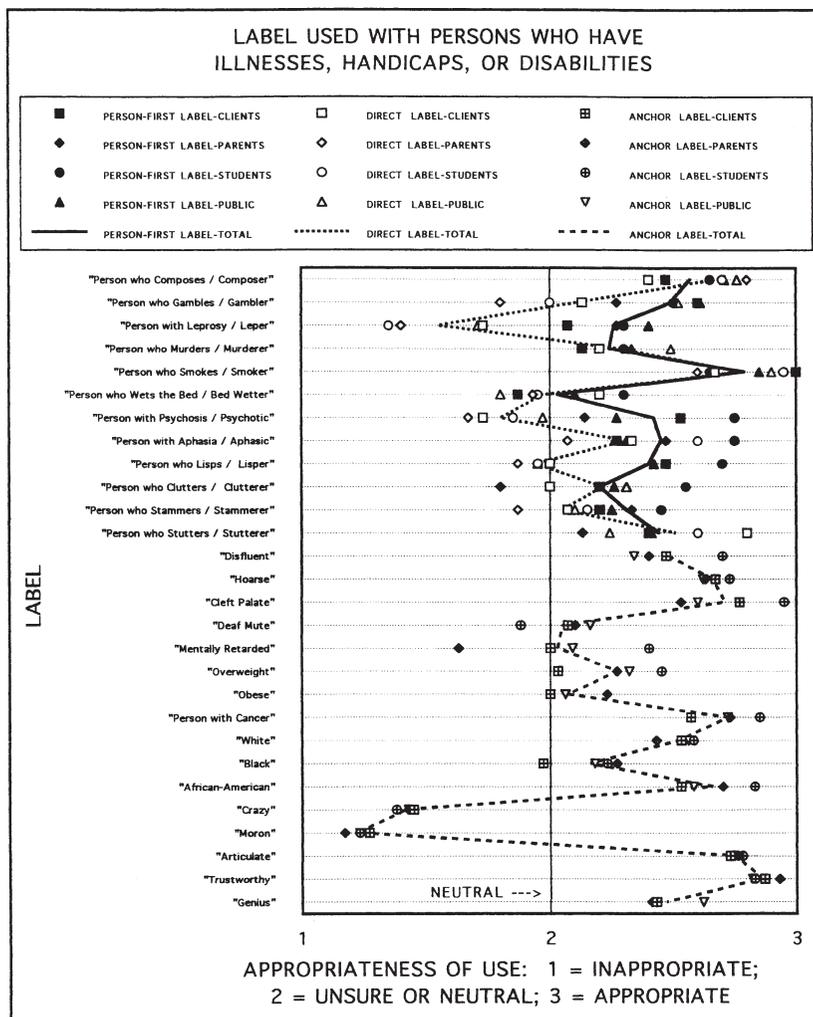
**Figure 6.** Summary of mean ratings for person-first labels, direct labels, and anchor labels for the A Component variable, “Discussions by doctors, lawyers, teachers, therapists, scientists, or researchers.”

And similar to the “Intent” variable, the lowest ratings were observed for “Person who murders”/“Murderer,” “Moron,” “Psychotic,” “Obese,” “Leper,” “Person who smokes”/“Smoker,” and “Bed wetter.” First impression ratings were below neutral for all speech-language-hearing terms. The highest ratings were given for “Trustworthy,” “Genius,” “Composer”/“Person who composes,” “Articulate,” and “White.” It should be noted that the vast major-



**Figure 7.** Summary of mean ratings for person-first labels, direct labels, and anchor labels for the A Component variable, "Conversations about the named person by his/her close friends and family members."

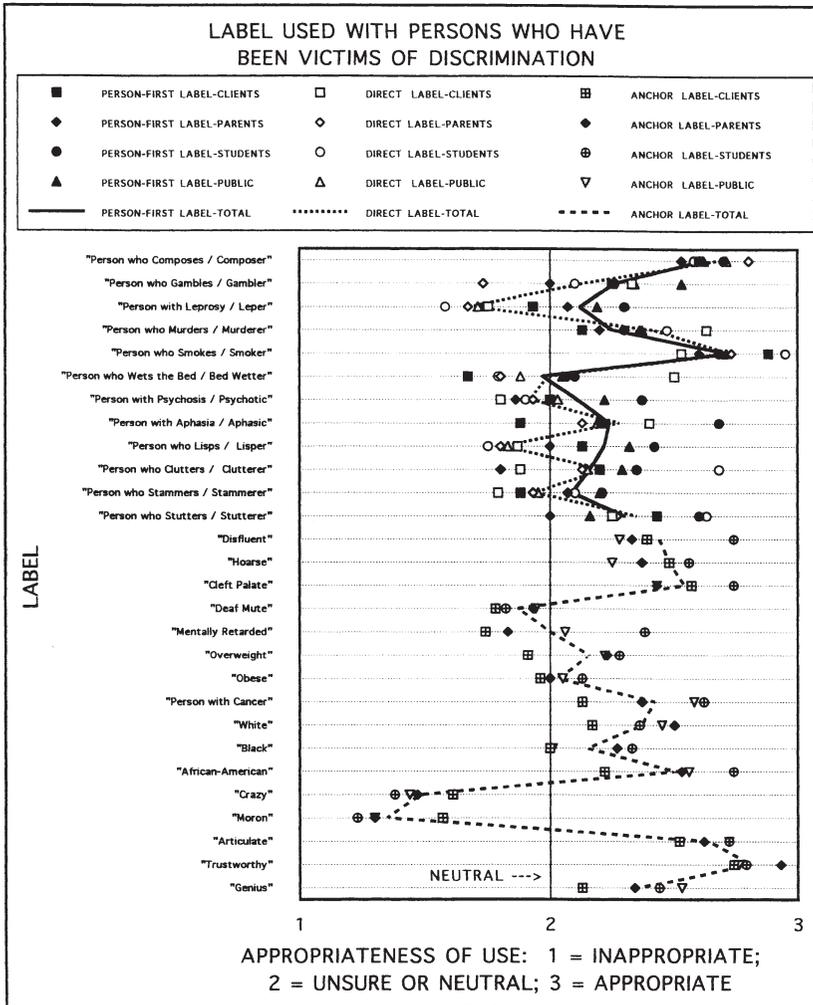
ity of subjects were Caucasian, which very likely affected scores for "White," "Black," and "African American." Finally, the variable for "Reaction" (how much like the person labeled did the respondent "want to be") was the most negative of the four comparable I/E Component variables (Mean = 3.60 [Clients = 3.68; Parents = 3.75; Students = 3.37; Public = 3.60]) (Figure 2). This variable was rated very low for "Murderer"/"Person who murders,"



**Figure 8.** Summary of mean ratings for person-first labels, direct labels, and anchor labels for the A Component variable, “Conversations with persons who have illnesses, handicaps, or disabilities.”

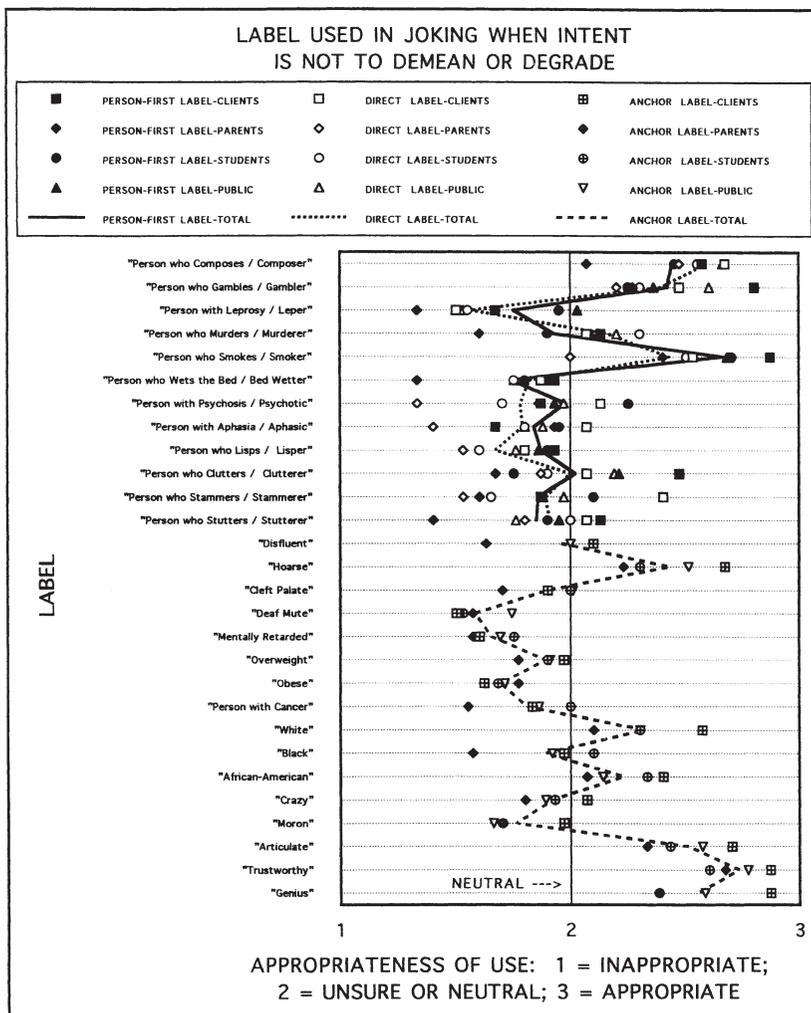
*“Smoker,” “Bed wetter,” “Psychotic”/“Person with psychosis,” “Stutterer,” “Mentally retarded,” “Overweight,” “Obese,” “Person with cancer,” and “Moron.”*

The variable, “What I know about [the] name,” is not directly comparable to the others; still, the results are both interesting and somewhat predictable (Mean = 3.46 [Clients = 3.31; Parents = 3.34; Students = 3.88; Public =



**Figure 9.** Summary of mean ratings for person-first labels, direct labels, and anchor labels for the A Component variable, “Conversations with persons who have been victims of discrimination.”

3.29]; maximum = 5) (Figure 5). Respondents reported knowing the most about: “*Person who smokes*”/“*Smoker*,” “*White*,” and “*Trustworthy*.” Students generally believed they knew more about the terms than any of the other groups, especially—and predictably—the speech-language-hearing terms. Overall, mean knowledge ratings were above neutral for all of the anchor terms except “*Disfluent*,” with a few lower than neutral ratings for “*Hoarse*,”



**Figure 10.** Summary of mean ratings for person-first labels, direct labels, and anchor labels for the A component variable, “Joking with others when the humor is not intended to hurt, offend, or oppress.”

“Cleft palate,” and “Deaf mute.” Among the speech-language-hearing labels, subjects reported knowing least about “Person with aphasia”/“Aphasic” and “Disfluent,” and most about “Person who stutters”/“Stutterer.”

Comparing the five A component variables, as expected, the most positive ratings were given for “Discussions by doctors, lawyers, teachers, therapists, scientists, or researchers” (Mean = 2.61 [Clients = 2.61; Parents = 2.62; stu-

dents = 2.59; Public = 2.60]) (Figure 6). “*Crazy*” and “*Moron*” were regarded as clearly inappropriate for these professionals to use. Somewhat surprisingly, “*Deaf mute*” was regarded as neutral or above, even by speech-language pathology seniors and graduate students who had taken coursework in audiology. The term, “*Clutterer*,” was questioned by parents (and many subjects indicated to examiners that they interpreted the term to mean “messy” or “untidy”). Slightly less positive were ratings for “Conversations about the named person by close friends and family members” (Mean = 2.54 [Clients = 2.49; Parents = 2.52; Students = 2.58; Public = 2.57]) (Figure 7). In this case, “*Leper*” was regarded less appropriate than “*Person with leprosy*” by students and clients. The variable, “Conversations with persons who have illnesses, handicaps, or disabilities” (Mean = 2.30 [Clients = 2.27; Parents = 2.22; Students = 2.39; Public = 2.32]) (Figure 8), received the next most positive ratings. “*Stutterer*” was preferred to “*Person who stutters*” in such conversations, but “*Person who stammers*” was preferred to “*Stammerer*.” Surprisingly, clients, of whom 53% were stutterers, rated the term, “*Stutterer*,” more appropriate than did any other group for “*Stutterer*” or “*Person who stutters*.” The greatest difference for speech-language terms in favor of person-first labeling occurred for “*Person who lisps*” versus “*Lisper*.” The next most positively rated variable was “Conversations with person who have been victims of discrimination” (Mean = 2.22 [Clients = 2.14; Parents = 2.17; Students = 2.33; Public = 2.25]) (Figure 9). The individual profiles for this variable were very similar to those for “Conversations with person who have illnesses, handicaps, or disabilities.” Labels were regarded as being least appropriate in “Joking with others [even] when the humor is not intended to hurt, offend, or oppress” (Mean = 2.04 [Clients = 2.16; Parents = 1.85; Students = 2.04; Public = 2.09]) (Figure 10). The only labels identifying problems deemed appropriate in jokes (i.e., above 2 or neutral) related to *gambling*, *murdering*, *smoking*, and being *hoarse*. Respondents rated “*Stutterer*” slightly more appropriate than “*Person who stutters*” for jokes as well. “*White*” and “*African American*” were regarded by these predominately Caucasian subjects as somewhat appropriate for joking; “*Black*” was slightly below neutral.

## DISCUSSION

This study might best be viewed as a preliminary study of negative beliefs and attitudes associated with certain labels for persons with identifiable differences or handicaps, with special reference to terms referring to fluency disorders. Considering all the labels evaluated, groups of people representing a wide range of age, education, and occupation have similar connotations and rules of use for labels. That is to say, diverse subjects sampled in this study basically agree on which labels are pejorative, which ones are not pejorative, and—more surprisingly—the degree to which certain labels are pejorative in

English. In 98% of 480 comparisons, person-first terminology did *not* make a significant difference. Only 10 *t* tests (2%) using the Bonferroni correction were statistically significant. Seven comparisons with “*Person with leprosy*” were more positive than “*Leper*,” as were three for “*Person with psychosis*” over “*Psychotic*.” Student and public groups each accounted for half of the significant results. There were no significant differences for the client or parent groups. For 640 anchor label comparisons, no *t* tests (0%) were significantly different.

There were a number of interesting trends. The rank order (and means) of the ratings for the first four variables in the I/E component, from highest to lowest, was as follows: “Personal experience” (5.97), “Intent” (5.45), “First impression” (5.10), and “Reaction” (3.60). In the first three of these, most fluency-related terms were rated below but near neutral. Subjects ranked “*Stutterer*” lowest of nine speech-language-hearing terms for their reaction (i.e., “I want to be”). The mean for “What I know about [the] name” for *stuttering* was 3.46, and, for this variable, “*Stutterer*” was rated highest of the nine communication disorders labels.

The rank order of the five A component ratings, from most to least appropriate, were as follows: “Doctors and other professionals” (2.61), “Friends and family” (2.54), “Illnesses, etc.” (2.30), “Victims of discrimination” (2.22), and “Joking” (2.04). Interestingly, clients, of whom 53% had a past or current stuttering problem, rated the term “*Stutterer*” more positively than the other three subject groups for joking and among the highest for three of the other four variables.

Except for the low ratings for *stuttering* for “My reaction” (i.e., “I want to be”), in general, there were no systematic differences observed between the direct or person-first labels for *stuttering* and *stammering*, or the anchor label, *disfluency*. This is somewhat surprising since clinicians often prefer the term “*disfluency*” to “*stuttering*” because it is felt to be less negative. The labels “*Clutterer*” or “*Person who clutters*” were generally perceived about the same as the aforementioned terms for fluency disorders, although, as noted, *cluttering* labels were often interpreted anecdotally by subjects as meaning “messy” or “untidy,” rather than as a label for a fluency disorder.

These analyses suggest that groups of people representing a wide range of age, education, and occupation, but also representing personal knowledge and experience with communicative disorders, or presumed lack thereof, make judgements based on similar connotations and rules for labels used to identify people. For example, with the exception of widely known terms that have stigmatized individuals (e.g., “*Moron*”), terms identifying serious mental illness (“*psychosis*”) or dreaded diseases (“*leprosy*”), person-first nomenclature made little difference in minimizing negative reactions. In addition, none of the nine speech-language-hearing labels were perceived to be negative in any form. The inescapable conclusion for the speech-language labels assessed is

that person-first terminology has little effect on lessening negative ratings. Even such archaic and questionable terms as “*Deaf mute*” and “*Lisper*” are not viewed by the public with nearly the negative valence as “*Moron*.” These two terms have been replaced by more accurate labels already, and “*Moron*” has been replaced by several variants of “*Mentally retarded*.”

With respect to the decision of whether or not to use the term “*Stutterer*” versus “*Person who stutters*,” this study clearly indicates that the former will not communicate any less sensitivity than the latter to most people, even those who suffer from speech-language disorders (including stuttering). Of course there are exceptions, especially among those who were in the forefront of the movement to promote person-first terminology in the stuttering self-help movement and in ASHA.

One unpublished study concluded that person-first terminology does result in less negative attitudes and beliefs about stuttering than direct labels (Robinson & Robinson, 1996). The authors coded short, open-ended responses of 24 adult subjects to the directive, “Please list the first five things that come to mind when you hear the term [‘stutterer’] or [‘person who stutters’]” as “positive,” “neutral,” or “negative.” The direct label resulted in fewer “positive” and more “negative” responses than the person-first label. Aside from the limited number of subjects tested and lack of detail about them, this study is hard to interpret for three reasons. First, it is not clear whether subjects responded to one or both versions of the study, and, if both, then in what order. Second, respondent’s comments referred to characteristics of the disorder (e.g., “Don’t call attention to the stuttering, concentrate on what they have to say” [coded as “positive”] or “nervous” [coded as “negative”]). It is possible, therefore, that some subjects may have responded to “stutterer” as a person with a disorder and to “person who stutters” as a normal speaker with occasional disfluency. The latter criticism could also be leveled at the current study, but, given the number of serious disorders mentioned herein, it is likely that respondents were “primed” to some extent to interpret ambiguous conditions as disorders or handicaps. Third, the Robinson and Robinson study did not compare reactions to the terms for stuttering with any other conditions, making it impossible to estimate subject biases about fluency versus other disorders or conditions.

In a larger sense, it seems important to differentiate the suffering that is inherent in a condition from the suffering that is caused by the labels used to name it. Conditions such as intellectual deficiency, brain damage, cancer, bed wetting (at certain ages), and obesity are, to varying degrees, negative and unfortunate. Persons with these problems do suffer and, from time to time, no doubt encounter belittling or derogatory attitudes, comments, and reactions from others. Similarly, “*stuttering*” conjures up images of helplessness, struggle, and derision. But it is equally true that modifying the name of an unfortunate condition typically neither eliminates nor reverses the hard realities faced

by those suffering from it. In fact, it can be argued that changing the name of a dreaded condition may have the undesired effect of euphemistically promoting the conclusion that something is not what it really is. The author has observed cases in which “disfluency,” used in lieu of “stuttering” in order to lessen the negativity of the diagnosis, has resulted in confusion (e.g., a client claiming not to “stutter”—only to be “disfluent”). There are other ramifications of person-first terminology as well. In the past few years, “PWS” (meaning “person who stutters”) or “CWS” (or “child who stutters”) have become acronyms, at first only in writing, but recently in verbal descriptions as well. One might question whether referring to someone orally as a “PWS” really communicates more sensitivity than referring to him as a “stutterer.”

Sykes (1992) makes a thought-provoking case that, in the U.S.A., we have become a “nation of victims,” in which more and more groups who have suffered through no perceived fault of their own, have rallied around that suffering, much as Blacks did so (legitimately) in the Civil Rights movement. Intending to empower their members, many groups have found themselves competing for evidence of the greatest degree of victimization by society. And language, i.e., the words or labels used to label their “conditions,” is taken as a major type of evidence. (Of course, there are well-known examples of the way that labeling can and has been used to harass or oppress, e.g., “*Moron.*”) Language is also used to further empower group members. Many groups have adopted the common strategies of coining new words or acronyms (e.g., “otherly-abled” or “PWS”), redefining existing words (e.g., “disfluency” and “dysfluency”), or blacklisting various labeling conventions (e.g., “handicapped” or “stutterer”), all to the presumed benefit of their members (cf. ASHA News, 1994). Of course, knowing and abiding by the most recent suggested changes in one’s own language is known popularly as being “politically correct.” Taken to its current extreme, however, Sykes argues that instead of empowering those who suffer, such measures can—and often do—trivialize serious violations or infringements against those who truly are victims.

Another reason to be cautious about changing terminology is that new terms inevitably invite confusion. The following partly contrived example illustrates the sort of unintended confusion that person-first labeling has engendered. The author has repeatedly carried out the following informal exercise in undergraduate and graduate classes in fluency disorders. First, normal speaking adults who know something about the clinical picture of stuttering are asked to raise their hand if they have ever—even once—truly stuttered, that is, not being able to get their desired word out and thereby repeating or prolonging a syllable or feeling “blocked.” Typically, the majority put an arm in the air. Next, they are asked to keep their hand up if they regard themselves as a “stutterer.” Rarely do any uplifted hands remain. Trying to use person-first labeling, the ensuing conundrum then follows in answer to the question, “Who are these people?”

“Stutterers?”

No, they do not have the clinical picture of stuttering.

“Nonstutterers?”

No, because the name has an unacceptable direct label.

“Persons who stutter?”

Yes, but the name does not differentiate them from real “persons who stutter.”

“Persons who stuttered once or twice but don’t really stutter?”

Not very good.

“Nonstuttering persons who stutter?”

This ridiculous description is probably the best label available using person-first nomenclature.

On a more serious note, many have recognized that the terminology in fluency disorders is in disarray. Accordingly, a task force of the Special Interest Division of ASHA on Fluency and Fluency Disorders recently drafted guidelines for consumers, clinicians, and researchers on terminology that reflected the greatest degree of professional consensus (American Speech-Language-Hearing Association, in press). Person-first terminology is recognized as a legitimate option within these Guidelines, primarily for use with clients when it is important to communicate that stuttering symptoms are not what primarily define a person with a stuttering problem but constitute only a few of many characteristics that make up that person. Nevertheless, direct labeling is preferred when incisive definition is important, such as in clinical diagnosis and description of research subjects.

## CONCLUSION

The results of this study suggest that for the speech-language pathology labels assessed, person-first terminology does very little to lessen negative attitudes of the public. Consequently, and to lessen the “trivialization” and confusion mentioned earlier, the author submits that policies by self-help groups, professional associations or journal editors, the media, publishers, and others promoting person-first and other types of labeling terminology, while clearly beneficial in some contexts, should not be made lightly. If policies are justified by the argument that certain labels will lessen or remove negative attitudes, or that certain labels will increase or promote positive attitudes or sensitivity, then public and professional opinion should be garnered for support. And, the information gathered should be shared and discussion encouraged. It is possible that a policy insisting on person-first terminology in the area of speech-language pathology, in general, or in fluency disorders, in particular, while well intentioned, may not be helpful in fostering appreciation of clients as people but simply confuse everyone concerned by suggesting that past labels—for which the overwhelming consensus is that they are not pejorative—are now unacceptable.

Furthermore, if labels are to be changed in the interest of enhancing sensitivity to those with communication disorders, the author submits that words or phrases used to label or describe people or disorders (e.g., “stutterer” versus “person who stutters”) need to be considered carefully and individually. That is, the categories or types of words to which a certain policy applies should not be allowed to expand haphazardly, thoughtlessly, or needlessly. Wholesale decisions involving groups of seemingly related words may create more problems than they solve.

It is never too late to debate questions such as the following in regard to labeling terminology. In the interest of better understanding the people we serve, where should lines be drawn between labels that are pejorative and those that are acceptable? By whom should the lines be drawn? Should lines even be drawn? And, how are lines that have been drawn unnecessarily either erased or redrawn?

---

This study could not have been completed without a great deal of help. The author gratefully acknowledges the help of Rae Jean V. Sielen, Renee Jones, Matthew E. McCulty, and Paula S. Townsend for their assistance in experimental design and analyzing data. He also is indebted to all of the students, clients, parents, and others who so willingly participated.

---

## REFERENCES

- American Psychological Association (1994). *Publication manual of the American Psychological Association* (4th ed.). Washington, DC: Author.
- American Speech-Language-Hearing Association (In press). *Guidelines: Terminology pertaining to fluency and fluency disorders*. Rockville, MD: Author.
- ASHA News (1994, September). *Asha* 36, 10.
- Executive Board Meeting Minutes (1993, December). *Asha* 35, 127–129.
- Robinson, B.W., & Robinson, B.F. (1996). *Person-first language and attitudes toward individuals who stutter*. Poster presented at the annual convention of the American Speech-Language-Hearing Association. Seattle, WA.
- Sykes, C. J. (1992). *A nation of victims: The decay of the American character*. New York: St. Martin's Press.