



Identifying correlates of self-stigma in adults who stutter: Further establishing the construct validity of the Self-Stigma of Stuttering Scale (4S)



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ABSTRACT

Purpose: This study was set up to further establish the construct validity of the Self-Stigma of Stuttering Scale (4S) by demonstrating its associations with other established scales and replicating its original factor structure and reliability estimates.

Method: Web surveys were completed by 354 adults who stutter recruited from Board Certified Specialists in Fluency Disorders, and adult chapters of the National Stuttering Association. Participants completed a series of psychometrically validated scales measuring self-stigma, hope, empowerment, quality of life, social support, anxiety, depression, and self-rated speech disruption.

Results: Higher subscale and total stigma scores on the 4S were associated with significantly lower levels of hope, empowerment, quality of life, and social support, and significantly higher levels of anxiety, depression, and self-rated speech disruption. The original factor structure of the 4S was replicated, and reliability estimates of the subscales ranged from adequate to excellent.

Conclusions: The findings of this study support the construct validity of the 4S and its use by clinicians and researchers intending to measure the construct of self-stigma in adults who stutter.

Educational objectives: Readers should be able to: (a) distinguish between the various components of self-stigma; (b) describe how the various components of the self-stigma model relate to hope, empowerment, quality of life, and social support, self-rated speech disruption, anxiety, and depression; (c) summarize the psychometric properties of the Self-Stigma of Stuttering Scale (4S) in terms of reliability, factor structure, and construct validity; (d) discuss how the 4S could be used in research and clinical practice.

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1. Introduction

People who stutter (PWS) experience public stigma in the form of negative stereotypes, prejudice, and discrimination (Gabel, Blood, Tellis, & Althouse, 2004; Logan & O'Connor, 2012; Maviş, Louis, Özdemir, & Toğram, 2013). The stigma associated with stuttering can negatively impact the quality of life of individuals who stutter (Boyle, 2013; Bricker-Katz, Lincoln,

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& McCabe, 2010; Plexico, Manning, & Levitt, 2009). In addition, PWS can experience self-stigma in which they internalize negative societal views about stuttering, which may result in reduced societal participation and accomplishment of life goals (Bricker-Katz, Lincoln, & Cumming, 2013; Daniels, Gabel, & Hughes, 2012; McAllister, Collier, & Shepstone, 2012).

Corrigan and colleagues proposed a four stage model to explain the self-stigma process, including stages of *awareness*, *agreement*, *application*, and *harm* (Corrigan et al., 2012; Corrigan, Rafacz, & Rüsich, 2011). According to this model, (1) individuals are made *aware* that they are stigmatized by the public, (2) they begin to *agree* with the stigmatizing attitudes of the public and stereotype others with the condition, (3) they *apply* the stigmatizing attitudes toward themselves personally, and (4) they experience psychological *harm* in the form of reduced well-being and societal participation. Some important assumptions of this model are that awareness precedes agreement, agreement precedes application, and psychological harm progressively increases from stages 1 to 3. In other words, application of stigma to the self is hypothesized to result in lower well-being than mere awareness of or agreement with publically stigmatizing attitudes.

The self-stigma model was applied to PWS in the development of The Self-Stigma of Stuttering Scale (4S) (Boyle, 2013). The 4S was intended to assess the multiple components of the self-stigma model described above and evaluate clients' need for treatment programs dealing with stigma reduction, as well as documenting progress in therapy that includes stigma reduction components. The 4S was created to be used by both clinicians and researchers for tracking changes in self-stigmatizing thoughts over time. The revised version of the 4S that was used in this study can be seen in the Appendix. It is a relatively brief scale (taking 3–5 min for participants to complete) that is the first to analyze self-stigma in adults who stutter using the multidimensional model of *awareness*, *agreement*, and *application*. Evidence of changes in self-stigma from assessment through therapy would therefore indicate progress and positive change in the cognitive dimension of a stuttering disorder, which is an important component to consider for improving clients' quality of life and social participation (Yaruss, Coleman, & Quesal, 2012). The scale was developed after a thorough literature review and interviews with PWS. The 33 items in the final version of the 4S underwent factor analysis and a three factor solution was most parsimonious. The 4S measures *awareness* (e.g., "Most people in the general public believe that PWS are insecure"), *agreement* ("I believe that PWS are generally nervous"), and *application* (previously labeled "self-concurrence" in Boyle, 2013) ("Because I stutter, I feel less sociable than people who do not stutter"). The *application* section also contains items measuring behavioral outcomes resulting from self-stigma (e.g., "Because I stutter, I stop myself from taking jobs that require lots of talking"), which Corrigan, Larson, and Rüsich (2009) label the "why try" effect. The 4S has shown evidence of internal consistency ($\alpha = .87$) and test-retest reliability ($r = .80$). In addition, initial evidence of construct validity of the 4S was shown by its significant negative correlations with previously established measures of self-esteem (Rosenberg, 1965), self-efficacy (Schwarzer & Jerusalem, 1995), and life satisfaction (Pavot & Diener, 1993). However, further establishing the construct validity of the 4S requires replication of its factor structure and internal consistency, as well as determining its relationship to established measures of other psychosocial variables (DeVellis, 2012; O'Leary-Kelly & Vokurka, 1998).

Livingston and Boyd (2010) conducted a systematic review and meta-analysis of data from 45 articles measuring the empirical relationship between self-stigma and a variety of psychosocial and disability related variables in individuals with mental illness. They found robust and consistent negative correlations between self-stigma and hope ($r = -.58$), self-esteem ($r = -.55$), self-efficacy ($r = -.54$), empowerment ($r = -.52$), quality of life ($r = -.47$), and level of social support/social integration ($r = -.28$). A positive correlation was found between self-stigma and symptom severity of the disorder ($r = .41$). Studies have also found significant positive correlations between self-stigma and anxiety disorders (Alonso et al., 2008; Ivanova, Hart, Wagner, Aljasseem, & Loutfy, 2012) and depression (Logie, James, Tharao, & Loutfy, 2013; Montesinos et al., 2012; Sehlo & Bahlas, 2013) in a variety of different populations.

The purpose of this study was to further establish the construct validity of the 4S by examining its relationships with variables that have been previously shown to be related to self-stigma. Specifically, scores on the 4S were analyzed in relation to established measures of hope, empowerment, quality of life, social support, anxiety, depression, and self-rated speech disruption. Based on previous evidence, it was anticipated that self-stigma scores would be negatively correlated with hope, empowerment, quality of life, and social support, and positively correlated with anxiety, depression, and self-rated speech disruption in adults who stutter. In accordance with the multi-component stigma model proposed by Corrigan and colleagues (2011, 2012), it was expected that the strength of these correlations would progressively increase from awareness through application of stigma. It was also of interest to determine if the factor structure and reliability estimates obtained in the previous study (Boyle, 2013) could be replicated with a different sample. It was anticipated that the original factor structure and reliability estimates would be replicated.

2. Methods

2.1. Participants

The survey software used in the study recorded that 569 people opened the survey link. However, only data from 354 participants could be used for several reasons. Thirty-nine individuals did not complete any portion of the survey. Thirty-six individuals could not progress past the screening questions (i.e., "Do you stutter?" and "Are you age 18 or older?") because they responded negatively to those questions. One-hundred and forty respondents did not complete any portion of the survey following the first few questions. After exclusion of these individuals from the analysis, respondents were 354 adults (200 men, 95 women, 59 unspecified) who reported that they stutter. The age of the participants ranged from 18 to 84

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