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**Title:** Stuttering and the Social Model

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**Author Statement**

The three authors wrote this paper collaboratively. Author order represents quantity of contribution.

**Competing Interest Statement**

All three authors are also the coeditors of the book *Stammering Pride & Prejudice*

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64 **Abstract**

65 Stuttering has traditionally been thought of as a defect located within an individual. As  
66 such, stuttering is caused by pathology, leading to impaired communication and reduced quality  
67 of life. Research from this medical tradition has looked to understand the etiology of stuttering to  
68 develop curative therapeutic approaches. From this frame, professionals and academics are  
69 experts and holders of knowledge; people who stutter the recipients of this expertise.

70 The social model emerged from within the disability rights movement and offers a  
71 counter narrative. It sees the way society is structured as disabling rather than physical  
72 impairment itself. Disability is experienced when a person is unable to participate fully in society  
73 through a mismatch between their body and the environment around them; thus, disability  
74 becomes a dynamic process, not an inherent characteristic. The social model highlights society's  
75 norms and values, and, in the case of stuttering, demonstrates how society is designed for, and  
76 expects, fluent speakers. From this frame, people who stutter are the experts of their experience  
77 and holders of knowledge; professionals and academics are their allies, collaborators, and  
78 advocates for social change.

79 This theoretical framework poses challenging questions of the foundational theories upon  
80 which stuttering therapy is historically rooted. They call into question the hierarchical structures,  
81 power dynamics and even purpose of stuttering therapy and research. In this discussion paper,  
82 we will explore the social model of disability and its implications for stuttering therapy and  
83 research. We discuss the benefits of a social model approach as well as its limitations.

84

85 **Introduction**

86 Published 30 years ago, *The Politics of Disablement* by Mike Oliver is generally  
87 perceived as a watershed moment for disability studies (Oliver, 1990; 2013). Contained within  
88 the book, outlined over three pages, was the social model of disability. The social model sees  
89 disability as the result of environmental barriers rather than an individual's impairment. It is in  
90 contrast to the medical model of disability, commonly employed by health professionals, that  
91 sees an individual's impairment as the source of disability. The front-cover of *The Politics of*  
92 *Disablement* provides a visual summary of the theory. It pictures a man in a wheelchair unable to  
93 access a polling station due to a set of steps in front of it. Under the medical model, the man is  
94 disabled by his physical impairment and cannot access the building because of his inability to

95 walk up the stairs. In contrast, under the social model, the assumed expectation of being able to  
96 walk up the stairs and the lack of a ramp or lift are the source of disability.

97         The social model came about through the formalization of ideas from the disabled  
98 people's movement of the 1970s and 1980s that campaigned and protested for adjustments to  
99 make society accessible to them - such as ramps on public buildings. The social model proved a  
100 powerful rallying cry to get these adaptations. The model itself would be discussed and dissected  
101 at length throughout the 1990s and 2000s in the disability studies literature: it would be lauded  
102 for its simplicity, criticized for its lack of nuance; praised for its pragmatic focus on societal  
103 barriers, admonished for denying the lived reality of impairment. If there is one thing everyone  
104 can perhaps agree on, however, it is that the social model started conversations and began to  
105 change the narratives around what it means to be disabled.

106         *The Politics of Disablement* also had two pages discussing stuttering (p. 57, 58). Mike  
107 Oliver used the example of stuttering to put forward how the social model could be used to  
108 improve the lives of those with non-visible, sensory, cognitive, and communication impairments  
109 as well as those with physical impairments. These two pages do not appear to have provoked  
110 nearly as much conversation and reaction within stuttering academia over the past thirty years.  
111 However, in the last decade people who stutter and therapists have shown renewed interest. They  
112 are keen to use the social model to reimagine how stuttering can be understood and talked about;  
113 how the role and scope of therapy can be broadened; what adjustments for people who stutter in  
114 education and employment can look like; and how speech differences can be de-stigmatized.

115         In this paper, we lay out how the social model of disability may be applied to stuttering,  
116 outline its benefits and limitations, look at some changes it may suggest in the fields of legal  
117 protection, media representation, therapy and research, and put forward some future directions.

118 Work in the field of disability studies has since looked to develop more coherent and complete  
119 models to understand disability, such as the political-relational model (Kafer, 2013), that we  
120 would encourage readers to explore and consider. From responses to our own work, however, it  
121 appears to us that a dissection and understanding of the social model/medical model contrast has  
122 been missed in stuttering academic journals so far, we hope this paper will provide the  
123 commentary the field desires. Allowing it to join a conversation on disability and identity that is  
124 progressing among people who stutter, therapists, and scholars exploring stuttering from an arts  
125 and humanities perspective.

### 126 **The Experience of Stuttering**

127         Although the social model of disability does not explain why people stutter, it does help  
128 us understand why stuttering is experienced the way that it is. Regardless of cultural context, the  
129 experience of stuttering documented in the medical literature is almost entirely negative. For  
130 decades, researchers and therapists have taken for granted that these negative experiences are  
131 consequences of stuttering itself. The social model is a useful framework for understanding these  
132 experiences in a more nuanced way. By making a distinction between our biology, or our  
133 *impairment*, and those social factors which negatively impact our life, and which *disable* us, the  
134 social model allows us to think critically about whether our impairments necessarily create  
135 disability or whether there might be other causes (Oliver, 1996).

136         Stuttering lends itself well to a social model analysis. One of the founders of speech-  
137 language pathology and a person who stutters, Wendell Johnson, said that, “stuttering is what  
138 you do trying not to stutter” (Johnson, 1961, p. 177). Johnson believed that speech disfluencies  
139 were a normal part of speech, which only become struggled when the speaker tried to suppress  
140 them in response to social feedback (Johnson, 1955). Johnson’s diagnosogenic theory is almost a

141 proto-social model, placing the etiology of stuttering entirely in listener response. Longitudinal  
142 research studying the onset of stuttering proved Johnson wrong; stutter is hereditary (Frigerio-  
143 Domingues & Drayna, 2017; Yairi & Ambrose, 2005; Yairi & Lewis, 1984). Nonetheless, he  
144 was largely correct that if we stopped trying not to stutter much of the struggle in our speech  
145 would go away. This idea has played an important part in the personal journeys of many people  
146 who stutter (Plexico et al., 2005, 2009a, 2009b). Indeed, most modern therapy approaches still  
147 play with this concept in one way or another. People who stutter are encouraged to stop fighting  
148 their stuttering, but instead allow it to happen and work with it to enable easier speech (Sheehan,  
149 1972; Van Riper, 1973). Yet for many people it remains difficult to let themselves stutter. Why  
150 might this be?

151         The stuttering literature paints a detailed picture of the negative consequences of  
152 stuttering. People who stutter often have increased anxiety in social situations (Blumgart et al.,  
153 2010a; Craig & Tran, 2006) and decreased quality of life (Craig et al., 2009). Stuttering exerts  
154 increased financial costs (Blumgart et al., 2010b) and reduces labor market outcomes (Gerlach et  
155 al., 2018). People who stutter are often steered toward lower status jobs and choose jobs that  
156 require less speaking (McAllister et al., 2012). Additionally, they are subject to role entrapment  
157 and vocational stereotyping (Gabel et al., 2004, 2008). People who stutter report being fired from  
158 jobs for stuttering as well as removed from jobs requiring speaking roles (Constantino et al.,  
159 2017). People who stutter are found less attractive by their peers (Van Borsel et al., 2011) and  
160 can struggle to form intimate relationships (Linn, 1998). They experience social rejection from  
161 childhood (Davis et al., 2002) through adulthood (Constantino et al., 2017).

162         If we look at this list uncritically, we can be convinced that stuttering is undesirable. The  
163 logical solution is to reduce or eliminate stuttering. If stuttering causes these problems, then

164 fluency can fix them. However, when placed under a critical lens this conclusion becomes  
165 problematic. It is not clear that disfluencies in speech should garner any of these consequences.  
166 Why should repeating syllables result in anxiety? Why would prolonging a sound lead to lower  
167 financial outcomes? The social model helps us to tease apart the physical behavior, the stuttering,  
168 from the social consequences of that behavior. Once this separation is made, we can critically  
169 evaluate the causes of these negative consequences.

170         For people who stutter and others with impairments, one of the causes of disability is the  
171 expectation of able-bodiedness. Historically, impaired bodies are not taken into account by wider  
172 society. Norms and societal expectations make able-bodiedness desirable and mandatory for  
173 participation. McRuer (2002) calls this *compulsory able-bodiedness* or the enforcement of an  
174 ideal body type on all. Sometimes this enforcement is clear and concrete. For example, the  
175 physical environment dictates who can access a space by using steps instead of ramps. Other  
176 times this enforcement is less tangible. For example, stuttering may make interactive voice  
177 response systems (automated phone menus) unusable. Similarly, pre-set times in oral  
178 examinations and presentations disadvantage those with unpredictable speaking patterns.  
179 Discourses around behaviors, and what they mean, can dictate how different bodies are  
180 understood by others.

181         In general, in any social interaction the expectation is able-bodiedness (McRuer, 2002).  
182 The physical body is invested with political and cultural meaning, resulting in our expected  
183 social experience corresponding to how closely we conform to that ideal. When this expectation  
184 is violated, the people in the given situation must interpret what this means. As already outlined,  
185 people who stutter can be interpreted as less intelligent, less capable, more anxious, and more  
186 nervous than fluent speakers (Byrd et al., 2017; Ferguson et al., 2019). Stigma and

187 marginalization develop around impairment as people attempt to distance themselves from these  
188 interpretations (Goffman, 1963). Stigma is both a mark of devaluation and the outcome of  
189 possessing a devalued trait (Shelton et al., 2010). This stigma permeates the collective  
190 understanding of impairment and creates negative cognitive, affective, and behavioral reactions  
191 towards individuals marked with it (Corrigan & Watson, 2002; Link & Phelan, 2006). These  
192 understandings do not just exist in the public domain, but are internalized by those marked by  
193 stigma, becoming self-stigma (Corrigan et al., 2009). Negative stereotypes become negative self-  
194 concepts. People with stigmatized identities can come to believe what society believes about  
195 them, colluding with the pervasive discourses that devalue them. This phenomenon is well  
196 documented among people who stutter (Boyle, 2013, 2018; Gerlach et al., 2021).

197         Under a social model lens, the challenges of stuttering have little to do with disfluency  
198 and everything to do with living with a socially stigmatized trait that is not accommodated by  
199 society. Not only are people who stutter punished by the society within which they live for  
200 violating expectations of able-bodiedness, but they internalize this discrimination and place the  
201 blame on themselves and on their stuttering. This creates a vicious cycle: a person stutters, they  
202 experience discrimination, they blame their stuttering, and then try their hardest not to stutter  
203 again. Ableism, discrimination against those who are not able-bodied, is the reason stuttering is  
204 so difficult.

205         Ableism also provides a helpful framework to understand the dynamics of avoidance and  
206 trying not to stutter which is so intrinsic to the experience of stuttering. As Swain & Cameron  
207 (1999, p.69) observed, “within an [ableist] society pressures to pass as normal or to aspire to  
208 some approximation of normality, on non-disabled terms, are manifest for all disabled people.” It  
209 follows that people who stutter are drawn to pass as fluent and mask the significance of their

210 disfluency to avoid the perceived stigma attached to a disabled identity. However, as Reeve  
211 comments, this comes at considerable personal cost:

212           A disabled person who is struggling to emulate the ableist norm, is manufacturing  
213           an identity as non-disabled; this takes emotional energy, is forever at risk of fracture and  
214           exposure and denies access to alternate ways of being in which disability is associated  
215           with diversity, as a site of potential resistance and possibility (2014; p.95).

216 An in-depth analysis of passing and its motivations revealed that people who stutter pass as  
217 fluent in order to access the able-bodied privilege that is denied them when they stutter  
218 (Constantino et al., 2017). If there were no social advantages to fluency, there would be no need  
219 to pass.

## 220 **Barriers to Stuttered Speech**

221           Van Riper, the grandfather of stuttering modification therapy, called stuttering, “a riddle,  
222 wrapped in a mystery, inside an enigma” (as cited in De Nil, 2009) and “at least as complicated  
223 as a multidimensional jigsaw puzzle, with many pieces still missing (Van Riper, 1982)”.  
224 Understanding the processes that disable people who stutter can be just as difficult as  
225 understanding stuttering itself. There is no single process that results in the disablement of  
226 people who stutter. Rather multiple factors play a part. A nuanced application of the social model  
227 will hopefully help us to appreciate some of the disabling barriers at play.

228           Take for example, a person who stutters interviewing for a job. The social model allows  
229 us to appreciate and deconstruct the potential complex and intersecting social, cultural, and  
230 structural barriers that disable people who stutter in this seemingly straightforward situation.  
231 Most tangibly, there may be structural factors about the job interview itself that may disable the

232 person who stutters. Time-limited interviews assume equal access to time through speech (Ellis,  
233 2020; St. Pierre, 2015). This temporal expectation disables disfluent candidates due to the  
234 unpredictability of stuttering, and creates a bias towards fluent speakers. However, structural  
235 barriers can also be more subtle: what if the interview is by phone? The phone is notoriously  
236 difficult for many people who stutter. Moments of stuttering can be misunderstood as poor  
237 connections and dropped calls. Without the mitigating effects of body language, stuttering can be  
238 misunderstood by listeners. Telephone interviews without accommodations can introduce  
239 disabling barriers for people who stutter.

240         The pervasive public stigma around stuttering is also likely to disable people who stutter  
241 interviewing for a job. Employers can perceive people who stutter as being a poor fit for jobs that  
242 involve verbal communication (Butler, 2014). Communication is valued as the most important  
243 employability skill (National Association of Colleges and Employers, 2016) and the stipulation  
244 for ‘excellent communication skills’ and ‘fluent in spoken English’ is routine in many job  
245 specifications today. The concept of ‘excellent communication skills’ can include ideals around  
246 how verbal speech should be spoken, such as coordinating timing of vocal delivery (Clark,  
247 2002), that are likely to clash with stuttering. Likewise, the ‘fluent in spoken English’ criterion  
248 contains a double meaning that people who stutter fail to satisfy. Yet, few positions necessitate  
249 rapid, fluent communication in today’s society. An occasional delay in communication is  
250 unlikely to be detrimental to performance in individual job roles and other communication  
251 attributes are arguably more important. People who stutter at interviews may be disabled by  
252 norms around verbal communication, as well as wider public stigma tropes and stereotypes  
253 around stuttering. This expectation also applies to the profession of speech-language pathology.  
254 Reports exist of graduate students with speech-language disorders being submitted to therapy or

255 being counselled out of the profession (Kittilstved, 2021; Ladavat, 2021). Some countries  
256 reportedly do not even allow those with communication impairments to become speech-language  
257 pathologists (Jandet, 2021).

258           Our appreciation of the exclusions that constitute disability should include those that  
259 work along psychological and emotional pathways. The oppression that disabled people  
260 experience operates on the ‘inside’ as well as on the ‘outside’ (Thomas, 2004). Self-stigma is  
261 common among people who stutter and can be disabling when seeking employment. People who  
262 stutter may perceive themselves as unsuitable for the role in the first place, particularly one with  
263 a high amount of speaking, and may self-select into other jobs (Butler, 2014). Indeed, people  
264 who stutter suffer from role entrapment in the form of vocational stereotyping (Gabel et al.,  
265 2004; 2008).

266           Furthermore, at the interview itself, people who stutter may employ a range of strategies  
267 to pass as fluent speakers and avoid stigma. These ‘avoidance strategies’ can negatively affect  
268 communication, by leading them to choose non-preferred words, abandon sentences that may  
269 have contained a stutter, and use convoluted phrasing to maze their way around possible stutters.  
270 They may even choose not to speak at all. Thus, people who stutter may be disabled at their  
271 interview due to their own attempts to manage their stuttering in a high-pressure situation.  
272 People who stutter pass as fluent in order to access able-bodied privilege; they would not need to  
273 do this in the absence of social stigma (Constantino et al., 2017).

274           These individual disabling barriers are not mutually exclusive and can interact in a  
275 synergistic fashion. For example, a person who stutters during a telephone interview may  
276 experience more self-stigma due to previous negative experiences on the phone. They may then  
277 decide to employ more strategies to camouflage stuttering, or revert to silence, and increase the

278 amount of disability they experience. The relationship between impairment and disability can  
279 also be dynamic. Stuttering may become more frequent when the person who stutters is  
280 experiencing anxiety or nervousness (Blood et al., 1997). If an individual who stutters is placed  
281 in a stressful, disabling situation, like a time-limited interview, their underlying impairment is  
282 likely to increase, potentially leading to further disability if this increased impairment is not  
283 accounted for.

284         The irony, however, is that whether stuttering is or is not disabling remains a contentious  
285 and oft debated issue within the stuttering community (Meredith, 2010). People who stutter are  
286 unlikely to apply for relevant reasonable adjustments to tackle tangible structural barriers, such  
287 as a time-limited job interview, if they do not consider themselves disabled in the first place.  
288 This reluctance to identify as disabled perhaps comes back to the enigma of stuttering. St. Pierre  
289 (St. Pierre, 2012) has described stuttering as a *liminal form of oppression* in that the person who  
290 stutters is not clearly perceived as abled or disabled by society. Similarly, Thomas (1999) talks  
291 of the ‘borderlands’ between the disabled and non-disabled worlds. The inherent variability of  
292 stuttering and the ability of many people who stutter to pass as fluent means the disability never  
293 appears absolute (Constantino et al., 2016; Constantino et al., 2017). Stuttering always appears to  
294 be tantalizingly within the control of the individual, to both the individual themselves and wider  
295 society, if they just applied themselves hard enough (St. Pierre, 2012).

296         Combining this liminal nature of stuttering with the widespread stigma associated with  
297 disability helps us better understand why people who stutter are reluctant to identify as disabled.  
298 This reluctance is disabling in and of itself, as relevant reasonable adjustments are not sought.  
299 Indeed, it can perpetuate a damaging vicious circle in which people who stutter do not recognize  
300 themselves as *disabled enough* to require support. Consequently, disability and inclusion

301 services rarely consider the needs of those who stutter despite the existence of real disabling  
302 barriers, resulting in limited support available and validity for stuttering as disabling when it is  
303 brought to the fore.

#### 304 **Removing barriers and tackling oppression using the social model**

305         The social model highlights that the narrow focus of the medical model may reinforce  
306 and reaffirm social norms and stigma rather than act as a vehicle through which these prevailing  
307 norms can be challenged and renegotiated (Oliver, 1996). The social model invites a dialogue  
308 that extends beyond the focus on individual loss and adjustment. Focusing, instead, on social  
309 change and removing the disabling barriers people who stutter face in their day-to-day life (See  
310 Box 1). As explored above, these barriers are multifaceted and nuanced, and so demand multiple  
311 levels and streams of intervention.

#### 312 Legal protection

313         One of the major successes of the social model has been increasing the accessibility of  
314 society to disabled individuals and enshrining these rights and protections against discrimination  
315 into law. The legal framework that derived from the disability rights movement has proven  
316 beneficial to people who stutter in challenging obvious and tangible discriminatory practices that  
317 make society inaccessible to them. In employment, people who stutter have been successful in  
318 challenging time-limited interviews, as well as making reasonable adjustments once in the  
319 workplace, such as time-off and financial support for stuttering therapy or training courses, the  
320 use of a private room for phone calls and video conference calls, and challenging discriminatory  
321 attitudes in the workplace. Similar successes have been seen in education, such as adjusting time  
322 limits for oral exams, and offering alternative assessment formats (STAMMA/Stammerers

323 Through University Consultancy/London South Bank University, 2021; Stammeringlaw website,  
324 2019). People who stutter have won lawsuits for wrongful termination and employment  
325 discrimination due to their stuttering (Weiner & Tetnowski, 2016).

326 Society today, however, largely remains designed for the fluent speaker. Everyday  
327 interactions - from banks to train station kiosks - are expected to happen in fast fluent tongue.  
328 People who stutter often feel the pressure to conform to these temporal norms. People who  
329 stutter report being actively discriminated against in these interactions, for example being denied  
330 service in a pub for appearing drunk and being detained at an airport (StutterTalk, 2016). The  
331 first author of this paper, a stutterer, has been removed from drinking establishments for  
332 stuttering and mistreated by police because they suspected him of intoxication. A U.S. Customs  
333 and Border Protection agent held a young woman who stutters, Kylah Simmons, because he  
334 thought she was lying about her stutter (for more information see Simmons, 2016). In response  
335 to these and similar situations, The Stuttering Foundation of America worked with Ms. Simmons  
336 to develop a downloadable “I Stutter Card” that identifies the individual carrying it as a person  
337 who stutters.

338 The ableist expectations of everyday interactions have largely remained unchallenged by  
339 people who stutter, however, the social model, and the legislation it has inspired, provides both  
340 means and strategies to change this. For example, this could involve a push for mandatory  
341 training for staff in the services and health industry on how to communicate with and  
342 accommodate people who stutter.

343

344

345 Media representation, role models, and language

346           Establishing stuttering as a viable way of speaking in the eyes of the public and repealing  
347 stereotypes will be crucial to tackling stigma towards stuttering. The media play an important  
348 role in perpetuating the societal stigma around stuttering. Film and television often use stuttering  
349 as a narrative prosthesis to show weakness, evil, or nervousness (Johnson, 2008). To tackle  
350 disabling stigma towards stuttering, there needs to be representation of people who stutter in  
351 which their speech differences serve as more than plot devices. For stuttering, it appears  
352 particularly necessary to move away from the ‘overcoming’ narrative that even pervades more  
353 recent positive and fuller portrayals of stuttering, such as the King’s Speech (Richman, 2020), to  
354 a narrative where stuttering is accepted and respected as a different and legitimate way of  
355 talking. The film *Rocket Science* is a good example of a more nuanced portrayal of stuttering.  
356 The main character learns to accept, rather than overcome, his stutter. Ensuring people with overt  
357 stutters are prominent in society and the media will be crucial in normalizing stuttering and  
358 reducing disability.

359           Moreover, the language commonly used around stuttering in today’s media needs to be  
360 challenged. In newspaper articles, people are typically described as ‘afflicted’ by ‘terrible’  
361 stutters, which adults try to ‘overcome’ or children ‘grow out of’. This language spills over into  
362 stuttering academic literature, such as stuttering being described as ‘intractable’, ‘comorbid’ and  
363 ‘persistent’ in academic articles, drawing from language more typically heard around palliative  
364 care (Alpern, 2019). The social model encourages a different set of words to understand and  
365 describe the experiences of disabled people, such as barriers, stigma and discrimination, that are  
366 less value laden. A 2020 global campaign focused on challenging negative language around  
367 stuttering, such as ‘defect’ and ‘afflicted’, on Wikipedia (STAMMA, 2020). More campaigns to

368 challenge ableist language and insert more affirming and positive language around stuttering into  
369 common discourse and stuttering academic circles will be vital to removing the disabling stigma  
370 attached to stuttering.

371 Therapy

372           The social model deprioritizes individual approaches to managing impairment, instead  
373 placing value on social change to improve the lives of people who stutter. This has a potentially  
374 paradigm-shifting influence on the focus of stuttering therapy and research.

375           Stuttering therapy from a social model perspective engages people who stutter, their  
376 families, friends, work colleagues, and communities in conversations about the dominant and  
377 alternative narratives around stuttering that coexist in society as well as the dynamics of stigma  
378 and self-stigma. This focus on developing cultural competence shifts the focus away from ‘what  
379 is wrong with me’ to critically examining ‘what is wrong with the broader system in which I  
380 live’. People who stutter are invited to ask, “Why does someone who speaks like me encounter  
381 so many barriers in this world?” This opens the door to therapy focusing on creating a stutter-  
382 friendly environment. Reducing social and self-stigma through the recognition, removal, and re-  
383 negotiation of structural, environmental, and attitudinal barriers enable people to live choicefully  
384 and stutter openly, confidently, and without shame. The social model thus empowers people to  
385 request reasonable adjustments at work or in education, to advocate for themselves, and identify  
386 and challenge microaggressions. Introducing people to stuttering activism and the disfluency  
387 pride movement offers opportunities to explore and discover new identities and communities.

388           It is important for therapists themselves to develop their own cultural competence and  
389 identify roles outside of the therapy room in which they can help to challenge and remove

390 disabling barriers, such as in consultancy work for employers and educational establishments, or  
391 involvement in local, regional, or national stuttering awareness programs (see Box 1). Such  
392 collaborations create powerful opportunities to influence societal attitudes as well education and  
393 employment practices. The 2020 and 2021 online Practice Interview events organized by 50  
394 Million Voices (50 Million Voices, 2021) are powerful illustrations of the mutual benefits of  
395 bringing together recruiters and human resources consultants interested in learning more about  
396 stuttering to take part in a briefing and series of practice interviews with people who stutter  
397 across different countries.

#### 398 Research

399 Research in stuttering has historically focused on a biomedical approach. The social  
400 model suggests we focus on identifying and dismantling the causes of disability for people who  
401 stutter, rather than the biomedical causes of impairment. It is positive to note the large body of  
402 work exploring stigma towards stuttering and documenting the barriers people living with a  
403 stutter can experience across multiple domains, such as educational, vocational, social, and  
404 psychological (St. Louis, 2015). However, there are limited complementary studies looking at  
405 evidence-based ways to improve the lives of people who stutter in these domains outside of a  
406 therapeutic or medical setting. For example, while the difficulties and impacts of stuttering on  
407 education have been well researched (Butler, 2013; Daniels et al., 2012; Isaacs, 2020; O'Brian et  
408 al., 2011), there is less work looking into effective strategies to support people who stutter in  
409 education, remove disabling barriers in the classroom, and ensure children who stutter have  
410 equal access to a good education. Best practices for ensuring inclusion of people who stutter in  
411 education, employment, and wider society are largely anecdotal rather than evidence based.  
412 Research is beginning to investigate effective anti-stigma strategies both in society at large

413 (Boyle et al., 2016) and the classroom (Langevin & Prasad, 2012; Weidner et al., 2018), but the  
414 scope, scale and institutional support of this type of research needs to increase for real change to  
415 occur.

416 The social model, taken to its extreme, may be seen to encourage funding towards  
417 biomedical research to be actively re-routed to societal/social interventions. At the least,  
418 appreciating the way society disables people who stutter would encourage a reflection on the  
419 prominence of biomedical research as well the narratives that commonly surround such research  
420 (e.g. a search for a 'cure' or 'fix' for people 'suffering' from speech impairments), which feed  
421 societal understandings of stuttering as an individual defect.

#### 422 Stuttering charities, communities, and activism

423 A prominent success of the social model has been the creation of a coalition of disabled  
424 people under a unifying aim (Shakespeare, 2010). As outlined above, people who stutter have  
425 been reluctant to identify as disabled. However, the social model offers an inclusive way to  
426 conceptualize disability that will hopefully enable people who stutter to identify how they are  
427 disabled and then ask for relevant reasonable adjustments to remove disability - utilizing legal  
428 protections if necessary. Stuttering charities are aligning their aims and mission statements with  
429 the social model of disability (50 Million Voices, British Stammering Association/STAMMA)  
430 and are increasingly looking at innovative ways to help remove societal barriers, particularly in  
431 the workplace via workshops and mentoring (such as 50 Million Voices, National Stuttering  
432 Association, Action for Stammering Children, and the National Stuttering Association). Box 1  
433 gives examples of societal interventions.

434

435 Box 1.

<b>Examples of societal interventions</b>
<ul style="list-style-type: none"><li data-bbox="248 465 1380 674">• <u>Action for Stammering Children</u> - 2018 <i>Stambassadors</i> scheme compiling a collection of video testimonials to connect successful people who stammer from the world of work with young people who stammer; 2021 <i>Stambition</i> mentoring program, both aimed at countering young people who stammer feeling they need to limit their employment choices and ambitions due to ableist norms and expectations around communication.</li><li data-bbox="248 680 1380 853">• <u>50 Million Voices</u> - 2020 and 2021 global virtual <i>Practice Interview events</i>, highlighting the mutual benefits of bringing together recruiters and Human Resources consultants who either stammer or are interested in learning more about stammering to take part in a briefing and series of practice interviews with people who stammer across different countries</li><li data-bbox="248 860 1380 1032">• <u>STAMMA/British Stammering Association</u> - <i>No diversity without disfluency</i> 2021 national campaign to increase the visibility and representation of stammering in the media. <i>Find the right words</i> 2020 a campaign to change the language used around stammering to more neutral terms rather than negative and value-laden pejorative ones.</li><li data-bbox="248 1039 1380 1137">• <u>National Stuttering Association</u> – <i>We Stutter at Work: Stuttering in the Workplace Presentations</i> offers educational presentations to businesses about stuttering and the value that people who stutter bring to the workplace.</li></ul>

436

437 Shakespeare (2010) has noted that the social model has also been effective in improving  
438 self-esteem among disabled people. The medical model places the blame and responsibility for  
439 disability on the individual's body; the social model shifts this blame and responsibility onto  
440 society - crucially altering how the individual is perceived and perceives themselves. Stuttering,  
441 in particular, is often seen as a moral failure (St. Pierre, 2012). Knowledge of the social model in  
442 and of itself can help to reduce the internalized stigma among people who stutter and improve  
443 self-esteem. The social model also redistributes the power present within medical model  
444 conceptions to disabled people themselves, as the disabled become the experts in how to better  
445 their lives.

446 Box 2.

<b>Suggested benefits of the social model</b>
<ul style="list-style-type: none"><li>● Simple to understand and readily applicable to daily life</li><li>● Provides a tool to campaign for and create social change (e.g. in legal protection)</li><li>● Moves focus away from medical rehabilitation that may benefit one onto environmental changes that can benefit many</li><li>● May help to develop novel research methodologies and directions that centralize the experience of disabled people, e.g. participatory and emancipatory research</li><li>● Encourages solidarity between individuals and different impairment groups as disability is a shared social experience</li><li>● Places power in the hands of disabled people, rather than professionals, as they are the experts of their experience of disabling barriers</li><li>● Removes the blame and moral responsibility for disability from the individual</li></ul>

447

#### 448 **Limitations to the Social Model**

449 The social model’s claim that disability is an exclusively social phenomenon strikes many  
450 people who stutter as radical. People who stutter have pushed back against attempts to conceive  
451 of stuttering as a social rather than an individual problem. Most critiques of the model take issues  
452 with its strict separation of impairment, which is biological, and disability, which is social  
453 (Beaudry, 2016). This criticism of the social model is not unique to stuttering and has been  
454 discussed in the literature at length (See Box 2).

455 For example, in response to the publication of *Stammering Pride and Prejudice*, an  
456 anthology that applies the social model to stuttering, one popular stuttering blogger wrote that  
457 the ideas in the book were dangerous because he saw stuttering as, “a serious malfunction that  
458 clearly affects [his] communication. And therefore it is inherently negative. It is a defect and it is  
459 not just ‘bad’ society that creates [it]. It is its neurobiology and maladaptive learned behaviors,  
460 mindset and conditioning [...] I see the real danger that we vilify people who do not agree [with

461 the social model] or [those in the public who] cannot be expected to be expert in how to handle  
462 every condition that affects a minority” (Weidig, 2019). The writer is arguing that stuttering is  
463 inherently painful and seeking to cure it will alleviate more suffering than an accommodating  
464 society. Additionally, by blaming others for our suffering we alienate potential allies.

465         This person who stutters clearly believes the social model does not take seriously the  
466 embodied experience of disability. He would not be the first to level this criticism (Thomas,  
467 2007). Indeed, Shakespeare and Watson (2002) believed that if the discussions about the  
468 problems experienced by individuals ignored impairment issues, disabled people might be  
469 reluctant to identify with the disability movement. Another example of people’s reluctance to  
470 take up the social model due to this impairment-disability demarcation can be seen from this  
471 transcript from Constantino *et al.* (2017), a qualitative study into the experience of passing as  
472 fluent. In response to the question, “What do you think would have to change to make stuttering  
473 be seen as less of a bad thing?” the participant answered:

474         Let [others] think whatever they think, let them do whatever they do. It’s my responsibility to  
475 change myself [...] I think the change has to be from me [rather] than from expecting the  
476 society [to change] [...] You cannot expect things around you to change.

477         The sentiment here is that you can only control what you do and think, as you cannot  
478 control others. This highlights the importance of personal autonomy and the right to access and  
479 engage in rehabilitation and speech modification. People who stutter have accused the social  
480 model of shifting their locus of control externally, putting them at the mercy of society, and  
481 robbing them of agency.

482           Inherent to these criticisms is a rejection of the social model’s fundamental claim that  
483 disability is a social construct. These people who stutter seem to be saying, along with  
484 Shakespeare and Watson (2002), that “people are disabled by society as well as by their bodies”  
485 (p. 11). Another way to put this is that many people who stutter believe that in a perfect world  
486 they would still struggle to speak.

487           An example from the stuttering community illustrates this concept well. Every year the  
488 National Stuttering Association (NSA), the largest self-help organization for people who stutter  
489 in the world, holds an annual conference in the United States. This conference is usually attended  
490 by close to a thousand people who stutter. Here, people who stutter are in the vast majority and  
491 attendees often have a profound experience. Perhaps for the first time in their lives they do not  
492 feel judged for how they talk, after all everyone stutters. They report that their speech becomes  
493 easier and they experience less anxiety talking (Trichon & Tetnowski, 2011). They feel friendlier  
494 and more outgoing (Trichon & Tetnowski, 2011). On its surface, the NSA is a great example of  
495 the social model at work. At the conference, the barriers to stuttered speech are removed. The  
496 attendees experience a profound difference in relation to their stuttering even though they are  
497 speaking the same way they do outside of the conference.

498           There is a caveat to this. Many people who stutter still struggle to speak, even when  
499 speaking to other people who stutter. Removing the barriers in society does not completely  
500 remove the experience of disability: people still struggle (French, 1993). Even in a barrier-free  
501 world, impairment still exists and can be the source of disability (Crow, 1996). Impairments can  
502 make life difficult outside of social discourse (Anastasiou & Kauffman, 2013; Morris, 2014;  
503 Shakespeare, 2013). Stuttering itself can cause physical jaw pain and tension, and the underlying

504 sensation of disfluency may be inherently uncomfortable to some people who stutter. The social  
505 model does appear to have problems meeting these critiques. As Shakespeare writes:

506       The social model so strongly disowns individual and medical approaches, that it risks  
507       implying that impairment is not a problem [...] The social model suggests that people are  
508       disabled by society not by their bodies. Rather than simply opposing medicalization, it  
509       can be interpreted as rejecting medical prevention, rehabilitation, or cure of impairment,  
510       even if this is not what either UPIAS, Finkelstein, Oliver, or Barnes intended. (2010, pp.  
511       269-270).

512       To be clear, mainstream social model theorists never suggested that impairments were  
513       problem-free. As a disabled tetraplegic, Oliver himself appeared frustrated with this accusation  
514       that his model failed to consider the limitations impairments impose. Oliver's defense of such  
515       critiques was to find them outside the scope of the social model. The purpose of the social model  
516       was a tool to focus collective hearts and minds on disabling physical and societal barriers that  
517       can be changed, rather than understand all individual disabled people's experiences and  
518       impairments that may not be amenable to change.

519       Nevertheless, this means people who stutter who consider their experiences of  
520       impairment important in creating disability will need to consider alternative frameworks. Likely,  
521       this will be people who find the experience of stuttering unpleasant and painful. They may look  
522       to understandings such as those introduced by Thomas (1999) of 'impairment effects' to describe  
523       the embodied consequences of impairment. Those who seek to find pride and solidarity in the act  
524       of stuttering, however, may similarly find the social model lacking due to its limited ability to  
525       create a positive appreciation of stuttering and their disfluent identity. The model only allows

526 disabled people to appreciate the ways in which society's construction makes their lives more  
527 difficult. Indeed, some members of the Deaf community have resisted the social model due to it  
528 not offering an understanding of deafness that includes the cultural and personal benefits of  
529 being Deaf (Lane, 2010). People who stutter may also need to look elsewhere to understand their  
530 experiences of disfluency as a source of spontaneity, creativity, and culture (Boyle et al., 2016;  
531 2019; Constantino, 2016; 2019).

532         Some people who stutters' refusal to take up the social model likely comes down to their  
533 hope for a cure. People who stutter may worry that a focus on society distracts from the ultimate  
534 goal of curing stuttering. When surveyed, an equal number of people who stutter would choose  
535 fluency as those who would choose freedom from having to think about their speech  
536 (Venkatagiri, 2009). Many people who stutter desire fluency. While social model theorists may  
537 implicate this desire as evidence of societal oppression, it nonetheless exists. It is not obvious  
538 why one desire is any more socially constructed than another. When told that they value fluency  
539 because of ableist discourses, they may reply that we do not value fluency because of anti-ableist  
540 discourses. When desire becomes relative it is difficult to prove one is better than another. Those  
541 of us who are passionate about stuttering and social change may also need to bear in mind that  
542 not everyone wants to be a disability radical. Some people just want to be ordinary, not different.  
543 They want to downplay the significance of their impairments and seek a mainstream identity  
544 (Finlay & Lyons, 1998; Shakespeare & Watson, 2002).

545         Even if a cure is not on the minds of those who criticize the social model, suggesting that  
546 all disability related to stuttering stems from society without taking into account impairment  
547 effects will continue to isolate people who stutter who are seeking changes to how they speak.  
548 People who stutter can already make significant changes to how they speak (Manning &

549 DiLollo, 2018). Whether these changes come through self-help networks, self-education, or  
550 stuttering therapy, people who stutter value them (Plexico et al., 2005). If people who stutter  
551 perceive the social model as asking them to pick a side (e.g. either society changes or I change),  
552 they may reject it. They may ask why they cannot both seek to maximize function and reduce the  
553 social impact of stuttering. They may see, “no reason why appropriate action on impairment –  
554 and even various forms of impairment prevention – cannot coexist with action to remove  
555 disabling environment and practices” (Shakespeare & Watson, 2002, p. 15). Thus, rather than  
556 adopting a singular position that holds the medical and social model in direct opposition, an  
557 appreciation of the plurality of these different perspectives may be preferred, and progression  
558 towards more nuanced and multi-dimensional understandings of disability.

559

560 Box 3.

<b>Common criticisms of the social model</b>
<ul style="list-style-type: none"><li>● Does not recognize or engage with the embodied experience of impairment</li><li>● Can be perceived as discouraging evidence-based medical approaches to maximize function and improve quality of life</li><li>● As disability is all about oppression, it hinders creating a positive self-identity and finding the potential gains of perceived impairments</li><li>● Resources are finite so the barrier-free utopia implicitly hoped for by the social model is an unsustainable myth</li><li>● Sees disabled people as a monolithic group and is unable to incorporate other important social identities into its framework, e.g. race, gender, and sexuality.</li></ul> <p>Suggested further reading: Shakespeare and Watson, 2002; Owens, 2015; St. Pierre, 2019</p>

561

562

563

564 **Future Progress**

565           The social model has had a profound impact on disability studies, but so far minimal  
566 impact on stuttering academia. This is surprising given the significance of public and self-stigma,  
567 as well as the myriad disabling barriers identified in the stuttering literature. While the social  
568 model is neither perfect nor complete, it is a useful tool for understanding how society creates,  
569 maintains, and exacerbates the disablement of people who stutter. It is simple to understand and  
570 apply. This ease of use helps people who stutter to see that much of their experience with  
571 stuttering is not their fault. The emphasis on social rather than individual change can save  
572 individuals both time and money by directing attention from self-improvement through therapy  
573 to political action. The focus on societal barriers also makes concrete what needs to change in  
574 society to allow people who stutter equal access to opportunities readily available to fluent  
575 speakers. This facilitates political movements and organizing campaigns, which can generate  
576 solidarity between people who stutter and other disabled people. It allows people who stutter to  
577 see themselves engaged in a common struggle for equal rights and access. There is strength in  
578 numbers; more can be accomplished by joining in solidarity with other disabled people than by  
579 going it alone. Finally, the distinction between impairment and disability theoretically frees  
580 stuttering from necessarily leading to reduced quality of life.

581           Nonetheless, the social model has shortcomings and people who stutter have rightfully  
582 criticized it. There are two main critiques. The first is that the strict separation between  
583 impairment, which is biological, and disability, which is social, is untenable. Many in the  
584 stuttering community argue that disability is both biological and social. People who stutter are  
585 disabled by the embodied experience of their impairment as well as stigma and discrimination.  
586 Stuttering can make speech exhausting, sometimes painful, in even the most accommodating of

587 circumstances. This leads to the second critique: there are approaches to mitigating this pain and  
588 discomfort that the social model would deemphasize. The speech-language pathology literature  
589 demonstrates the positive results of therapy. Therapy might not always increase fluency but it  
590 can improve the experience of stuttering. People who stutter have argued that the social model's  
591 neglect of the individual for the social puts the person who stutters at the mercy of society and  
592 robs them of agency. It suggests that the people who stutter must continue to be a victim of  
593 ableism until society changes. Finally, the social model construes both impairment and disability  
594 as negative. While the separation of impairment from disability frees impairment from  
595 necessarily causing disability, it leaves it unexamined. What we consider an impairment is just as  
596 socially constructed as what we consider a disability. This separation is both arbitrary and  
597 unhelpful for creating new and positive meanings around stuttering.

598         Despite its shortcomings, we believe the social model is an important first step towards  
599 developing a more liberating theory of stuttering. Individually and together, we have given  
600 multiple talks internationally about the social model and stuttering and people who stutter are  
601 always interested about these ideas and ask for more information. Yet, there is scarce literature  
602 that puts the stuttering and the social model in conversation. Therefore, we see this paper as a  
603 stepping-stone, the start of a conversation that can help realize the potential gains of the social  
604 model in stuttering as well as address its limitations. People who stutter have asked for a  
605 conceptualization of stuttering that acknowledges the embodied difficulty of stuttering and that  
606 preserves their agency, allowing them to make changes to their speech if they wish.

607         There are promising models of disability that can accommodate these requests to some  
608 degree. Academics working from *relational models of disability* are often addressing the social  
609 model critique that impairments can be disabling without barriers (Kafer, 2013, Garland-

610 Thomson, 2011, Thomas, 1999). As Kafer puts it, “People with chronic illness, pain, and fatigue  
611 have been among the most critical of this aspect of the social model, rightly noting that social  
612 and structural changes will do little to make one’s joints stop aching or to alleviate back pain...  
613 Focusing exclusively on disabling barriers, as a strict social model seems to do, renders pain and  
614 fatigue irrelevant to the project of disability politics” (2013, p. 7). Relational models are neither  
615 purely medical – they do not see disability as resulting straightforwardly from bodily pathology –  
616 nor purely social – they make no distinction between impairment and disability. Instead of  
617 appealing to these binaries, relational models see pain, fatigue, and other embodied experiences  
618 (e.g., effortful speech during stuttering) as well as socially constructed desires for certain body  
619 types and societal barriers as all constituting disability. From this perspective a strict social  
620 model is untenable because, “it overlooks the often-disabling effects of the body ... [and  
621 because] ... both impairment and disability are social” (Kafer, 2013, p. 7). Disability is not an  
622 attribute of a body but is rather an event that occurs when certain bodies encounter certain  
623 situations, environments, and attitudes. It is a misfit between a body and the conditions in which  
624 it finds itself (Garland-Thomson 2011). Disability, therefore, is a dynamic identity that changes  
625 over time and in different circumstances.

626 Another promising conceptualization of disability is the neurodiversity paradigm, which  
627 finds value in the diversity of brains and believes the idea of a normal neurotypical brain is  
628 socially constructed (Jaarsma and Welin 2012). This paradigm promotes positive identity  
629 formation around neurodiversity and stresses the benefits to society of embracing all neurotypes  
630 (Singer, 1998, 1999). Importantly, neurodiversity advocates recognize that all neurotypes come  
631 with strengths and vulnerabilities. This allows individuals to harness the strengths of their  
632 neurodiversity while still working on areas they feel would improve their quality of life (Kapp et

633 al. 2013). Recent work has already put neurodiversity and stuttering in conversation with each  
634 other (Constantino 2018; Gillespie-Lynch et al. 2020).

635 A similar concept that emerges from the lived experiences of people who stutter is  
636 stuttering gain (Constantino 2016). Stuttering gain suggests that we do not need to medicalize  
637 our stuttering nor do people who stutter need to seek a homogenized experience of speaking  
638 found in fluency. Rather, there are valuable experiences we have while stuttering that we would  
639 not have if we were fluent. These experiences represent a gain that sits alongside the challenges  
640 that can also accompany stuttering. Stuttering is not a one-dimensional negative experience, but  
641 is complex, offering both benefit and adversity, like most other human attributes. Articulating  
642 what we gain from stuttering helps us embrace diversity between individuals and move away  
643 from the binary distinction between the impaired and the able-bodied. This empowers people to  
644 see their stuttering as a natural variation in speech, their unique voice among thousands of  
645 possible speech patterns. These developments have paved the way for a nascent ‘stuttering pride  
646 movement’ that opens up the potential for people who stutter to create their own novel frames of  
647 reference to conceptualize their experiences (Aston, 2020; Ellis, 2020; Isaacs, 2020; Kittilstved  
648 et al., 2020 St. Pierre, 2015).

649 These new ways of thinking build on the foundation provided by the social model’s  
650 attempt to separate the construct of impairment from disability, as well as ensuing critiques of  
651 this separation. We encourage researchers and speech-language therapists to engage with these  
652 alternative models of disability, however far and counterintuitive from their current  
653 understandings of stuttering they may appear. We are hopeful that through such dialogue we can  
654 not only find ways to improve the lives of those who stutter, but also reveal what stuttering can  
655 teach us about ourselves and the world.

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