



## Coping with a child who stutters: A phenomenological analysis

Laura W. Plexico\*, Embry Burrus

Auburn University, United States

### ARTICLE INFO

#### Article history:

Received 17 August 2011  
Received in revised form 12 June 2012  
Accepted 14 June 2012  
Available online 23 June 2012

#### Keywords:

Parenting  
Coping  
Stress  
Stuttering

### ABSTRACT

Qualitative methods were used in the form of a phenomenological analysis to explore how families cope with having a child who stutters. Twelve participants, 2 men and 10 women, who have children who stutter participated in this study. The participants were asked to consider their experiences with being the parent of a child who stutters. Analysis of these data resulted in 3 primary categories. The results indicate that parents experience and cope with stresses associated with being the parent of a child who stutters. The participants described feelings of uncertainty and concern as well as the desire to do what is best for their children. Results highlight the importance of providing information and avenues of support that will help parents more effectively cope with having a child who stutters.

**Educational objectives:** The reader will be able to: (a) describe, from the perspective of a parent of a child who stutters, the themes associated with the process of coping with a child who stutters, (b) describe types of coping resources, (c) describe the factors that influence the choice to use emotion-focused and problem-focused coping strategies, and (d) describe four specific areas to consider when providing resources for families of children who stutter.

© 2012 Elsevier Inc. All rights reserved.

### 1. Introduction

Past research on parents of children who stutter has focused on goal-setting behaviors, parental reactions to stuttering and parental environment (e.g., Bloodstein, Jaeger, & Tureen, 1952; Goldman & Shames, 1964; LaFollette, 1956; Meyers & Freeman, 1985). There is currently no research to indicate the degree or nature of stress experienced by parents of children who stutter. We do not have a clear understanding of the extent to which the symptomatology of stuttering itself, the diagnostic process, a concomitant disorder, or any associated problems (e.g., bullying) result in parental stress. There is some evidence to suggest that parents can experience some stress when they are involved in the therapeutic process (Goodhue, Onslow, Quine, O'Brian, & Hearne, 2010; Hayhow, 2009; Packman, Hansen, & Herland, 2007). The paucity of stress and coping research is unfortunate because the experience of parenting a child who stutters could be stressful or challenging for many parents. And if stress is experienced, our understanding of how parents cope with that stress is limited.

Research has demonstrated that families of children with disabilities experience higher levels of stress or distress when compared to the families of typically developing children (Bailey & Smith, 2000; Kazak & Marvin, 1984). They have also been found to encounter a variety of challenges such as overcoming the disappointments associated with diagnosis, managing health and educational networks, and guiding their children toward being a successful adult (Floyd, Singer, Powers, & Costigan, 1996; Glidden, 1989). Further difficulties encountered by parents of children with disabilities include feelings of

\* Corresponding author at: Department of Communication Disorders, 1199 Haley Center, Auburn, AL 36849, United States. Tel.: +1 334 844 9620; fax: +1 334 844 4585.

E-mail address: [lwp0002@auburn.edu](mailto:lwp0002@auburn.edu) (L.W. Plexico).

anxiety, tension, isolation, anger, overprotection, resentment, and sadness, as well as the need to increase control within the family unit (Lardieri, Blacher, & Swanson, 2000). The parents of children with disabilities face the challenge of coming to terms with a problem of which they most likely have a poor understanding, whether illness or disability, and learning how to manage or cope with the problem. Research has shown that when faced with a challenge or stressor individuals use a variety of different coping strategies to manage the stressor.

### 1.1. Models of coping

Models of coping are commonly used in research to understand the coping processes or strategies associated with a particular phenomenon or stressor. The process or transactional model of stress and coping emphasizes the way in which individual's cope with stressors in an effort to maintain well-being (Lazarus & Folkman, 1984) and is recognized as the most thorough model for understanding the processes of stress and coping (Beresford, 1994; Coyne & Smith, 1991). Lazarus and Folkman (1984) defined coping as "the process of managing demands (external or internal) that are appraised as taxing or exceeding the resources of the person" (p. 283). Within this model, coping is viewed as a recurrent and ongoing process. Coping is evaluated in terms of how a stressful event is appraised by the individual, and then in terms of the way in which one manages the problem. Appraisal refers to how a stressor is perceived or judged by the individual. The way in which a stressor is appraised will influence the coping strategy used. Therefore, within the transactional model the efficacy of a coping strategy is evaluated in terms of the match between the stressor, its appraisal and the chosen coping strategy rather than in terms of mastery of a problem (Lazarus & Folkman, 1984).

Coping strategies, or any cognitive or behavioral effort used to manage a source of stress, may be one way parents of children who stutter adapt to the stresses associated with stuttering. Coping strategies can be *problem-focused* or *emotion-focused* in nature (Lazarus & Folkman, 1984). The type of coping strategy used is influenced by whether the source of stress is appraised as chronic (i.e., requiring endurance) or manageable. If an individual thinks they can constructively manage a stressor, problem-focused coping is often used to reduce the impact of the stressor, whereas emotion-focused coping is used more often for stressors appraised as chronic (Carver & Scheier, 1994; Carver, Scheier, & Weintraub, 1989; Folkman, 1992). Problem-focused coping efforts are associated with efforts to actively control or modify internal or external stressors, while emotion-focused coping efforts are often more defensive and avoidant in nature (Lazarus & Folkman, 1984).

Generally speaking, problem-focused coping strategies such as problem solving, confronting the source of stress, and seeking support are more effective and associated with less psychological distress, greater adjustment, and more positive outcomes. Conversely, emotion-focused coping strategies such as denial, avoidance, and minimization are generally viewed as less effective and associated lower levels of adjustment and more negative outcomes. This trend has been demonstrated in research on parents of children with disabilities (Essex, Seltzer, & Krauss, 1999; Gavidia-Payne & Stoneman, 2006; Glidden & Natcher, 2009; Hastings, Kovshoff, Brown, Ward, & Espinosa, 2005; Judge, 1998; Kim, Greenberg, Seltzer, & Krauss, 2003; Sloper, Knussen, Turner, & Cunningham, 1991). An exception to this outcome is that coping strategies such as positive re-appraisal and reframing, which are considered emotion-focused in nature, can increase well-being and generate positive outcomes (Glidden, Billings, & Jobe, 2006; Glidden & Natcher, 2009; Hastings, Allen, McDermott, & Still, 2002). Generally speaking, coping efforts cannot be compartmentalized into a good-bad dichotomy. The effectiveness of a given coping effort, whether problem-focused or emotion-focused, needs to be evaluated in terms of its appropriateness in the face of a given stressor.

It is important to understand the stressors that parents of children who stutter face and the ways in which parents have coped. This work has implications for understanding and improving parent training and the therapeutic process. The purpose of this phenomenological study was to focus on a group of parents who are coping with having a child who stutters, with the goal of describing *in detail* the underlying factors that may be relevant to this phenomenon. The primary question to be investigated in this study was stated as: What is the essential structure of coping with being the parent of a child who stutters? The specific goals of this study were to:

- (1) Develop an understanding of what parents of children who stutter actually think or do to cope with their child's stuttering.
- (2) Develop a perspective on the functions that the coping strategies serve.
- (3) Develop a perspective on the impact that coping choices have on the child who stutters and the parent.

## 2. Methods

A phenomenological qualitative research approach was used as the method for understanding the coping experience for parents of children who stutter (Cresswell, 1998; Moustakas, 1994). Questions formed from a phenomenological perspective are aimed toward developing a description of the essence of the experience being investigated. The essence is a core meaning derived through the evaluation of shared experience over time and across several different situations (Moustakas, 1994). The researcher arrives at this essence by studying the everyday lived experiences of persons who have experienced the phenomenon of interest. The essence should capture how the participants make sense of the events and accounts being explored (i.e., being the parent of a child who stutters) and should convey an empathic understanding of how the participants were making sense of their experiences (Smith & Osborn, 2008). The participants' views and experiences are paramount

**Table 1**  
Description of participants.

Name	Age	Race	Highest level of education completed	Occupation	Gender	Child's stuttering severity	Child's age	Child's therapy
P01	44	African American	High School	Electrician	Male	Moderate	11	School
P02	32	Caucasian	High School	Housewife	Female	Moderate	6	2 yrs School
P03	30	Caucasian	Undergraduate Degree	Housewife	Female	Moderate	7	3 yrs School and Private
P04	31	African American	Graduate Degree	Housewife	Female	Moderate	6	3 yrs School and Private
P05	25	African American	Junior High School	Housewife	Female	Moderate	5	2 yrs School and Private
P06	41	Caucasian	Undergraduate Degree	Office Manager	Female	Moderate	10	School
P07	45	Caucasian	Undergraduate Degree	Housewife	Female	Mild	14	5 months Private
P08	39	African American	Undergraduate Degree	Beautician	Female	Moderate	7	3 yrs School and Private
P09	43	Caucasian	Undergraduate Degree	Data Analyst	Female	Moderate	7	1 yr Private and School
P10	49	Caucasian	High School	Sales	Female	Mild	8	1 yr Private
P11	31	African American	Undergraduate Degree	Realtor	Male	Mild	6	Private
P12	29	African American	High School	Banking	Female	Moderate	8	1 yr Private

because it is believed that those who have experienced the phenomenon being studied are most suitable for providing comprehensive descriptions about the phenomenon being studied (Moustakas, 1994).

## 2.1. Participants

Both general and specific criteria were used to select participants for this study. In general, participants needed to be able to (a) provide rich descriptions of the phenomenon, (b) adequately communicate their experiences with the phenomenon, and (c) be willing to fully share their experiences about the phenomenon. Specifically, participants needed to (a) be the parent of a child who stutters, (b) be coping with a child who stutters, and (c) be over 19 years of age. Exclusion criteria included the presence or history of a psychiatric disorder or language disorder.

The participants in this study include 2 men and 10 women who self-reported that they were the parents of a school-aged child who stutters who had recently or was currently receiving speech services for a fluency disorder. The participants are diverse in their age, ethnicity, and occupations, as well as their child's severity of stuttering, age and gender. This diversity is optimal because the data that result from a diverse sample is more likely to represent a broader range of experiences and be more all-encompassing of the phenomenon being investigated (Patton, 2002). The participants ranged from 25 to 49 years of age ( $M = 36.58$ ,  $SD = 7.77$ ) and lived in Alabama or Tennessee at the time of the study. Six of the participants were Caucasian and 6 of the participants were African-American. All of the children of the parents included in this study were between the ages of 6 and 14 ( $M = 7.92$ ,  $SD = 2.57$ ) and were currently or had previously received school or private therapy for stuttering. One of the participants held a graduate degree, 6 held an undergraduate degree, 4 completed High School, and 1 completed Junior High School. Their occupations included electrician, housewife, office manager, beautician, data analyst, sales representative, realtor, and banker (see Table 1 for an overview of the participants' demographic information).

## 2.2. Procedure

### 2.2.1. Recruitment

Participants were recruited through either personal contact of the researcher, through word of mouth, or through personal contact of regional clinics and fluency programs. Participant recruitment continued until saturation was reached. Saturation was reached when the addition of new interviews did not lead to new understandings, which indicates that data collection is complete (Glaser & Strauss, 1967).

### 2.2.2. Interview

Each of the 12 participants took part in one semi-structured interview. All of the interviews were conducted by the first investigator who has received training in qualitative interviewing. The interviews lasted approximately one hour and took place in a quiet private location. The interviews did not have a pre-established time frame and took as long as it was necessary for the interviewer to feel that she had adequately captured the phenomenon of interest. The interviewer used a series of open-ended questions and unplanned prompts to elicit the participants' personal experiences with the process of coping with having a child who stutters. The open-ended questions were worded in a manner that would bring forth

the participants' personal experiences without imposing any biases from the interviewer. The interviewer constructed and made use of an interview guide to facilitate the interview process.

The interview questions outlined in the interview guide were used to elicit the ways in which parents physically, emotionally and cognitively manage the experience of having a child who stutters. The questions were developed after a review of the coping literature and were designed to elicit specific coping behaviors, the way in which specific coping behaviors influence outcome, and the effect that different contextual factors can have on the process of coping with having a child who stutters. The participants were allowed as much time as they needed to respond to each of the interviewer's questions. When necessary the interviewer also used unplanned prompts to elicit further elaboration on a topic or to check general understanding of what the participant described. To enhance the depth and dependability of the data, the interviewer frequently asked the participants to ground their comments by providing specific situational examples. Each of the interviews was recorded on a high quality digital audio recorder. Each recording was then transcribed and analyzed following the procedures outlined in the following section.

### 2.3. Analysis

Moustakas (1994) and Colaizzi's (1978) approach was used to conduct the data analysis. Their process of inquiry promotes a part to whole analysis of the participants' experiences and is widely used in phenomenological research. The analytical process can be broken down into a series of seven steps.

1. First, each of the investigators read the participant's interview transcript to acquire an naïve understanding of the ideas put forth by the participant and to facilitate a more holistic view of the participant's experience during the analysis process.
2. After reading the transcript, it was divided into meaning units and each meaning unit reflected a significant statement and one main idea that related to the question of interest. A new meaning unit is created each time the investigator perceived a transition in meaning.
3. Once the meaning units were identified, a keyword or phrase was assigned to each meaning unit that best reflected the formulated meaning behind the significant statement in each meaning unit.
4. After the meaning units were identified and coded, the researchers used the constant comparative method (Patton, 2002) to develop categories that represent recurrent themes across participants. The constant comparative method was used because it encourages the investigator to identify commonalities among the themes by comparing each meaning unit with every other meaning unit.
5. After the recurrent themes have been identified the investigator integrates the resulting themes into a rich description of the phenomenon being investigated. In other words, the investigator writes a description of "what" the participants' experienced and "how" the experience unfolds.
6. After a rich description of the phenomenon has been developed, the investigator reduces the rich description into a composite description of the essential structure of the phenomenon.

### 2.4. Credibility

Credibility was addressed according to the procedures used by and outlined by Cresswell (1998) and Patton (2002) to enhance the rigor and quality of the analysis process.

1. All interviews were tape-recorded with a high quality digital recorder and transcribed verbatim.
2. Staying within the tradition of phenomenological analysis, the researchers took on the perspective of *Epoche*. "Epoche is a Greek word meaning to refrain from judgment, to abstain from or stay away from the everyday, ordinary way of perceiving things" (Moustakas, 1994, p. 33). The process of Epoche requires the researchers to address and become aware of and suspend their personal biases, viewpoints, and assumptions regarding the phenomenon of interest. With Epoche, the researchers were able to approach the data in its pure form with an open mind without imposing any a priori judgments. The 2 investigators identified and attempted to suspend their personal biases and preconceptions at the outset of the investigation.
3. Saturation was achieved. The validity and credibility of the findings is enhanced when data collection continues and new participants are added until no new information is obtained from the addition of a new sample. In other words, you sample "to the point of redundancy" (Lincoln & Guba, 1985, p. 202).
4. Triangulation was used to check for any inconsistencies in the findings. Triangulation can enhance the credibility of the findings because it can bring forth any weaknesses in the conclusions drawn. The process of identifying weaknesses in advance enhances credibility because the researcher is then afforded the opportunity to develop deeper insight into the phenomenon of interest (Patton, 2002). For this study, triangulation was accomplished through multiple analysts. The first investigator in this study is a fluent speaker with no history of stuttering, had a Ph.D. in speech-language pathology, and has eight years of experience in the area of fluency disorders. The second investigator is a person with a history of stuttering, a clinically certified speech-language pathologist with a MCD, and ten years of experience in the area of fluency disorders. A graduate assistant also participated in data analysis. She is a fluent speaker with no history of stuttering and was pursuing a graduate degree in speech-language pathology at the time of the study. Participant inquiry was also

**Table 2**

The 3 categories and number of the participants, out of 12, who contributed meaning units to each subcategory.

---

1. Uncertainty about nature and cause of stuttering
1.1. Parents question typicality of child's disfluencies and the child's ability to overcome stuttering (N = 11)
1.2. Parents experience a lack of certainty over cause and cure of stuttering and whether it should be acknowledged at home (N = 12)
1.3. Coping with child's stuttering results in feelings of uncertainty because it is persistent yet variable and can get more complex with time (N = 7)
2. Coping strategies used to manage stuttering
2.1. Nonprofessional management strategies used by parent to address child's stuttering (N = 11)
2.2. Parents want their child to speak more fluently and therefore seek professional help as a way of coping with child's stuttering (N = 12)
2.3. Personal experience with stuttering is advantageous when having a child who stutters (N = 9)
3. Parents cope with fear that their child will have negative experiences or live a restrictive lifestyle
3.1. Parental concern that child will live a restrictive lifestyle or experience negative emotions as a result of stuttering (N = 12)
3.2. Active parental involvement is necessary to protect the child from negative experiences and manage bullying (N = 11)
3.3. Parent has to manage the reactions of friends and family to child's stuttering (N = 12)

---

attempted. However, none of the participants completed and returned a questionnaire on the appropriateness of the essential structure and derived categories.

### 3. Results

The primary purpose of this study was to develop an increased understanding of the ways in which parents cope with having a child who stutters. To accomplish this task, 12 parents of children who stutter were interviewed. They provided rich descriptions of their experiences that informed the development of a description that outlines the essential structure of the experience of being the parent of a child who stutters. The first level of analysis involved the extraction of 1840 meaning units from the interviews provided by the participants. After the meaning units were extracted and coded, the constant comparative method was used to find commonalities across the meaning units and resulted in the identification of 3 categories and 9 subcategories (see Table 2 for a list of the categories and subcategories).

#### 3.1. Uncertainty about nature and cause of stuttering

##### 3.1.1. Parent questions typicality of child's disfluencies and his or her ability to overcome stuttering

Eleven participants contributed meaning units to this subcategory. This subcategory resulted from the participants' descriptions of (a) how there was an initial lack of certainty over the typicality of observed disfluencies and whether the child's disfluencies would persist, (b) how they initially thought or hoped the child would outgrow stuttering, (c) the process of their child receiving a formal diagnosis of developmental stuttering, and (d) concern over whether the child would be able to overcome stuttering. At the onset of stuttering, the participants indicated that they were uncertain about whether the disfluencies they were observing were typical for young children or something they should be concerned about. P4 stated,

It was a very tense situation, just for everybody because we didn't know what was going on. Like, is this something really serious? Or should I just keep waiting? You know, everybody kept telling me, "Oh, you know kids do that all the time." But it just didn't seem like something that would still be going on if it wasn't going to be an ongoing issue.

In addition to not being certain about the typicality of their child's disfluencies, the participants indicated that they had thought and hoped that their child would outgrow the disfluency. Doctors, family, and friends told the participants that the disfluency they were observing was probably nothing to be concerned about, that it was "just a phase" (P12), and the child would "probably just grow out of it" (P2). However, when stuttering persisted and was appearing to progress, the participants indicated that they realized "it's not a game now" (P11) and began to question whether the child would outgrow stuttering and began to seek services.

##### 3.1.2. Parent experiences a lack of certainty over cause and cure of stuttering and whether it should be acknowledged at home

Eight participants described how, despite a strong desire to know, they continued to feel a lack of certainty over the cause of stuttering and whether there was a cure for stuttering. When asked to speculate about the cause of stuttering, the participants associated the onset of stuttering with a trauma or traumatic event that had occurred in the child's life, heredity, nervousness, and being mentally slow or advanced. After speculating about the possible cause of stuttering, the parents expressed some dissatisfaction about not knowing what brings about stuttering and that no one else seemed to have the answer either. The participants also indicated that they would like to know "Is it going to go away?" (P9). While most of the participants indicated that they knew that there was no guaranteed cure for stuttering, they wished they had a better understanding of the disorder, the treatment options, and the likelihood of whether it would persist.

All twelve of the participants also discussed whether or not they thought stuttering should be discussed within the home environment. Ten of the twelve participants indicated that they currently felt or at one time felt that stuttering should not be acknowledged in the home environment. The reluctance to discuss stuttering at home resulted from fear that it would make their child feel uncomfortable or embarrassed about talking at home. They also felt that if there was nothing they could do about it, then they should not bring it up. And when stuttering was acknowledged it was not referred to as stuttering. The

participants were more comfortable with an alternative term like bumpy speech or they would direct the child to modify their speech in some way. For example, P12 stated,

We don't talk about it at all. Um, like when we leave here we don't talk about, you know, what happened in class, but we do tell them, you know, to use like their easy speech. Smooth it out. Don't be in a hurry. But we don't really talk about it.

Two of the participants, who also stuttered, indicated that they openly discussed stuttering at home and felt it was important to let their child know that "It's okay to have a stutter" (P10). Some of the participants indicated that they did discuss stuttering with their child when their child questioned them about their speech. P2 responded to her little boy in the following manner,

I've told him that, you know God makes us all differently. You know, and like his dad and his brother, have glasses. You know, I say, "Some people have trouble with their vision and they need glasses or they're even blind. And some people have trouble with hearing, and so they need hearing aids. And some people have trouble walking and have to have a wheelchair." You know, and so I just told him, "And some people have trouble speaking, and you know, it doesn't mean you are a bad person, or that I'm a bad person, it's just that's the way that we're made, and that's where we have more trouble."

Other participants indicated that when their child began to receive speech services that they became more comfortable asking their child to modify their speech. However, all but three of the participants were uncomfortable with the idea of discussing with their children how they felt about stuttering.

### 3.1.3. *Coping with a child who stutters results in feelings of uncertainty because it is persistent yet variable and can get more complex with time*

Seven participants contributed meaning units to this subcategory. The participants described how, as their children got older, stuttering appeared to get worse and managing their speech and environment was becoming increasingly more complex. The participants indicated that knowing the problem was persistent and a problem they could be helping their child manage for an unknown length of time was challenging and caused them to feel overwhelmed and sad at times. They were uncomfortable with the idea that there is not a clear end point to the process of coping with a child who stutters. P4, in particular, struggled with this issue. She stated,

... if I know it's going to be just like a finite period for them, it's a lot easier for me to sort of deal with that. Only because for myself, I deal much better with things that are, even if it's really rough, if it's only gonna be for a short period of time. It's easier for me to deal with that, than something that I can see it being like a chronic thing.

## 3.2. *Coping strategies used to manage stuttering*

### 3.2.1. *Nonprofessional management strategies used by parents to address child's stuttering*

The participants ( $N = 11$ ) described several strategies that they used to manage their child's stuttering. Prior to receiving speech services, the strategies predominately used by the participants included instructing the child to slow their rate of speech, instructing the child to breathe, telling the child to think about what they are going to say, actively listening to the child, providing the child their undivided attention, and reducing time pressure. Verbally instructing the child to slow down and/or think about what they are going to say were the two most frequently used strategies. Nine of the participants described how they would relay to their children that they are actively listening and providing their undivided attention to reduce time pressure and mitigate frustrations with their speech. More specifically, they made a point to be calm, increase eye contact, and let their children finish what they were saying and not speak for them. The participants' intentions were to make sure their children did not feel rushed or pressured. P4 described how she tries to reduce time pressure when she stated,

So I started really focusing on . . . , letting them know we have a lot of time, and you know, you don't have to feel pressure to go ahead and say what you have to say, or just being more mindful of that. . . . So, you know they didn't feel like they had to hurry up and talk, or hurry up and get the thoughts out.

The participants indicated that they used these strategies because they often could not understand what their child was saying, which would cause both them and the child to get frustrated. For example, P12 stated,

I really want to listen to them. But then they stutter so fast, and it gets so difficult for them to say it, then you know it confuses me. And I'll be like 'Okay, slow down, stop talking, and calm down and then tell me.'

In addition to encouraging their children to modify their own speech, the participants described how they tried to alter some of their own behaviors in an effort to make things easier for their children. Two of the participants described how they tried to be more mindful of their own speech rate as an effort to provide a good model. Five of the participants indicated that they felt a personal responsibility to provide their children with an ample amount of verbal and non-verbal reassurance and encouragement as a form of support. They discussed the importance of instilling confidence and self-esteem and felt

that through those efforts their children would be better adjusted and able to handle any difficulty or challenge they were presented with. They also did not want their children to feel as if they had to face any problem alone. The participants indicated that they wanted to assure the child that it is “okay” and that they are there for them. For example, P11 told her child that “Whatever the problem you go through, mom and dad [will] always be here. So don’t feel that you have to go through this problem alone.”

All of the participants also discussed the ways in which having a child who stutters could be difficult and challenging. One of the most prominent barriers the participants experienced was that “It requires a lot of time and a lot of mental effort” (P6). Specifically, it takes time and effort to get the child what they need and it takes more time and effort to listen to the child. Some of the participants described the process of listening to their child speak as “overwhelming,” “frustrating,” and “confusing.” P2 described how it takes a conscious effort to listen to what the child is saying versus always paying attention to how the child is speaking. She stated,

I have to be careful that when he’s talking to me that, you know, I’m thinking about what he’s saying and not, you know, how he’s saying it. Because obviously the most important thing is what he’s saying to me. I want to help him, but I don’t want to, you know, for that to always be a focus when we talk, either. And so I’m trying to find the good balance in that.

In addition to requiring effort, the participants also indicated that having a child who stutters requires patience. The participants discussed how, because understanding their child’s speech could be challenging at times, they made a conscious effort to be patient and stay calm so their child could say what they wanted to say without interruption.

### 3.2.2. *Parents want their child to speak more fluently and therefore seek professional help as a way of coping with child’s stuttering*

With growing concern that stuttering was something that their child would not “grow out of” (P5), all of the participants ( $N = 12$ ) indicated that they sought services to be proactive in the process of helping their child manage stuttering and the impact stuttering was having on their child’s life because they wanted their child to speak more fluently. Overall, the parents wanted their children to be able to control their own speech. For example, P6 stated,

We’re just trying to find him help. You know, so it doesn’t get worse, so he’s not made fun of, so he can cope with just talking in general. . . . I want him to be able to just be in control of himself and not have to be told by people on the street or his friends. “Man, you’re going to have to slow it down, I just can’t understand you.” I mean, I don’t want that. You know, I want him just to be able just to do it himself. To where he’s understood by everybody.

Parents’ sought services privately and through the school system. The participants indicated that they were instructed by their child’s speech therapist to tell their child to (a) slow down, (b) think of what they want to say, (c) have their child repeat himself/herself after a moment of disfluency, (d) use smooth and easy speech, or (e) draw out the disfluent sound. The most frequently used techniques were having the child repeat him or herself after a moment of disfluency and encouraging the child to use smooth and easy speech. The parents’ perception of how well their child was responding to therapy or progressing in therapy varied. Some parents described therapy as helpful with observable improvement in their child’s speech whereas other parents found therapy to be unhelpful or not suiting their child’s needs. Overall, there was a notable level of dissatisfaction with services that were received through the school system. In general, the parents stated that the services they received were “not adequate enough” (P6), “could be better” (P2), or were hesitantly described as “okay” (P1). The parents’ dissatisfaction was routed in feelings of being uninformed and uninvolved in their child’s therapy. The parents were also frustrated because they felt that their children were participating in group therapy that was not focused on fluency. For example, P2 stated,

It’s been a little frustrating to me, a bit, just because the speech therapist at my son’s school seems to concentrate more on pronunciation than on fluency. He is in a group of kids that she’s helping and the other kids in that group need help with pronunciation. And so he just kinda gets thrown in with that too.

Eight of the participants described how they thought it would be beneficial or was beneficial to be informed and a part of the therapy process. The participants indicated that by observing therapy or discussing the child’s therapy outcomes they felt more knowledgeable about stuttering and they were able to help their children keep up with speech assignments, because when they ask their children outside of the therapy session they are generally told that they did “nothing.” The participants also felt that by being included or involved in the therapy process they were better able to facilitate or reinforce what was being taught in therapy. P1 discussed how he felt he needed to be involved in the therapy process when he stated,

You got to reinforce. Uh, and see now I know what to try and teach him. And stuff. ‘Cause . . . if he didn’t remember it then, how can he come back and tell me? ‘Cause sometimes I say “Remember they said that?” And he says “Oh, yeah. Yeah. Now I remember.” So uh, that’s it. And see, you have to go back and at least let him know, you know, other little techniques that he didn’t remember.

While several of the participants indicated that it would be beneficial to be involved in the therapy process, two participants indicated that they found using the techniques they observed in therapy frustrating and unrealistic. They found

it unrealistic in terms of the amount of time they could give. They found reinforcing some of the techniques and following some of the procedures frustrating because they often did not feel natural and the child did not always respond as well as they did in therapy.

### 3.2.3. Personal experience and/or support is advantageous when having a child who stutters

Having some personal experience with stuttering was described as advantageous by nine of the participants. Three of the participants were people who stutter and viewed that as an “advantage” (P2). They felt they were at an advantage because they know what it is like to be a person who stutters and how to help their child with their speech because they have been through speech therapy before. Knowing someone who stutters or having an extended family member who stutters also appeared to desensitize some of the participants to the experience of stuttering. They described how they were comfortable being around stuttering. One participant (P4) had two children who stutter and described how much easier it was to cope with the second experience when she stated,

So, then when my second son started doing the same thing, I was a lot more relaxed about it. I just stayed more relaxed throughout the whole thing because I guess I have been through it before, and I saw the therapy work for my oldest son, and you know, I knew that eventually he would sort of pick up the techniques.

Ten of the participants sought after or desired a support system to help them cope with having a child who stutters. Most of the participants ( $N=7$ ) received either informational or emotional support from family or friends. Only one parent had received support from a formal support group for parents of children who stutter. The family member that provided the participants the most support was the mother. The participants indicated that their mothers provided emotional support and served as a “sounding board.” Friends were often used when the participant wanted a referral for services or advice. The one parent (P3) who joined the formal support group found it to be a “helpful” and informative experience, but she also indicated that she found the support group a little scary when she stated,

It always kind of scared me when people were there and their kids were like sixteen and seventeen and they had been in therapy for [years]. It kind of scared me a little bit. You know, I was like “Ok, are we going to be doing this for- for years and years?”

A final form of support discussed by six of the participants was faith-based support. The participants discussed how they received support from their church or through their relationship with God. P2 described the role faith played her life when she stated,

I do have a strong belief in God, and um, I trust him totally, you know, and I know that he’s not trying to do bad things in our lives or anything . . . It’s my hope and my prayer that um, God can teach [my child] a lot in through his troubles, as well. And there is a lot to be learned, in that um, that people are not valued by their abilities.

### 3.3. Parents cope with fear that their child will have negative experiences or live a restrictive lifestyle

#### 3.3.1. Parental concern that child will live a restrictive lifestyle or experience negative emotions as a result of stuttering

All twelve participants contributed meaning units to this subcategory. This subcategory resulted from the participants’ descriptions of how they were concerned or feared that their child would live a restrictive lifestyle, receive negative reactions from listeners or be labeled as disabled by a listener. They described how they wanted their child to appear normal, feel accepted, and not be socially ostracized by their peers or other adults. The participants described how they could see that their children were becoming uncomfortable in specific situations that required speaking and on occasion would hold back or withdraw from those situations. The participants feared that their children would feel ashamed, self-conscious, or embarrassed of stuttering. They did not want their children to suffer socially. P9 stated “I don’t want him to be ostracized. That would break my heart. I don’t want him to be that kid.”

They described how they wanted their children to have friends, make new friends, and approach another person if they wanted or needed something. They also wanted their children to be able to get up in front of a group of people and speak. The participants wanted these things for their children because they felt that their children would miss opportunities if they held back or withdrew from situations. P6 described how she does not want her son to miss opportunities when she stated,

You know that “Oh my goodness, I stutter so nobody’s gonna want to talk to me.” Or, you know, “I stutter a little bit so I don’t want to have to get up in front of a bunch of people and talk.” Or, “I’ll never have a girlfriend because I stutter.” I mean, you know what I mean? Or, “I’ll never be able to get a job because they will make fun of me because I stutter.” I mean I don’t want that to be an issue for him. I want him to be able to work through it and to overcome it to where, I mean, he can have . . . , a productive life.

They felt that if stuttering impacted their children’s social functioning they may not reach their full potential.

Stuttering was also described as having a negative connotation and they did not want their child to be rejected by their peers or for other listeners to assume that stuttering somehow reflects their child’s mental capacity. P3 described how she did not want her child to be perceived as retarded when she stated,

I don't want them to think that he is retarded or slow or anything like that. And um, I'm afraid that the general public doesn't really understand what it means to have a stutter and that you know, that it's not-it doesn't indicate something else.

The participants also described the degree to which they felt their child was experiencing negative emotions and social rejection as a result of stuttering. Ten of the participants indicated that they felt that stuttering did not bother their children most of the time. P7 stated "I think it bothered me that it didn't bother him." While, generally speaking, the participants' children were not troubled over stuttering, they did indicate that their children would act or express feelings of frustration. In particular, they indicated that their children would get frustrated when they felt they were not being listened to or when they were stuck and could not get their words out. The participants also indicated that their children were more upset about stuttering at school or in formal settings than at home.

### 3.3.2. *Active parental involvement is necessary to protect the child and manage bullying*

Eleven of the participants discussed how they had concerns about their child being bullied. They also discussed the ways in which they were managing situations that involved their child being bullied. The participants expressed varying levels of concern, from mild to significant, over whether their child was or would experience bullying. The participants who were mildly concerned were the parents of children who were not actively being bullied. The participants with moderate-to-significant concern were the participants of children who were experiencing bullying. However, all but one of the participants indicated that they did not want their child to be "ridiculed or teased" (P1), and they felt they had little control over whether it happens. The participants who had children who were experiencing teasing or bullying described how it is difficult to cope with and they wanted to protect their child. For example, P6 described how bullying is difficult to cope with when she stated,

... he's being made fun of because of his talking. You know, he's been called stutter-face, umm, blabber-mouth ... I don't know, just different, you know, names. So, that coping thing has been hard for me because I just wanna go and shake these kids.

The participants described that when their child experienced teasing or bullying, active involvement on their part was necessary to remedy the problem. The participants described how they would initially talk to the teacher to see whether the problem could be handled by the teacher within the classroom. If the participants did not see the results they desired after talking to the teacher, they indicated that they would move up the hierarchy of authority within the child's school setting until they saw the results they desired (e.g., principal, director, superintendent). In addition to working with the school personnel, the participants indicated that it was also important to discuss teasing and bullying with their child. The participants told their children that teasing and bullying is not acceptable and that it hurts the feelings of the person who is being teased or bullied. They would tell the child that no one deserved to be the target of teasing and bullying and if they are being bothered they do not have to take it. They told their children, at least initially, that if someone was bothering them that they should tell an adult. P11 approached the topic somewhat differently from the other parents and said the following when his son talked to him about being teased,

He like, "but dad I don't understand why they pick at me." I said "Just don't worry about it. If you slow down and say what you got to say, you know, eventually they understand that you know everybody have problems. So you just don't worry about what the kids say. Just do what you got to do in school and that's it." He like, "I'll try."

When two of the participants felt that telling an adult was not working and the child continued to be teased and bullied, two of the parents gave their children permission to physically fight back. For example, P8 stated,

So after awhile, I said, "So, now I told him, if somebody hits him, just hit him back." I mean, just fight 'em, you know, 'cause they gonna keep, when you go into the bathroom, they kicking the doors open while you using the bathroom, and I said, "you's just going to have to fight your way out of there." So I told the principal, the teacher, and whoever else, said, "Don't call me up here about a fight, because I tried to do it you all's way, and it's not working.

The participants felt that educating their child's peers or the children within the school could help reduce the occurrence of teasing and bullying. P2 stated,

I guess I wish there was more, in schools where they would talk about kids that are different, you know. And, you know, not to point out anyone but just that it wouldn't be such a, I mean ... most kids have not heard anyone who stutters. And so they hear it and they don't have any idea that he can't help it or something like that. And when you can tell kids that, they're totally fine with it, you know, and so I just feel like it would help kids who stutter if kids around them had heard, you know, that they're trying, they can't help it, but just be patient with them and it's not a big deal. You know, and then kids can just kind of move on.

The participants felt it would be helpful if the people in the child's environment understood what their child was going through and that they need to be patient.

### 3.3.3. Parent has to manage the reactions of friends and family to child's stuttering

All of the participants indicated the degree to which they had to deal with the negative reactions of others to their child's stuttering. Some of the participants described how they had to cope with family members, friends, teachers, and the general public. The degree to which the participants had to cope with the reactions or responses of immediate family members, extended family members and the general public varied from not at all or very little to fairly extensively. The participants described how they sometimes felt that they needed to educate others on the appropriate way to respond to their child's stuttering, model appropriate behavior or responses to moments of disfluency, and outwardly let others know that they were addressing the problem. If the child who stutters had siblings, teasing and giving the child who stutters enough time to talk was another problem that required addressing. The participants' comfort level with addressing the aforementioned issues varied from very comfortable to very uncomfortable. The discomfort most often came from being uncertain on how to best address the problem and some general discomfort with the topic of stuttering. P3 described how she had hoped she would not have to address her child's stuttering when she stated,

Before, you know, when I'd have people around or other family around, I'd just kind of hope that we would kinda ride through it, and this would be over you know, in a year or two, I'm like well, this doesn't really seem like that's how it's gonna pan out, so let me go ahead and deal with it the way that I think is best. And you know, go ahead and, yeah, be more assertive and say, "This is what's happening." You know, "This is how- and this is why he's doing this. And this is what you've gotta do." You know?

Seven of the participants indicated that they felt it was important to make their child's teacher aware of the child's stuttering. Most of the participants informed the teacher of the child's stuttering as they would inform the teacher of any other problem. When they chose to address it with the teacher they would mention it as an aside as though the problem did not deserve or require much attention. It was not until a problem manifested academically or with peers that the participants decided to get into more details with the child's teacher. The details usually involved some education about the nature of their child's stuttering, encouraging patience, and sometimes some problem-solving on how to manage situations like teasing or bullying.

### 3.4. Essential structure of being the parent of a child who stutters

Parents frequently experience uncertainty over whether observed disfluencies in their child's speech should be considered typical speech behavior. This may result in an initial uncertainty over whether to seek services, or consult a professional for advice. Parents find it difficult to cope with having a child who stutters because stuttering is highly variable, persistent and gets more complex with time. It is also unclear to most parents whether stuttering should be acknowledged in the home environment. Having a child who stutters is viewed as a challenging experience in that it can require increased effort and patience. Parents of children who stutter seek speech services because they want to help their child speak more fluently and manage stuttering. They also want to reduce the likelihood of their child living a restrictive lifestyle, reduce the likelihood of teasing and bullying, and prevent their child from experiencing negative emotions due to stuttering. Parents often tried to modify the speaking behavior of their child or their own personal behaviors to cope with the experience of stuttering. Parents feel that they need more support from professionals and others in their environment.

## 4. Discussion

Prior research has demonstrated that parents of children with disabilities experience stress associated with being the caregiver of a child with a disability. The primary purpose of this study was to discover, from the parent's perspective, themes that can help clinicians understand the stresses experienced, coping strategies used, and needs of parents of children who stutter. Twelve participants were able to provide comprehensive descriptions of experiences and stresses associated with being the parent of a child who stutters. The degree of stress experienced and the way in which parents chose to cope with that stress was individualistic, however, some commonalities were observed among the participants.

### 4.1. Parental coping

As indicated, it is evident that there are stresses and pressures associated with being the parent of a child who stutters. The participants in the current study made use of both problem-focused and emotion-focused efforts, often concurrently, to manage the stresses associated with having a child who stutters. The coping process followed a common pattern in which there was a brief period of denial or minimization (i.e., emotion-focused coping) that occurred at the onset of the child's stuttering. Given how uncertain the participants were about what they were experiencing and how most of the people they sought advice from told them not to worry about it because it is most likely a phase their child will outgrow, the use of minimization or denial is to be expected and logical. Minimization or denial is often used when one feels that there is little that can or should be done. The use of minimization, in this case, should be viewed as a preemptive effort on the participants' part to make the problem less overwhelming and to decrease their own personal distress when faced with uncertainty.

However, as time progressed and stuttering persisted the participants' began to question and gradually replace their efforts to minimize the problem with acceptance that a problem may exist, and the participants actively seeking specific

informational and assistive forms of support and guidance (i.e., problem-focused coping). After seeking help, they continued to cope with feelings of uncertainty and the desire to do what is best for their children. The participants described how they struggled with not knowing the cause of stuttering, whether their child would be able to overcome stuttering, and how to best manage stuttering. They expressed concern over whether their children would suffer socially, academically and vocationally as a result of stuttering. They expressed fear that their children could be socially ostracized and miss opportunities which could cause their children to not meet their full potential as an adult. The participants coped with their feelings by trying to do what they felt was best for their child, which entailed enrolling them in therapy, encouraging the use of speech techniques, and trying to maintain patience in the face of feelings of helplessness, frustration, and sadness.

#### 4.2. Resources for parents of children who stutter

There are four basic areas that need consideration when working with the families of children who stutter: the provision of information, development of a support network, the family system, and creating a team atmosphere (Berry, 1987). Information and support are resources that individuals often draw upon in times of stress. With the appropriate resources, the stresses associated with being the parent of a child who stutters could be mitigated or adequately coped with. Within the coping literature it has been demonstrated that when resources are unavailable or an individual does not have access to a particular resource they become more vulnerable to the effects of stress and may experience poorer adjustment. When resources become or are made available individuals become more resistant and less vulnerable to the adverse effects of stress (Lazarus & Folkman, 1984).

Support, whether social or professional, was a resource that the participants in this study desired or tried to utilize. Social support has a number of functions and can include informational, emotional and practical help. The most frequently utilized source of social support discussed by the participants in this study was close family and friends. It is important to note that family and friends that serve as sources of support can also be a source of stress. The participants discussed how they had to manage the reactions of friends and family and how they sometimes felt they were more critical of how they were managing the problem.

Professional support is the least intimate type of support but has the potential of relieving some of the burdens that can be associated with informal or social support (Schilling, Gilchrist, & Schinke, 1984). To receive professional services, initial contact usually becomes the responsibility of the parent. However, parents often are unaware of the services that could be available to their child or they feel uncertain about the best time to galvanize services (Ayer, 1984). The participants in this study discussed how the process of when and where to receive services was not always straightforward. Family, friends and pediatricians often encouraged the participants to put off seeking services because they felt the child would outgrow stuttering. This advice resulted in feelings of guilt for a few participants who questioned whether they waited too long to seek services. Yairi and Carrico (1992) surveyed pediatricians and found that the large majority of pediatricians prefer to use a “wait and see” strategy. They suggested that in order for children to receive services in a timely manner, speech-language pathologists need to make pediatricians aware that speech-language pathologists are experts on stuttering and the most logical resource for services. Our results indicate that pediatricians may still need to be provided more information about childhood stuttering and the best time to recommend services. Both the National Stuttering Association and Stuttering Foundation offer materials to educate pediatricians and family physicians. Educating pediatricians is important because it would increase the chances of the child receiving early intervention.

Outside the formal therapeutic context, one way parents can address their daily stresses and pressures with having a child who stutters is through access to consumer-based support organizations. There are a few existing consumer-based support organizations (e.g., National Stuttering Association or Friends) and parents should be encouraged to appreciate the many benefits of these organizations, which includes national and regional meetings, newsletters, and information available on the internet. By taking advantage of either the direct and/or indirect avenues of support offered by these organizations, parents can get the message that “they are not alone” and benefit from the insight and experiences of other parents. Another advantage of consumer-based support organizations is that they can facilitate the process of desensitizing parents to stuttering.

Information on stuttering is another resource that was utilized or desired by the parents in the current study. The provision of information is one of the most powerful tools a clinician has for, (a) helping parents understand stuttering, (b) alleviating any negative emotions related to stuttering the parents might be experiencing, and (c) getting parents to understand, agree with, and follow through with therapy recommendations. Parents need to be provided with written as well as spoken information and the delivery of information should be spread out over time. The goal should be for parents to feel informed but not overwhelmed. Information delivery should not be initiated only upon parental request. Most parents want more information than they ask for. They often hesitate to ask questions because they feel that they do not know what questions to ask when the time to do so presents itself (e.g., at the end of an evaluation) and they often fear that they will ask an inappropriate question.

The participants in this study were experiencing a variety of emotions and had numerous questions about the nature of stuttering and how to best manage stuttering in a variety of contexts. Most of the participants' concerns could be addressed through parent counseling. To provide effective counseling, we need to know what parents think about stuttering, how they feel about stuttering, how they are currently managing the problem, and any problems they have experienced that relate to having a child who stutters (Zebrowski & Schum, 1993). The parents in this study clearly indicated they wanted to know more

about the nature of stuttering, about what causes stuttering, about what therapy entails, how long their child will require services, what will be required of them during the therapeutic process, how to manage school, family and peer situations that occur outside the therapeutic context, whether or not and how to acknowledge stuttering in the home environment, how to manage bullying, and what they can or should be doing to help their child manage stuttering at home and school.

Once the parent has inquired about receiving speech services and the recommendation for therapy has been made, it is important to remember that for optimal therapeutic success we need to address more than just the child who stutters – we need to consider the families of the children we treat as well. A family systems approach can be utilized and facilitate the process of developing a collaborative and understanding relationship with parents. When considering the family system, Berry (1987) suggests considering the roles, responsibilities and interaction patterns of each of the family members included in the family system. When the family system is taken into consideration, the clinician can make informed recommendations on how members of the family (e.g., mother, father and siblings) can best contribute to and facilitate the therapy process. Understanding the roles and responsibilities of the various family members is necessary for gaining an appreciation of the range of responsibilities required of the family system. This can be especially important when the family system includes multiple siblings and extracurricular activities. If the range of responsibility for the family system is not appreciated and discussed, there is the risk of having unreasonable expectations of the family, which could consequently result in the child's parents feeling guilty or frustrated when they cannot follow through with recommendations (Berry, 1987). Parents also sometimes need help brainstorming ways to incorporate therapy goals into their family system or daily routine. While parents want to follow through with therapy suggestions, they often feel they do not have the time or they feel uncomfortable about their ability to implement the suggestions.

Recent studies have described the experiences of parents who were actively engaged in the implementation of the Lidcombe Program, which is a parent-based behavioral treatment program. They reported findings that indicate even parents who attended weekly sessions, were trained by the SLP, and received feedback on their techniques still found it difficult to incorporate the treatment into their daily lives, and felt unsure in their ability to correctly implement the program (Goodhue et al., 2010; Hayhow, 2009; Packman et al., 2007). For example, Goodhue et al. (2010) revealed that mothers can harbor feelings of guilt. Their guilt ranged from feeling they had done something to cause their child's stuttering, to feeling badly about not doing the treatment on a daily basis, to blaming themselves if the child's stuttering did not improve. Therefore, it is possible that a parent who has not been given specific training, lacks confidence implementing the SLP's suggestions, or has feelings of guilt that surround the treatment process may first have to cope with their own emotional discomfort before they can adequately provide support for their child.

Finally, one of the most effective ways to alleviate stress and facilitate a good parent-professional relationship is to create an environment where parents feel they are an important part of the therapeutic process. To facilitate the development of a team-like atmosphere, parents need to be included in the treatment decision-making process. Parents often know best what is most practical for their child and the family system as well as what motivates their child. Because clinicians often only get to see a snapshot of the problem, parents can be invaluable when it comes to gaining greater insight into the scope of the problem beyond clinic. Creating a team-like atmosphere can be particularly challenging within the school setting. All of the parents in this study expressed some dissatisfaction with the services they received in the school setting, and their dissatisfaction appeared to stem from feeling uninformed and uninvolved with the therapeutic process. Both the National Stuttering Association and Stuttering Foundation provide materials that provide useful information about how to advocate for a child who stutters in the schools.

Clinicians have a clear responsibility to the parents of children who stutter. Addressing the needs and concerns of the parents is as critical as addressing the needs of the child, and of course, to the degree possible, the two should coincide. Clinicians who are not addressing the needs and concerns of the parents – and parents who choose not to take part in the therapeutic process – are not as likely to generate a successful outcome. Without the parents' understanding the therapeutic process and the changes that would result from the associated behavioral and cognitive goals, accomplishments will not be acknowledged and rewarded by parents and other immediate and extended family members. It is also important to recognize that while formal support or speech services can be a beneficial resource for some parents, it can also be a form of stress for others. Specifically, some parents may find the experience of interacting with any kind of health care professional overwhelming, frustrating, and stressful (Lloyd-Bostock, 1976). However, if a child is going to improve his or her ability to communicate, the communication between the clinician and the parents is critical.

#### 4.3. Limitations and future research directions

This study represents the experiences of twelve parents of children who stutter. While the demographic characteristics of the participant pool were diverse, the participant pool cannot be viewed as a representation of all parents of all children who stutter. In addition, the results of this study are based on the participants' descriptions about their experience in coping with a child who stutters, not upon formal observation. It is possible that the participants' descriptions about how they cope with having a child who stutters do not entirely match how they actually cope with the experience. Readers should interpret these findings with the understanding that other parents may relate different experiences and beliefs about the experience of coping with stuttering. However, the rich descriptions brought forth in the analysis of the participants' experiences can inform clinicians and researchers about the stresses associated with being the parent of a child who stutters. Another potential limitation of this study was that the results of the study were not enhanced by participant feedback. Feedback

questionnaires were sent to each of the participants, however none were returned. The poor response rate was a result of the intensive and time-consuming analysis and the time it took to later contact the participants.

Future research might focus on a number of findings that emerged from this study. Research could evaluate the effect that parent counseling or the provision of information has on parental stress levels. More specifically, there could be empirical investigation into whether parent coping or parent counseling influences degree of adjustment or distress levels experienced by the parents of children who stutter. A study could also be conducted to look at whether the coping strategies of parents of children who stutter quantitatively differ from the coping strategies of parents of children who do not stutter or the parents of children with other communication disorders.

#### 4.4. Conclusion

In order to relieve the many forms of stress experienced by parents of children who stutter, clinicians need to provide information that will help parents more effectively cope with their situation. This includes providing information on the nature of stuttering, the cause of stuttering, teasing and bullying, support groups, and involving parents in the therapeutic process so that they can understand and facilitate the desired therapeutic changes beyond the clinic environment.

### CONTINUING EDUCATION

#### Coping with a child who stutters: A phenomenological analysis

##### QUESTIONS

1. Which one of the following best reflects the transactional model of coping:
  - a. It is a model that depicts coping as a passive unconscious process
  - b. It is a model that emphasizes the influence family life and family reactions
  - c. It is a model that emphasizes how individuals cope with a stressor
  - d. It is a model that describes coping as an operant process
  - e. It is a model that emphasizes the influence of culture on coping
2. The participants indicated which of the following:
  - a. Knowledgeable about the nature and cause of stuttering
  - b. Uncertain about the nature and cause of stuttering
  - c. Uninterested in the nature and cause of stuttering
  - d. In denial about the nature and cause of stuttering
  - e. All of the above
3. Which one of the following was NOT a strategy used by parents to address their child's stuttering:
  - a. Instructing child to slow rate
  - b. Telling the child to think about what they are going to say
  - c. Active listening
  - d. Instilling confidence in the child
  - e. Withholding rewards
4. For the parents in this study:
  - a. The majority felt at some time that stuttering should not be acknowledged in the home environment
  - b. They felt fearful that acknowledging stuttering would cause the child discomfort
  - c. They were reluctant to use the word stuttering
  - d. They were uncomfortable having a discussion about any emotions experienced as a result of stuttering
  - e. All of the above
5. A family system approach takes into consideration:
  - a. Family interaction
  - b. Genetics
  - c. Family functions
  - d. A and C
  - e. All of the above

### References

- Ayer, S. (1984). Community care: Failure of professionals to meet family needs. *Child: Care Health and Development*, 10, 127–140.
- Bailey, A. B., & Smith, S. W. (2000). Providing effective coping strategies and supports for families with children with disabilities. *Intervention in School and Clinic*, 35(3), 294–296.
- Beresford, B. A. (1994). Resources and strategies: How parents cope with the care of a disabled child. *Journal of Child Psychology and Psychiatry*, 35(1), 171–209.
- Berry, J. (1987). Strategies for involving parents in programs for young children using augmentative and alternative communication. *Augmentative and Alternative Communication*, 3(2), 90–93.
- Bloodstein, O., Jaeger, W., & Tureen, J. (1952). A study of the diagnosis of stuttering by parents of stutterers and non-stutterers. *The Journal of Speech and Hearing Disorders*, 17(3), 305–315.

- Carver, C. S., & Scheier, M. F. (1994). Situational coping and coping dispositions in a stressful transaction. *Journal of Personality and Social Psychology*, 66(1), 184–195.
- Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, 56(2), 267–283.
- Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Vaile, & M. King (Eds.), *Existential phenomenological alternatives for psychology* (pp. 48–71). New York: Oxford University Press.
- Coyne, J. C., & Smith, D. A. F. (1991). Couples coping with a myocardial infarction: A contextual perspective on wives' distress. *Journal of Personality and Social Psychology*, 61, 404–412.
- Cresswell, J. W. (1998). *Qualitative inquire and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.
- Essex, E. L., Seltzer, M. M., & Krauss, M. W. (1999). Differences in coping effectiveness and well-being among aging mothers and fathers of adults with mental retardation. *American Journal of Mental Retardation*, 104, 545–563.
- Folkman, S. (1992). Making the case for coping. In B. N. Carpenter (Ed.), *Personal coping: Theory research, and application* (pp. 31–46). Westport, CT: Praeger Publishers.
- Floyd, F., Singer, G., Powers, L., & Costigan, C. (1996). Families coping with mental retardation: Assessment and therapy. In J. Jacobson, & J. Mulick (Eds.), *Manual of diagnosis and professional practice in mental retardation* (pp. 277–288). Washington, DC: American Psychological Association.
- Gavidia-Payne, S., & Stoneman, Z. (2006). Marital adjustment in families of young children with disabilities: Associations with daily hassles and problem-focused coping. *American Journal of Mental Retardation*, 111, 1–14.
- Glaser, B. J., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine.
- Glidden, L. M. (1989). *Parents for children, children for parents: The adoption alternative*. Washington, DC: American Association on Mental Retardation.
- Glidden, L. M., Billings, F. J., & Jobe, B. M. (2006). Personality, coping style, and well-being of parents rearing children with disabilities. *Journal of Intellectual Disability Research*, 50, 949–962.
- Glidden, L. M., & Natcher, A. L. (2009). Coping strategy use, personality, and adjustment of parents rearing children with developmental disabilities. *Journal of Intellectual Disability Research*, 53(12), 998–1013.
- Goldman, R., & Shames, G. H. (1964). Comparisons of the goals that parents of stutterers and parents of nonstutterers set for their children. *Journal of Speech and Hearing Disorders*, 29(4), 381–389.
- Goodhue, R., Onslow, M., Quine, S., O'Brian, S., & Hearne, A. (2010). The lidcombe program of early stuttering intervention: Mother's experiences. *Journal of Fluency Disorders*, 35(1), 70–84.
- Hastings, R., Allen, R., McDermott, K., & Still, D. (2002). Factors related to positive perceptions in mothers of children with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 15, 269–275.
- Hastings, R., Kovshoff, H., Brown, T., Ward, N., & Espinosa, F. D. (2005). Coping strategies in mothers and fathers of preschool and school-age children with autism. *Autism*, 9, 377–391.
- Hayhow, R. (2009). Parents' experiences of the Lidcombe Program of early stuttering intervention. *International Journal of Speech-Language Pathology*, 11(1), 20–25.
- Judge, S. L. (1998). Parental coping strategies and strengths in families of young children with disabilities. *Family Relations*, 47, 263–268.
- Kazak, A. E., & Marvin, R. S. (1984). Differences, difficulties, and adaptation—Stress and social networks in families with handicapped child. *Family Relations*, 33, 67–77.
- Kim, H., Greenberg, J. S., Seltzer, M. M., & Krauss, M. W. (2003). The role of coping in maintaining the psychological well-being of mothers of adults with intellectual disabilities and mental illness. *Journal of Intellectual Disabilities*, 47, 313–327.
- LaFollette, A. C. (1956). Parental environment of stuttering children. *Journal of Speech and Hearing Disorders*, 21(2), 202–207.
- Lardieri, L. A., Blacher, J., & Swanson, L. H. (2000). Sibling relationships and parent stress in families of children with and without learning disabilities. *Learning Disability Quarterly*, 23, 105–116.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping*. New York: Springer.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Lloyd-Bostock, S. (1976). Parents' experience of official help and guidance in caring for a mentally handicapped child. *Child: Care Health and Development*, 2, 325–338.
- Meyers, S., & Freeman, S. (1985). Mother and child speech rate as a variable in stuttering and disfluency. *Journal of Speech and Hearing Research*, 28, 436–444.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.
- Packman, A., Hansen, E. J., & Herland, M. (2007). Parents' experience of the Lidcombe Program: The Norway–Australia connection. *Research, Treatment and Self-Help in Fluency Disorders: New Horizons*, 418–422.
- Patton, M. Q. (2002). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.
- Schilling, R. F., Gilchrist, L. D., & Schinke, S. P. (1984). Coping and social support in families of developmentally disabled children. *Family Relations*, 33, 47–54.
- Sloper, P., Knussen, C., Turner, S., & Cunningham, C. (1991). Factors related to stress and satisfaction with life in families of children with Down's Syndrome. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 32, 655–676.
- Smith, J. A., & Osborn, M. (2008). Interpretive phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to methods*. London: Sage.
- Yairi, E., & Carrico, D. M. (1992). Early childhood stuttering: Pediatricians' attitudes and practices. *American Journal of Speech Language Pathology*, 1, 54–62.
- Zebrowski, P. M., & Schum, R. L. (1993). Counseling parents of children who stutter. *American Journal of Speech Language Pathology*, 2, 65–73.

**Laura W. Plexico**, Ph.D., is an assistant professor in the Department of Communication Disorders at Auburn University. She received an undergraduate degree in communication disorders from The University of Montevallo, a master's degree in speech-language pathology from The University of Memphis, and a doctor of philosophy from The University of Memphis. She teaches courses in fluency disorders and speech science. She has presented research to the professional meetings of the American Speech-Language-Hearing Association, International Fluency Association and World Congress for People who Stutter. She is a member of Division 4 (Fluency & Fluency disorders) and a member of the National Stuttering Association. She is also a peer-reviewer for Division 4 *Perspectives* and has served as a reviewer for *The Journal of Fluency Disorders*.

**Embry Burrus**, MCD, is a certified speech-language pathologist and associate clinical professor. Her areas of interest include children with developmental delay, children and adults who stutter, and supervision. She is the author of *Mama and Margaret*, a memoir about her older sister with Down syndrome, and co-author of *Professional Communication in Speech-Language Pathology: How to Write, Talk and Act like a Clinician*. Before becoming a clinical professor, she practiced in Atlanta, Georgia, where she worked with children in the public schools, Head Start, and Early Intervention.