

CHAPTER D: D I S C U S S I O N

1. CHANGE IN FAMILIES' PERCEPTION OF STUTTERING AND COPING THROUGH THE YEARS AND FACTORS INFLUENCING IT

"We both step and do not step in the same rivers. We are and are not".

This Heraclites' epigram on the river flux demonstrates the philosophical idea that the world is constantly changing. The river is changing and at the same time we are changing as well. Small changes on the river banks are sometimes hardly noticeable but there are moments in life when people have to face surprisingly unexpected changes that affect the flux of the river of life such as illness or disability of loved ones in the family.

The external change life imposes on people sets off a crisis leading to a totally different journey in their lives.

Our investigation tried to picture a moment in the middle of this journey of 26 families – parents and their school-aged children who stutter and to describe some aspects in their coping.

Results showed that at the point in our families' journeys that we investigated about 85% of mothers and 73% of fathers of school-aged children who stutter reported a positive change in attitude towards their child's stutter. The strong tendency towards statistical significance regarding the difference in percentage between mothers and fathers may imply that more mothers than fathers made such a change in attitude. That may stem from the fact fathers and mothers begin from a different starting point when dealing not only with stuttering but with any offspring's disability in general. Research shows that mothers of young

developmentally disabled boys report a significantly greater number of depressive symptoms than fathers (Bristol, Gallagher, & Schopler, 1988) and in the case of autism specifically, are more likely to claim that their child's disability affected their emotional well-being (Gray, 2003).

We set out to trace factors which supported that positive attitudinal change parents reported towards stuttering. No relation to onset age was found.

Clearly, the time since onset alone was not enough to induce such a change, so there must have been other influential factors such as actions families had taken in order to cope.

Onset age did not relate to reports of change in the family due to stuttering, either. However, a pattern emerged where a higher percentage of parents reported change in the family due to stuttering with pre-school onset age. Cautiously treated, this finding supports the notion that coping (e.g. changes in ways of thinking and/or behavior) must be observed over time, as a process (Lazarus & Folkman, 1984). About 39% of parents did not sense any change in the family. 75% of them had children with school-age onset, a fact which did not afford them enough time to go on with the process which could have influenced their feelings.

Reports of change in attitude towards stuttering or change in the family due to stuttering were not affected by changes in the child's fluency, according to our findings. More than half of the families reported fluctuating fluency through the years and only about 40% reported positive change in the child's fluency. Since about 80% of parents reported change in attitude and about 61% of parents reported change in the family, there were probably other factors affecting the feeling of change in the family, too.

One of these factors could be the time of their first professional counseling.

When reporting change of attitude towards stuttering a pattern emerged indicating that the later the first professional counseling, the higher the percentage of positive change in parents' attitude towards the child's stuttering. Since our sample is rather small we should be cautious in our conclusions. Nonetheless, this pattern may imply that professional counseling helped only when parents were emotionally ready to accept it: some time after onset but not necessarily immediately thereafter. This notion concurs with clinical insights on counseling. As Luterman (2008) designates: "the information given by the professional early in diagnosis is seldom retained by the clients because affect is so high". Parents need time to progress to another stage of coping in order to be able to listen to information and accept reality (Fortier & Wanlass, 1984).

Another prominent factor influencing the family's sense of positive change was former stuttering in the family. Families with stuttering in close family reported a higher percentage of no change or negative change in the family than families with either stuttering in remote family only or no former stuttering at all. Clinical experience with other developmental disabilities like autism, Down's syndrome or learning disabilities shows that recurrent cases in the family make it harder for parents to cope because of the energy invested in the first child and, to compensate for the feelings of unsuccessful parenthood, the hope of bringing a healthy child into the world. . Sometimes parents fantasize about having a fluently speaking child despite being married to a stuttering person or having a stutter themselves. This fantasy stems from "being there" and knowing how stuttering affected their own lives (Kigel & Lahat, 1987).

Couple cohesion was also an important factor relating to change of attitude towards stuttering. Families whose father and especially mother

scored their couple cohesion higher reported significantly more positive changes in attitude towards the child's stuttering.

Such findings may indicate that couple cohesion affects the individual ability of men and women to change their attitudes towards a stressor like the stuttering of their child.

Former research about parents of children with other disabilities supports these findings. Pederson (Luterman, 2008) examined families with a disabled child and found that when there was an emotionally distant father, there was an emotionally distant mother as well. The mother's ability to parent was, to a great extent, a function of the satisfaction she obtained in her marriage. In our case, couple cohesion was found to correlate to the mothers' ability to positively change attitude towards stuttering, a change which surely has an impact on their motherhood style. Gallagher, Cross and Scharfman (Luterman, 2008) identified characteristics of parents who were judged by professionals to have made a successful adjustment to the birth of a child with a disability. They found the major sources of strength were the parents' personal qualities and the quality of husband-wife relationship.

In light of this data, it is reasonable to assume that women who feel supported by their spouses overcome the possible feelings of pain and failure in motherhood and let go of guilt feelings associated with having a child with a disability; hence, they are afforded the opportunity to change their perspective on the stuttering of their child.

Nonetheless, there is a possibility of a reverse effect in which positive change of attitude enhances couple cohesion, since it diminishes spouse blaming or guilt feelings that have the potential of distancing the couple.

Couple cohesion was an additional factor influencing reports of change in the family due to stuttering. Parents, especially fathers, who reported

positive change in the family scored significantly higher on couple cohesion than those who reported no change or negative change.

Another aspect of change was found in the answers parents gave to the question about self-appraisal of coping with stuttering as a family. Most parents were either ambivalent or had some degree of acceptance towards stuttering without a significant difference between mothers and fathers. Parents, especially fathers, who expressed pain scored significantly lower on couple cohesion than parents reporting ambivalence or acceptance to different degrees. Once again we see that couple cohesion is a powerful factor relating to the ability of a parent to move forward on the coping path from being immersed in pain to ambivalence and to some kind of acceptance. In our opinion, the ambivalent period and the different degrees of acceptance in our findings are equivalent to Fortier & Wanlass' (1984) stages four and five, previously mentioned in the theoretical background chapter (page 9). In stage four the focus moves to the external world: looking for information, which at this stage becomes more emotionally acceptable as mentioned earlier, choosing between alternatives (therapies; strategies of coping), planning, admitting the reality of having a child who stutters and beginning to feel some relief. Stage five is a stage of compliance: family solidarity and recognition of the child's needs. This solidarity enables acceptance to different degrees. Other researchers have found some similar findings studying families with children who have other disabilities. Kersh, Hedvat, Hauser-Cram, and Warfield (2006) studied marital quality and its contribution to the well-being of parents of children with developmental disabilities. Among the 67 families who participated they found that for both mothers and fathers, greater marital quality predicted lower parenting stress and fewer depressive symptoms above and beyond socio-economic status, child

characteristics and social support.

Margalit and Klietman (2006) studied maternal stress, reported by mothers whose infants were diagnosed as having developmental disabilities at the beginning of participating in an early intervention program. They found that mothers who considered their family members as being close and supportive (according to their family cohesion scores on the FACES III questionnaire) experienced lower levels of stress.

These findings support the notion that couple cohesion, which is in fact a measure of marital quality, may help change the exclusivity of pain feelings to a wider range of mixed feelings allowing for the possibility of a more positive view on the situation: pain is inevitable but there is more to it than that. Mixing the color of pain with colors of another perspective creates the option for a new painting of the coping experience.

At the same time, moving forward on this path towards relief and/or positive coping may enhance couple cohesion as well.

Lavee (2004) who studied couples under daily stressors found that stressful days were associated with an increased dyadic distance, which is in fact a temporary decrease of couple cohesion.

According to Lavee (1997), the majority of research about the effect of stressful situations on marital quality has employed quantitative analysis (correlation or group comparison) and has supported the assertion that stressful events have a deleterious effect on marital relationships.

However, he points out that stress may also affect the relationship in a positive way. This has been found with regard to certain lifecycle transitions, particularly that of the empty nest syndrome (Menaghan, 1983b; White & Edwards, 1990) and non -normative transitions (Hartman & Hartman, 1986), as the result of coping with a serious illness, such as a spouse's cancer (Gritz, Wellisch, Siau, & Wang, 1990) or a child's cancer (Barbarin, Hughes, & Chesler, 1985). It appears that stressful experiences

have the potential of strengthening the relationship resulting in increased cohesiveness and a more tightly bonded couple. (Lavee, 1997).

Luterman (2008) shares his own experience working with groups of healthy spouses of individuals with chronic illnesses. He found that the families that grow and prosper through the adversity of the disability are the older, longer married couples whose companionship has been tested over time. Other families that succeed are newly married couples who enter into the marriage knowing about the disability and have openly and honestly made the choice. "The couples most at risk" says Luterman "are those who have been married only a few years and have not been subjected to enough external stress to strengthen them, or those who have not yet established openness in their marital communication."

The deduction from this experience may be applied to our families with school-aged children who stutter, and confirms that couple cohesion does influence a sense of resilience in the family, especially if the parents are married long enough. Families in our sample group had school-aged children, which means they probably have been married longer than families whose children are at the onset of stuttering, which often takes place in the pre-school years. This may also contribute to our results but further research is required to confirm such a hypothesis.

There is nothing new in claiming that stress has the potential for personal growth. Kazak and Marvin (1984 in Luterman 2008) found that out of 56 families in which a child had spina bifida, a significant portion of the parents reported that their marriage was strengthened as a result of the child. Our results show that although most parents reported having to deal with fluctuations in their child's stuttering, a fact that surely made it harder for them to accept it (Kigel & Lahat, 1987), most of them reported

a positive change in attitude towards stuttering which was strongly correlated to couple cohesion.

The significant difference between parents who express pain and those who are ambivalent on couple cohesion scores, may imply that we are dealing with two distinct stages parents go through on the way to acceptance or compliance with their child's stuttering.

Luterman (2008) quotes Matson and Brooks' (1977) stages of coping which were found in interviews with people who had multiple sclerosis. These were denial, resistance, affirmation and integration. Luterman explains that resistance differs from denial in that people acknowledge to themselves that they have a problem and they work very hard to defeat it. This is reminiscent of the ambivalence reported by families in our research. Parents did acknowledge the stuttering but were very sure of discovering a way to defeat it. For them it was only a matter of finding the right speech therapist or doing more exercises that would make everything alright.

In our opinion, parents who expressed pain were in a stage more advanced than denial. They acknowledged the problem and were grieving it. Luterman (2008) claims that denial occurs any time there is a new demand on parental resources, requiring that they be wise or strong. This usually happens at the time of diagnosis. Most of the parents in our research were several years post-diagnosis because their children were already school-aged and most onsets are diagnosed at pre-school age. This could explain the fact that parents expressed pain (in more than 42% of cases) instead of using denial (not even one case!) during the interviews.

In addition to couple cohesion, spouse support reported by parents was also found to be a powerful correlate to positive change of attitude: all of the parents who reported spouse support reported positive change of attitude towards their children's stuttering. Other parents, mostly fathers, who did not report spouse support, reported positive change of attitude in a significantly lower percentage (65%). In fact, couple cohesion scores and spouse support reports are two different measures describing the same entity. This result is reinforced by findings concerning families with young developmentally disabled children where spouse support was the best predictor of the fathers' parental functioning (Bristol, Gallagher & Schopler, 1988). Another finding was quoted by Margalit et al. (2006) in which maternal stress has been linked to limited spousal support and may have negative affects on family cohesion in families with children who have disabilities (Mahoney et al., 1992).

Interestingly enough, we found that couple or family adaptability (as scored on FACES III) was not significantly related to change of attitude or change in the family due to stuttering, as reported by parents in the interview.

In accordance with our findings, we believe that family and especially couple cohesion enables the change of attitude and other necessary changes in the family's coping. When parents feel they have a "safe place" (Katz, 2000) at home they allow themselves changes in beliefs, thoughts, attitudes etc., thus employing more efficient strategies of coping.

It seems flexibility and adaptability are not constant traits but rather affected by conditions of couple relationship and family climate.

As Froma Walsh puts it in her book "Strengthening family resilience", change may be frightening largely because family members fear losing

control of their lives in a runaway process which might leave them even worse off than they are in their present predicament. In case of changing attitudes towards stuttering parents may feel that change of attitude will leave them with no resources for fighting stuttering and saving their child. This may serve as a major obstacle to flexibility and adaptability.

Changes are not possible under threatening conditions.

Walsh (1998) offers nine keys to family resilience and divides them into three categories which are: family belief systems; organizational patterns and communication processes. Connectedness is one of the keys under the organizational patterns category. She explains that members of the family need to believe that they can turn to one another in face of adversity and at the same time their own efforts, sense of competence and self-worth will be nurtured and reinforced.

Cohesion as expressed in our investigation is the parallel of Walsh's concept of connectedness as a key to family resilience and serves as the buffer of the couples' fears hence enabling adaptation and positive change of attitude towards stuttering.

2. INFLUENCE OF FORMER STUTTERING IN THE FAMILY

When correlating FACES results for couple changeability scores and former stuttering in the family, we found significant difference between parents with stuttering in close family and in remote family or none at all. The first group scored lower couple changeability than the others.

Clinical experience shows that parents of stuttering children experience elevated levels of anxiety which may be even higher when there is another case of the same nature in the family. Parents who stutter themselves may be overly reactive, concerned and stressed over the child's stuttering problem (Ramig, 1993).

The couple may already feel exhausted because of coping with the former case, and may need any and all remnants of energies in coping with another one. In order to avoid additional stress, both feel that a change in their marital relations is "not urgent". As mentioned in the first section of our discussion, stress does not serve as fertile soil for change.

Some data showed differences between mothers and fathers with former stuttering in the family. One of them was in response to the question about what will happen if stuttering will not disappear. For mothers there was a statistically significant difference in answers between those with stuttering in close family and those without. 78% of mothers with no former stuttering in the family reported they would accept the situation of stuttering. 62% of mothers with stuttering in close family reported great disappointment in case stuttering would not disappear.

Fathers reported a higher percentage of acceptance of stuttering than mothers, and a lower percentage of disappointment when there was former stuttering in close family (usually their own).

From an evolutionary perspective mothers are perceived by society and thus perceive themselves as the one in charge of the child's well being. Having a child with some kind of disability already has the potential of causing a mother guilt feelings on the grounds of not fulfilling her duty as expected. After coping with this feeling with a spouse or herself, experiencing it for a second time may cause greater frustration and a greater need for a "correcting experience", an opportunity to prove she is a "good mother". It is hard to accept a phenomenon that may be interpreted as failing as a parent because of an inability to prevent and/or get rid of stuttering, which might be a hereditary trait passed on to her child, or because she was "irresponsible" for marrying a man from whom the child might inherit stuttering.

As previously mentioned, another aspect of change influenced by former stuttering in the family was reports of change in the family due to stuttering. Stuttering in close family had a strong tendency to influence a higher percentage of no change or negative change reports, compared to families with no stuttering in the family or with stuttering in remote family only. This result can be explained by the fact that families with former stuttering may prefer to ignore the situation, or alternatively, feel a great deal of pain because of recurrent stuttering and find it more difficult to be empowered compared to families with no former stuttering. Again, we find the fingerprints of excessive stress that would not allow positive change.

Rolland & Walsh (2006) denote that it is important to understand the family's coping strategies in response to past stressors and specifically to past illness, disability or loss. These patterns are transmitted across generations in family beliefs, such as shared pride or shame, myths, taboos and expectations. Such inquiry helps the therapist to understand the meaning of the current illness or disability experience for the family and to predict its coping style.

In light of this insight we believe that the parents' ability to accept stuttering may stem from the family's narrative of coping with the former case of stuttering within it. Narratives of resilience may encourage acceptance of the recurrent case of stuttering in the family, but pessimistic narratives of failure or depression are prone to end up with great disappointment with recurrent cases in the family. There is a possibility that fathers are influenced by their own feeling of success in living with stuttering but mothers may have a different narrative. For example, in one of the families we interviewed the father said "I think it (stuttering) will disappear... I feel like I got over it, I rarely have it

today...people survive it and it makes them tougher" at the same time his wife answered "but what if he (their son) won't be like you?" and elsewhere, she told the interviewer about her husband "He was a mechanic and today he is a taxi driver, he is doing things he is good at but I don't want my son to be a mechanic... for that he needs good speech". The father's narrative asserts that he overcame stuttering but his wife's narrative asserts that he overcame stuttering by having jobs where he didn't have to do much talking, which means being satisfied with very little in life. She expects much more of her son. Her husband's narrative is not an optimistic from her perspective.

Kigel and Lahat (1987) found that when one of the parents, frequently the father, stuttered himself, he tended to be less limiting regarding his child's behavior explaining that he understands his child's feelings since he felt the same when he was younger.

This kind of "total acceptance" of child behavior even when it is not desirable may pose differences of opinions about child rearing between the couple ending with a decline in couple or family cohesion. But this was not the case in our research; we did not find any relation between couple cohesion scores and former stuttering in family.

Regarding results dealing with former stuttering in the family and its influence on parents' perception of the child's stuttering, there is a possibility of differences between stuttering mothers and stuttering fathers. Waters, Doyle, Wolfe, Wright, Wake and Salmon (2000) reported parental gender and self-reported health influence on parent-reported child health. In a survey of 5340 parents' health-reports for themselves and for their children, they found increased odds of mothers with self-reporting poor global health reporting their children with poor global health, that were not observed for the fathers. This effect may be relevant

to stuttering too, and affect the mother's self-blame and acceptance of the child's stuttering (since mothers tend to think their children's problems resemble their own and see themselves as the reason for the problem).

There was no relation found between the parents' perception of stuttering severity or frequency and former stuttering in the family.

It seems that former stuttering in the family did not affect parental judgment of stuttering severity measures.

Answers to the parent interview question "can you imagine stuttering will not disappear" were not influenced by former stuttering in the family either ; most fathers and mothers reported they could imagine such a situation, which is a rather realistic perception of stuttering potentially reflecting therapy's influence. Yet we have to bear in mind that being realistic does not necessarily mean giving up the hope for healing which in turn, keeps the coping journey on-going. In the words of Martin Luther King: "We must accept finite disappointments but we must never lose infinite hope" (in Walsh, 1998). Sustaining hope in the face of life adversities enables us to carry on. Walsh (1998) reports Beavers' and Hampson's findings about high-functioning families who have been found to hold a more optimistic rather than pessimistic view of life.

3. STRATEGIES USED BY PARENTS AND CHILDREN

3.1 Parents' Strategies

Results showed that both parents were equally frequent in expressing pain. This confirms the fact that both parents are worried and stressed by their child's stuttering but according to our findings each gender has its own typical way of coping with it.

Mothers used the strategy of "external support" significantly more than fathers. This is similar to Altieri (2006) who found the same results with parents of autistic children. Importance of accessibility to external support is emphasized by our following findings:

Many parents reported they shared their concerns about their child's speech immediately after onset, but more than a third of them did not. Out of those who shared concerns only about a half were offered help by their families or friends. When taking into account the fact that mothers sought out external support more than fathers - lack of such support due to various reasons such as poor intergeneration relationship, the grandparents' tendency to be more stressed than their children (the child's parents) or because of shame and embarrassment - an important resource of coping is taken from these mothers hands and may affect their overall coping. It definitely decreases their alternative resources for coping, if they don't find couple cohesion satisfactory.

Another strategy used more by mothers than by fathers, on a nearly significant difference, was "reappraisal".

All mothers who used "reappraisal" reported a positive change of attitude towards stuttering. Among mothers who did not report use of "reappraisal" one third did not report change of attitude towards stuttering with a statistically significant difference between groups.

Mothers who did not use the "despair" strategy, reported positive change of attitude towards stuttering in more than 90% of cases. Mothers who used "despair", reported positive change of attitude in only one third of the cases. These results show that the strategy in use had a dramatic influence on positive change of attitude towards stuttering. Such a change

means relief and more efficient coping not only for the mother but for the whole family as well.

Fathers used "suppression of feelings" to a significantly greater extent. This finding is similar to Gray's (2003) who investigated gender differences in coping regarding parents of children with high functioning autism. He reported that fathers on his sample were much more likely to report suppression of feelings as a coping strategy even when they experienced considerable emotional distress.

Resuming our findings: fathers also tended to report more "guilt feelings" on one hand, and to show more "compliance" than mothers on the other, but we did not find any statistical significance for the gender differences in use of these strategies.

The fathers' coping was also influenced by the strategies used. As for "guilt feelings" – fathers who reported "guilt feelings" reported a positive change of attitude towards stuttering only in 40% of cases. When they did not report "guilt feelings" positive change of attitude towards stuttering went up to 85% of cases! There is no doubt that a positive change of thoughts by giving up guilt feelings, paves the way to positive feelings thus to a positive change of attitude.

That is a good reason to deal with these feelings during counseling and try to lessen their influence on parents' coping.

Both parents' results confirm common personal experience that it is more difficult to change your attitude to a positive direction when you're feeling guilty or desperate.

As for the "compliance" strategy, gender differences were referred to by Goldberg, Marcovitch, Macgregor and Lojkasek (1986) who investigated parents of children with Down's syndrome: "effects of a child's handicap on fathers differ from those upon mothers. Fathers reported fewer distress symptoms, higher self-esteem, a more internal locus of control, and less

support than did mothers, possibly reflecting traditional role divisions in the family."

From our point of view, "reappraisal" may have made it possible for mothers in our sample to move away from "guilt feelings" albeit with the combination of spouse support or other kinds of support. Moving away from guilt feelings enabled positive change of attitude towards stuttering and some relief.

We think this is part of the evolutionary and traditional role division in the family between the genders as Goldberg et al. (1986) pointed out. Women see themselves as responsible for their children's well-being and health. If there is any difficulty in these domains in a child's life and it is incurable, women perceive it as failure of motherhood which makes it harder to comply with the problem. There were mothers who expressed it literally during the interview: (What if stuttering won't disappear?) "I'll never forgive myself".

Fathers tended to "suppress feelings" thus not having to face their emotions. At the same time, we couldn't find any relation between using this strategy and positive change of attitude towards stuttering. In fact, the results presented a pattern in which the percentage of fathers who reported positive change of attitude was higher among those who did not use "feeling suppression"! It seems this strategy is efficient for immediate pain relief but not for efficient coping in the long run.

In accordance with the above-mentioned role division theory, fathers see themselves in charge of the family's maintenance and protection, therefore they are less responsible for health and well-being problems. Naturally it is easier for them to accept or comply with problems in this domain.

Walsh (1998) delineates differences in gender socialization that may explain these differences in strategy use: women are socialized to define

themselves within a relationship while men are reared to define themselves through individuation and separation from a relationship. Not surprisingly, this leads to differences in comfort with intimacy and dependence. In times of crisis, men who are uncomfortable with vulnerability tend to distance emotionally from their partners and sexualize their needs for closeness, comfort and support.

The results dealing with parents' thoughts about the child's future once again revealed a father-mother difference. Though a high percentage of both parents reported future planning without relation to stuttering, fathers did so significantly more. Mothers found it harder to see the future without the stutter's influence. This result reflects the above-mentioned findings regarding differences between genders in the family according to traditional roles and societal expectations, which affect the self image mothers and fathers have about the role they play.

Further confirmation of this notion, via additional contextual insight is presented by Lazarus (1996), who stresses in his data, that gender differences were interpretable in terms of differences in the source of stress, namely, the well-being of a family member or any other external problems.

Looking at the parents' strategies, we see that beyond problem-focused strategies such as finding therapy (which all of them did) or exercising fluency techniques with their child, most of the other strategies used were emotion-focused: looking for external support (emotional), reappraisal, despair, suppression of feelings, guilt feelings, compliance etc.

Gray (2006) who investigated coping over time with families who have autistic children in a longitudinal study, found that coping strategies changed from problem-focused in the initial study to more emotion-focused 10 years later in the second one. He supports Lazarus' (1996) assumption that aging is linked to the use of more emotion-focused

coping strategies. It seems that parents' coping strategies found in our sample concur with this idea. However, in order to get a realistic perspective of changes in coping with child's stuttering over the years more research must be done on coping with parents of pre-school children who stutter on one hand and adolescents who stutter on the other.

3.2 Children's Strategies

Children showed a totally different profile from parents with regard to strategy usage. They used avoidance much more than parents. Not only did they report avoidant behavior but they practically avoided answering questions during the interview as well.

On top of it all, we found that their parents encouraged them to do so. Both parents described their child as socially adjusted mostly when he or she avoided direct violent reaction to teasing or bullying. For children who reported avoidance **all** parents reported adaptive behavior. For children who did not report avoidance only less than half of the parents reported adaptive behavior. For children who reported hitting behavior not even one parent reported adaptive behavior. These results show that parents perceived avoidance as a positive reaction strategy and seemed to reinforce their children's use of it.

These results concur with clinical experience which shows that children are expected to refrain from stuttering by controlling their speech and at the same time to control their behavior even when they are verbally attacked or bullied by peers. Wertheim (1973) also found that children who stutter are reinforced to over-control their feeling regulation which in turn results in deterioration of speech fluency.

Nearly 40% of the children tended to focus directly on the problem. This focus was expressed by explaining stuttering to the bully, calling attention to the bully's disadvantages or hitting the bully. We called these reactions problem-focused strategies (Lazarus & Folkman, 1984). Surprisingly, there were children who were courageous enough to report seeking external support and even reappraising their feelings or actions. Sandstorm (2004) cited Causey and Dubow's results which suggested a positive association between seeking social support and self-esteem. Kochenderfer-Ladd and Skinner (in Sandstorm 2004) examined the role of coping strategies as potential moderators of the effects of peer victimization on children's adjustment. Interestingly, they found that the effectiveness of particular strategies also appeared to vary as a function of gender. For example, victimized girls benefited from the use of support seeking, whereas victimized boys did not.

In our sample there were only 4 girls, and every one of them reported avoidant reactions, partly with parents' guidance, one of them denied having difficulty with speech during the interview and another one described using different strategies in different circumstances: when speaking with strangers who asked about stuttering, she explained what she knows about it (problem-focused). When reacting to bullying at school she tried to ignore it, as if nothing happened (avoidance). In any case, the small number of girls does not allow us generalizations but the impression is of a wide use of avoidance, partly reinforced by parents but partly due to typical gender role expectations; as Sandstorm (2004) delineates in light of her findings: "Gender atypical coping strategies were associated with poorer functioning, raising the possibility that gender role expectations contribute to the relation between coping and adjustment. For example, girls who approach peer problems in a direct,

assertive, or solution-oriented fashion may be disliked or viewed as maladjusted because their behavior contradicts the stereotyped expectation that females should be introspective and more attuned to feelings than instrumental goals. Similarly, boys who ruminate about interpersonal dilemmas may be particularly prone to ostracism because males are expected to act on problems rather than dwell on emotions." Since the number of girls in our sample is too small to speculate about gender differences this may serve as another subject for continued strategies oriented research with a greater sample of stuttering girls.

About 15% of the children in our sample used "denial" which was unique because parents did not report or demonstrate using this strategy at all during their interviews.

Anna Freud in "Ego and The Mechanisms of Defense" (1977 translated to Hebrew) regarded denial as a typical childhood defense mechanism in which "the childish ego is free to get rid of undesirable facts by denying them but nevertheless it keeps the ability of reality judgment intact".

Sandstorm (2004), who investigated how elementary school-aged children cope with common rejection experiences, found that poorly accepted children who used high levels of cognitive restructuring, minimization, and ignoring in response to peer rejection experiences were viewed as *less* aggressive by peers than their more realistically minded counterparts. This finding, consistent with a growing body of literature on the benefits of positive illusions (e.g., Taylor & Brown, 1988), suggests that the ability to ignore, de-emphasize, or reinterpret potentially hurtful rejection experiences may be particularly adaptive for unpopular children. Sandstorm (2004) speculates that the use of denial might allow rejected children to distance themselves from an *immediate* rejection experience, and therefore minimize the engagement of automatic aggressive

responding. After all, children who do not acknowledge feeling hurt or rejected are unlikely to generate hostile attributions about their peers' negative behavior, or initiate retaliatory behavior against them.

Another study by Rudenberg, Jansen and Fridjhon (1998), who investigated children's coping with an ongoing climate of violence in South-Africa, found that denial and distancing appeared to be the most commonly used defense mechanisms in the face of violence.

Both of these findings encourage thinking that denial may serve as a very useful strategy in avoiding direct conflict and its consequences on one hand, and keeping social status balanced on the other , for school-aged children who stutter just as for any other child.

At the same time, complete denial of social difficulties is likely to carry its own set of problems. As Sandstorm (2004) points out, poorly accepted children who remain completely blind to their lowly status are unlikely to make needed improvements in their interpersonal strategies, resulting in continued rejection over the long term. For children who stutter the same notions are valid with the addition of reaction to stuttering itself: Denial of inefficient strategies of coping does not enable looking for other, more efficient ones.

Avoidance, looking for external support, reappraisal and denial were all used by children and are all emotion-focused strategies. Lazarus and Folkman (1984) denote that whereas problem-focused efforts may be more effective when used in situations perceived as controllable, emotion-focused efforts may be more adaptive in situations perceived as uncontrollable. Children in our sample too, showed a variety of coping strategies which we suppose were used according to their conceptualization of the extent to which the bullying situation was controllable. This notion may be another factor influencing children's

coping beyond parents' perceptions and gender expectations and may serve as a subject for further research.

3.3 Additional conclusions with regard to the child's interview

Children were asked how many friends they had. Most of the children (89%) reported they had 3 - 7 friends or more at school. This datum is rather optimistic since children on this sample feel they do have friends at school more than in any other place even though they often suffer from bullying or teasing at the same place (Subellok, Katz-Bernstein & Vinbruck, 2008). This means children may not be as lonely as parents or therapists are anxious to think and not even as much as they themselves tend to think sometimes, because of stuttering. They may feel lonely because "nobody understands their problem" but not necessarily due to lack of friends. Wood's (1974) results confirm this notion. He found no significant differences between stuttering and fluent boys on social position measures, suggesting that whether or not an elementary school-aged boy stuttered was of minor importance in determining his social role among his peers.

In order to further investigate this assumption we looked for data about fluent children and their distribution of friends. Strauss and Polack (2003) investigated social marginalization of overweight children in a cross-sectional cohort study of 90,118 adolescents aged 13 to 18 years. They found that overweight adolescents received significantly fewer friendship nominations from others (mean number of friendship nominations was 3.39) than were received by normal-weight adolescents ($M=4.79$). Using their means of normal and over-weight children we can see that both means of nominations they found fall between 3 - 7 friends, just as reported by the children who stutter in our research.

With regard to stuttering children we found that Marge (1966 in Furnham & Davis, 2004) reported that dysfluent children held a lower social position than fluent ones. Davis, Howell and Cook (2002) found that children who stutter were rejected significantly more often than were their peers and were significantly less likely to be popular. When compared to children who do not stutter, the children who stutter were less likely to be nominated as 'leaders' and were more likely to be nominated to the 'bullied' and 'seeks help' categories.

When the children were asked if they knew the reason for the interview most of them reported they did know, but approximately 40% were not sure or reported they did not know.

When asked whether their parents had a talk with them about stuttering, 70% of the children reported their parents did talk with them but 54% reported they did not remember what their parents said. In addition, out of the 27% who reported their parents did not have a talk with them, there were parents who reported they did.

In general, the children's interview questions were quite often answered "I don't know" or sometimes not answered at all.

We interpret this behavior as reflecting the avoidance or denial strategies mentioned previously.

When asked who was it easier to talk with, the children reported friends and teachers in 58% of the cases. It seems that most of them preferred talking with non-authoritarian figures or figures whose authority wasn't emotionally biased. Some even preferred talking with people who did not know them at all. Maybe they felt like "opening a new page" in a relationship without the history of stuttering or maybe they felt strangers

don't really care how they talk and there is a fair chance they would not meet again so it was not important what the stranger/s thought.

The most difficult to talk situations were at school, on the phone or shopping, but about 19% reported no difficult to speak situations. Some of them reported that speech is always the same for them - either hard or easy; or that the difference is not dependent on the situation but rather on stress and non-stress periods.

When asked if they get remarks about their speech, 73% reported they did get such remarks. This result confirms the clinical experience of children and adults who stutter and suffer from environmental remarks.

Since the environment deals with stuttering, and not always in a preferable manner, it becomes vital to guide parents to talk about it with their children as part of their professional counseling.

When asked about the kind of reactions they got within the family, 31% of the children did not answer! Another 68% reported normal to supportive reactions to their stuttering. Another 8% reported bullying. The high percentage of "no answer" once again raises the possibility of unpleasant experiences that were denied, while talking to a stranger (the interviewer) whom the children could have tried to impress.

At the same time, we have to keep in mind that many parents did not want to leave their child alone with a strange woman (the interviewer) and listened in nearby or from a distance. There is a possibility that the children were aware of this and couldn't answer freely thus preferred not to answer at all.

Questions about outside of school friends' reactions resulted again with 31% who did not answer. Another 30% reported bullying and about 40% reported normal to supportive reactions.

No significant difference was found with regard to the frequency of "patient" responses of family and friends outside of school.

This accentuates the fact that family may be a safe place but potentially it is another "battlefield" for the stuttering child. On the other hand, friends may be supportive no less than family with their reactions to stuttering. In any case, admitting such unpleasant experiences takes courage and is not always obvious.

As previously mentioned, the pattern of "no answer" is understood as part of a defense strategy children used.

When asked about school the percentage of children who reported being bullied went up to 50%, while another 31% did not answer. It seems as though it is hard to admit such experiences, but children tend to be more willing to admit they happened at school since it is more likely to be experienced there (Subellok, Katz-Bernstein & Vinbruck, 2008). School is a highly competitive society and as such encourages impatience and violence, consequently the bullying experience there may be more intense than in any other social ground children may choose.

Nearly 60% of the children reported avoidant reactions to bullying such as continuing to do what they were doing before the negative comment or not reacting at all to that comment.

About 40% of children's reported reactions were either being active in a more socially acceptable way (talking with the child; calling an adult for help) or in a less socially acceptable manner (beating, cursing etc.).

The manner of reaction was found to be related to the parents' perception of their child's adaptive behavior, as detailed earlier in the context of avoidance strategy.

50% of the children reported they got negative reactions to stuttering. This datum confirms that the social reaction to stuttering has to be dealt with through therapy since most of the children suffer negative feedback that may aggravate their stuttering if they do not receive sufficient support. It is prone to affect their self-image without relation to stuttering and thus affect their present achievements and even affect them later on in life.

With regard to reactions children wanted to get, about 62% reported wishing for normal or patient reactions. This wish also reflects clinical experience where children complain about impatience, which impacts their adult life as well since they are already conditioned to think people don't have time to listen to their speech. It was interesting to find that 19% of the children wished to be helped and an additional 3.8% wished to be encouraged. Clinical experience shows children usually do not like their listener to say the words instead of them; despite this, the above mentioned children may be either special in their ability to get and use help or very dependent.

All the children could find something they do well.

When asked about something they do not do as well as others, more than 80% did find that something, but 19% did not. This 19% may be part of the hard core of children who avoided answering questions dealing with unpleasant subjects by not knowing the answer - using denial as a major strategy.

It is rather natural to avoid saying things about yourself that make a bad impression when talking with an adult stranger like the interviewer, but most of the children overcame this. It is plausible that these children are

the kind we meet in the clinic who think they have to do everything perfectly and without mistakes.

More than a third of the children reported their friends tell them what they do well and another third reported their parents are the ones who tell them. This illustrates that friends may also be a source for comfort and resilience, a source we should look for with the child at the clinic. It is startling that even today, with so many readily available ways of acquiring information about parenting such as on the internet and books that come out everyday, not all parents realize the importance of acknowledging the child's abilities and therefore it is essential that they be guided to do so through counseling in the clinic (Faber & Mazlish, 1998).

Other children reported teachers, grandparents and siblings as those who acknowledge their abilities. These sources of positive feedback may in some cases replace low parental awareness of such needs and help build up the child's resilience in the clinic.

Werner and Smith (Walsh 1998) reported studies of children's resilience. They spent 40 years following the lives of nearly 700 children reared in hardship on the island of Kauai. The children were mostly born to poor unskilled sugar plantation workers of various racial descent and a third of them were "at risk" because of exposure before age 2 to at least four additional risk factors such as serious health problems, familial alcoholism, violence or mental illness. Another Werner article quoted by Walsh (1998) emphasized that all the resilient children in the Kauai study had "at least one person in their lives who accepted them unconditionally, regardless of temperamental idiosyncrasies, physical attractiveness or intelligence".

In our research, teachers and grandparents may be the benevolent adult children reported about, who strengthened their resilience.

As a clinical recommendation we should keep in mind asking and encouraging children to find an adult mentor when parents' support is not available for some reason.

In about 62% of the cases, the children's reaction to their stuttering was negative, usually meaning they fantasized about the elimination of their stutter. As they put it in their own words: "Please, light a fire and throw the stutter into it" (11 year old boy); "I would like to throw it away to the garbage can" (8 year old boy); "destroy it" (10 year old boy). This percentage is somewhat low compared to our expectations that all the children would feel negatively towards their stutter.

In fact 27% of the children had positive feelings towards their stutter and did not want to eliminate it ("I would make the stutter smaller and add it to the good things I have" – 11 year old girl). However, even the positive attitude towards stuttering depended on some change – making it smaller. About 8% were ambivalent, for example: "I would keep the ball of stuttering or maybe not, I prefer swimming but if I had to choose between having a fight and stuttering I would choose stuttering" (7 year old boy). Some children demonstrated a complex relationship with their stuttering which cannot be addressed in a simple "positive or negative" categorization.

When comparing children's attitude and parents' change of attitude towards stuttering there was no significant relationship. The vast majority of children had a negative attitude towards stuttering although most of the parents reported a positive change in their attitude towards stuttering.

4. RELATIONS BETWEEN PARENTS' AND CHILD'S PERCEPTION OF STUTTERING AND COPING WITH IT

A high Correlation coefficient was found between frequency of stuttering reports given by parents and children. This indicates that parents and children felt the same way about the stuttering frequency and were either rather realistic or mutually influenced. Zebrowsky (1993) concluded that parents' perceptions of their child's speech are formed, at least partially, in response to what the child is actually doing. Prizi-Jakovac (1999) found that parents' attitudes toward and understanding of children's stuttering correlated with objective measurements of stuttering frequency, block duration, and physical concomitants, as well as with stuttering intensity assessments and stuttering intensity self-assessments of the children. In our sample the result was similar regarding parent and child perception of stuttering frequency as a measure of severity.

It is quiet surprising that even though frequency of stuttering is perceived similarly by parents and children, in the clinic parents are more eager for therapy than the child who usually denies the problem or the feelings involved.

We compared children who reported their family tells them things they do well to children who did not report their family tells them things they do well.

The first group was found to have a significantly higher family cohesion score by both parents. It seems that in families with higher family cohesion, parents tend to talk with children about their positive traits or functioning and not only about their problems or disadvantages.

In addition, children reported easier speech in the family where parents' couple cohesion reports were significantly higher. The same tendency was found for family cohesion reports of these children.

In our sample we found that family cohesion, and especially couple cohesion, is strongly related to easy speech in the family and children's acknowledgement of their advantages.

As previously mentioned, the same factor of higher couple cohesion was strongly related to the parents' positive attitude change towards stuttering and positive change in the family. It was also related to ambivalence and different degrees of acceptance as reported by parents with regard to self-appraisal of the family's coping.

Integration of all these findings implies that the best thing that can happen to a stuttering child is having parents who keep close and supporting relationships first of all between themselves as a couple. It seems that a positive relationship between parents inspires them to view their child who stutters and the disability in spite of its existence, in a positive manner. They are able to acknowledge and verbalize the child's advantages and even to "forgive" the stuttering, and by doing so facilitate the child's talk with them and with other family members. It is as if they are saying "when we're together the problem becomes smaller".

This is not the result of ignoring the stuttering because we have seen that parents are rather realistic with regard to stuttering frequency and to the fact that it may not disappear. Instead it is the parental ability to see some more colors in the picture, other aspects of their child as well. It prevents identifying the child and the stuttering as a united entity and enables differentiation between them. It is realizing that there is a living, breathing child who has a problem, as an alternative to thinking that the child **is** the problem.

Couples who are close and supportive give one another a "safe place" to be as both people and parents, thus each enables the other to support their child who stutters. In order to support someone else, especially one's own child, people first and foremost must feel they themselves are supported.

This notion is supported by Walsh's (1998) family resilience theory who emphasizes that in times of trouble, family members do best when they can turn to one another for support and collaboration. She refers to Stinnett and his colleagues who found that pulling together is one of the most important processes in weathering crises.

As mentioned above, when discussing "avoidance" as a typical strategy used by stuttering children, it is important to stress in this context once again: both parents described their child as socially adjusted mostly when he or she avoided direct violent reaction to teasing or bullying but not when the child reported hitting behavior. These results show that parents perceived avoidance as a positive reaction strategy and seemed to reinforce their children's use of it. Given that this strategy was so widely used among our subjects it is inevitably concluded that the parents' perceptions influenced the children's behavior in implementing the "avoidance" strategy.

To summarize our conclusions on this subject, we didn't find any direct influence of parents' perceptions on their children through comparing attitudes towards stuttering. Nevertheless, we found indirect expressions of parental influence through family and couple cohesion affecting the child's self-image (acknowledgement of the child's advantages) and stuttering severity (difficulty of speech with family members). In addition, we found influence of parental demand to avoid overt aggression expressions in society and over-control of behavior on children's avoidant behavior in social situations.

As professionals we know that the parental image of the child (as characterized by negative or positive traits and abilities) may affect the

child's self-image, and by doing so, impose either mental stress or relief. This in turn and excessive control of behavior in general and of speech in particular, may affect either fluency or stuttering severity. In our sample we can see that family cohesion, especially the relationship between parents as expressed by couple cohesion, has an influence on speech as well.

Yet we have to take into account that there may be an interactive relationship between speech and couple cohesion which means that changes in fluency or stuttering severity may affect couple cohesion by the mere fact that the child's stuttering is in itself a stressful situation for the parents. Given that stress has the potential of distancing the couple and reducing couple cohesion (Lavee, 2004), relieving the stress by lessening the severity of stuttering may have the effect of drawing them closer once again.

5. CLINICAL IMPLICATIONS

1. When counseling one parent, the professional should keep the other parent in mind as a supporting person in the background. The other parent should be kept informed in order to take part in making decisions concerning the child and the therapy, according to the relationship and the possibilities.
2. In the best case scenario and if possible the professional can try to make parents aware of their couple cohesion by inviting both of them to come to therapy and during the meetings, accentuate the moments when they can empathize with one another by expressing their feelings about the stuttering of their child.

In addition, the fact that both parents work together with their child in a common effort towards easy speech and communication has a cohesive

value of its own, provided the child's age and developmental needs are taken into account. This does not imply that both parents at the same time have to take the child to therapy, do exercises or get counseling, but rather that both are involved in therapy in a way that is suitable to both of them and engenders a feeling of reciprocal support. During the interviews some mothers reported shared responsibility even though they were the ones' taking the child to therapy, exercising or receiving counseling. In spite of all that they felt supported by their spouses and did not perceive it as carrying the burden alone.

These recommendations do not necessarily suggest that the speech therapist professional is in charge of couple cohesion during stuttering therapy, but rather that by using professional tools the therapist can contribute to couple cohesion, which in turn generates progress in the parents' coping and consequently, their child's coping as well.

Couple cohesion may enhance parents' ability to keep the boundary between the couple unit and the children's unit in the family thus avoiding undesirable parent-child coalitions which may contribute to stuttering maintenance by the child who stutters through becoming the "identified patient".

Another recommendation regarding couple cohesion is encouraging parents to take care of their own well-being and their own relationships in various ways outside the therapy room (spending time together; sharing; going to family therapy if needed).

2. Given that the environment will always react to stuttering but not always in a desirable manner, it is vital to guide parents, as part of professional counseling, on how to talk with their children about responses to remarks aimed at their stuttering,.

3. Counseling of parents should refer to behavior control demanded from the child, to the range of possible assertive behavior strategies, and to

encouraging the child to consider these strategies, if they are effective and suitable, as plausible options. At the same time counseling may offer other ways to discharge negative energies children may have such as Marshall Arts or other physical activities.

4. It is important to get information about the parents' coping resources within and outside of the family and to refer to them during counseling.

5. It is necessary to deal with guilt feelings and despair during counseling and try to lessen their influence on the parents' coping.

Both parents' results confirm a common personal experience that it is harder to change to a positive attitude when one is feeling guilty or desperate.

6. It is important to reveal the family's narrative about stuttering especially for families with former stuttering. That narrative may have a dramatic impact on both the parents' and child's coping. Sometimes there has to be invested effort in order to change their narrative so that progress can be made in therapy.

6. SUGGESTIONS FOR FURTHER RESEARCH

1. In order to get a realistic perspective of changes in coping with a child's stuttering over the years, more research must be done on coping with parents of pre-school children who stutter on one hand and parents of adolescents who stutter on the other. A longitudinal study may fulfill the same purpose.

2. A larger sample would enable researchers to get significant results on several issues such as, among others, the following: parental perceptions influence on child perceptions, gender differences in strategy use of school-aged stuttering children. The latter may serve as a subject for continued strategies oriented research with a greater sample of girls who stutter.

3. It is necessary to add some objective measures to subjective reports on a number of issues, for example: an objective measure of stuttering severity besides the subjective assessment of child and parents. Another issue is social marginalization of stuttering children not only according to their own report but through their peers' reports as well, so that results would be as objective as possible. It is desirable in this case not to give children a range of numbers in advance, as it was done on our research questionnaire, but to ask for specific names and numbers of friends they and their peers have in mind. Having this kind of results will enable examination of relations between the number of friends, stuttering severity and temperamental factors of school-aged children who stutter.
4. We assume that the children in our sample demonstrated coping strategies use according to their conceptualization of the extent to which the bullying situation or speech situation was controllable. This notion may be another factor influencing children's coping beyond parents' perceptions and gender expectations and may serve as subject for further research.
5. The subject of individual differences between stuttering children according to personal traits, requires further study. In that way we will be able to offer different children the suitable therapy according to their needs.
6. In order to find the proportion of parental influence contrasted to peers influence and to the child's self-image and coping strategies with stuttering it is desirable to use a variety of measures for each of these subjects and find their relative influence on coping in order to consider them properly in the clinic.
7. Walsh (1998) draws attention to the fact that her concept of "family connectedness", which is in fact synonymous with our concept of cohesion, is culturally biased. High cohesion or separateness is not

necessarily pathologic but frequently dictated by ethnic group norms. Comparison of the results of this study with a similar one that was already conducted in Germany (Subellok 2005) will enable us to examine cultural influences on family and couple cohesion and on the coping in families of school-age children who stutter.

7. SUMMARY AND CONCLUSIONS

The onset of stuttering is in fact the onset of a family crisis, like the discovery of any other developmental or childhood disability. This crisis sets into motion a coping process with specific stages and involves the use of strategies that may be efficient to different degrees in their contribution to resilience.

Self-appraisal of parents in our research seems to reveal stages they go through coping with their child's stuttering during the school-age period which resemble stages of coping with other childhood disabilities, as detailed below:

1. Feeling pain and sadness when acknowledging the problem.
2. Ambivalence – feeling pain and at the same time hope, trying to treat stuttering in order to eliminate it.
3. Acceptance to different degrees – beginning to acknowledge stuttering would not disappear and accept it first in specific conditions (home environment; family; intimate conversations etc.) and later on in some public situations as well.

Transition between these stages is achieved with growing couple cohesion, especially between the stage of pain expression and sadness and the stage of ambivalence.

Couple cohesion and spouse support enabled positive attitude change towards stuttering through the years for parents of school aged children and positive change in family due to stuttering as well. Stuttering

frequency reports of children and parents were highly correlated but did not relate to change of attitudes.

In families with higher couple cohesion children felt it was easier to talk with family members and were acknowledged for their advantages and thus were able to build a versatile self-image composed of abilities, instead of exclusively identifying with the stuttering disability.

In families with former stuttering there was a tendency to report negative or no change in the family due to children's stuttering.

Former stuttering in close family made it harder for mothers to accept that stuttering would not disappear and caused them great disappointment.

On the other hand, fathers in these families accepted the idea more easily. Strategies of coping differed between mothers and fathers moving ahead in the coping process. Fathers used more suppression of feelings and mothers used more external support and reappraisal. The last strategy was the only one found to be related to positive attitude change towards stuttering. Parents reporting despair or guilt feelings found it harder to change their attitude towards stuttering.

Children's coping was characterized by avoidance which was a strategy evidently encouraged by their parents. Children who used avoidance were all reported as socially adaptive by their parents, which was significantly more than children who did not.

Our major general conclusion of this study confirms once again the importance of supporting and counseling parents of stuttering children as a part of the interventions (Rustin & Purser, 1991; Katz-Bernstein, 1991; Rustin, Botterill & Kelman, 1996). Derived from that conclusion is the imperative need to train Speech Clinicians to master the skills of counseling parents, both as a basic skill for informal talks during treatment of the child, as well as a specialized skill, included as part of the treatment (Katz-Bernstein, 1991).

