

"I can't think of anything to write about except families. They are a metaphor for every other part of society."

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CHAPTE A: THEORETICAL BACKGROUND

1. What is stuttering?

Defining the stuttering disorder is a complicated task. Yairi and Ambrose (2005) exemplified it in the observation that "everyone knows what stuttering is except the expert".

They point out that many proposed definitions have been expressions of various points of view regarding the etiology and nature of the disorder, for example: Coriat (1943) regarded stuttering as psychoneurosis; Eisenson (1958) thought of it as a transient disturbance in communicative propositional language usage; Van Riper (1971) regarded it as a temporal disruption of the simultaneous and successive programming of muscular movement in the production of speech and Brutten and Shoemaker (1967) thought of stuttering as a form of fluency failure resulting from conditioned negative emotion.

Yairi and Ambrose (2005) cite The World Health Organization's definition (1977) "disorder of rhythm of speech in which the individual knows precisely what he wishes to say, but at times is unable to say it because of involuntary, repetitive prolongation or cessation of a sound". As illustrated, the different definitions describe stuttering as a psychiatric disorder, a language disorder, a motor disorder and a learned disorder, while the latter places considerable weight on subjective experiences of the person who stutters in addition to symptomatology.

Motsch (1992) points out the intermittent character of stuttering. Very few people who stutter demonstrate other language disorders. The appearance of the disorder depends on the subjective appraisal of the situation: how much stress does the person who stutters feel is put on him by the environment's expectation that he/she will be fluent. Therefore, according to Motsch, early interaction has to be considered for families with stuttering children as a part of the intervention.

In our research we were interested in the subjective point of view of children who stutter and their families so we continued searching for a definition that includes not only the symptomatology, but the consequences for the function of the individual in his environment as well.

DSM4 includes additional symptoms such as blocking, circumlocutions and physical tension, and also indicates interference with academic, occupational achievements or social communication as diagnostic criteria for stuttering.

Yaruss (2007) suggested the World Health Organization's International Classification of Functioning, Disability and Health as a framework for considering the overall experience of stuttering disorder.

This classification describes Body Function (BF - what the body does) and Body Structure (BS - what the body has) and also Activities (how BF and BS relate to what a person wants to do on a daily basis) and Participation (what a person wants to do in his /her life as a whole). With regard to these elements, Yaruss (2007) goes on to describe the stuttering experience as follows:

Body Function: People who stutter experience uncontrolled speech fluency. They experience various degrees of impairment in body function related to fluency of speech, rhythm of speech and speed of speech.

Body Structure: Anatomical structures of the vocal tract, respiratory system and larynx are considered to be intact in people who stutter, however recent research revealed evidence of neuroanatomical differences between people who stutter and people who do not stutter. Confirming such evidence through additional research may warrant an application of a code indicating impairment in body structure.

Activities and Participation: People who stutter frequently experience difficulty producing messages and participating in conversations and discussions.

These difficulties may have a broader effect on the speaker's life. When dealing with school-aged children it may be expressed in forming relationships and interacting according to social rules, succeeding in education and participating in community events and various social interaction (with family members, friends, teachers, religious practices etc.) (Yaruss, 2007).

Contextual Factors: this section includes Personal factors and Environmental Factors.

In the fluency disorders literature the personal factors are referred to as the affective, behavioral and cognitive reactions a speaker may experience to his or her stuttering. These may include embarrassment, shame, anxiety and fear as affective reactions; tension and struggle during speech and avoidance of words or situations as behavioral reactions; and reduced self-esteem associated with the individual's ability to deal with stuttering as cognitive reactions.

Environmental factors include parents, teachers, peers, coworkers, employers and speech therapists.

This indicates that stuttering has a potential of interference in various aspects of social life and must be treated from this point of view.

Since families are the first social construct within which children live and grow, their significance in children's lives is obvious. This idea leads many clinicians to think that child stuttering may be affected by home environment, parents' personalities and their child-rearing habits (Rustin & Purser, 1991; Mallard, 1991; Motsch, 1992; Yairi, 1997). The reverse - the continuous influence of stuttering on a child's family - has usually been overlooked by researchers (Katz-Bernstein, 1992; Yairi & Ambrose, 2005; Subellok, 2005).

In this work we will try to shed more light on these two-way relations between the child's stuttering and the child's family from both the parents' and child's point of view.

2. Why school-aged children?

Clinical experience shows that therapy for school-aged children is somewhat more complicated than for younger children.

Why is that?

Usually the child goes to therapy because the parents think there is a problem of speech. The child either finds it hard to admit that there is a problem or thinks "I'm OK". In case the child does want therapy, it is due to a feeling of failing in social relations at school either with adults and /or with peers, and blames it on stuttering.

According to Erikson (1950), at this age the child enters a stage of industry, which means "he adjusts himself to the inorganic laws of the tool world". Consequently, "the child's ego boundaries include his tools and skills" at the end of this stage.

One of the major tools used in order to be industrial and productive at school either in social relationships with peers or in school tasks (with teachers) is speech. Hence being skilled in fluent speech may become

crucial for the child's developing industry. Failing to develop such competence may lead to a sense of inferiority (Erikson, 1950) which is a feeling expressed quite often in therapy by stuttering people, even in the more advanced stages of life.

School-aged children who stutter may need support in order to pass this stage with feelings of productivity. Family life may prepare them for school life (Erikson, 1950). The family has to play a role not only in preparing the stuttering child for school life, but also in coping with stuttering.

A further consideration is that social demands begin to be a central issue affecting the school aged child's self- estimation. Becoming aware of his or her lack of fluency, the family can no longer protect the child from comparing his or her speech to the speech competence of other children. This work deals with the question of coping from the family's perspective and therefore includes the child's perspective as well.

The family deals with rearing a child who has an apparently poorly honed "productive tool" called "stuttering". This, after some years of experience as parents to a child with an exceptional speech, since stuttering usually begins much earlier, in the preschool period (Rustin, Fry & Nicholas, 1987; Yairi, 1993). It seems parents are prone to be disappointed because spontaneous recovery never happened and feel burned-out on one hand, or that they developed better ways of coping which make life easier for them and /or their child, on the other (Subellok, 2002).

One way or the other many families have to deal with the dilemma, as Featherstone (1993) expressed it:

"Do we have to accept the child's limitation in order to accept the child? Is it possible to accept it on one hand but still go on fighting for making a

change? Does acceptance not mean somewhat reducing efforts fighting for your child?"

Since coping is a process as mentioned above, interviewing parents of school-aged children makes it possible for us to learn from people who are going through the process in real time and have already gained some experience in that subject matter. This will provide us with a foundation to plan a better support system for the family as a part of clinical interventions.

We interviewed the children themselves in order to understand their point of view as well as their parents'. It was essential to speak with children who have some level of awareness as to their situation, and who have some history with their disability. This could be better achieved with school-aged children than with pre-schoolers. Like their parents, children also had to cope with the fact that spontaneous recovery is not going to happen. As soon as they enter adolescence, their peers would gain greater significance in their lives and would probably be a potential influence on their attitudes. Therefore, we felt it was important to interview children before major peer influence takes place.

In light of the above mentioned ideas we thought interviewing families with school-aged children would provide some relevant information, scientific or clinical, on coping with stuttering.

3. What do we mean by "coping"?

The term is defined by Lazarus and Folkman (1984) as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person".

They emphasize that this definition is process-oriented rather than trait-oriented. It also makes a distinction between coping and automatic adaptive behavior, since efforts have been invested.

These efforts to manage are not dependent on outcome, so "coping" includes "anything a person does or thinks, regardless of how well or badly it works."

The word "process" indicates that we are dealing with a time consuming phenomenon and not a single point event, in which case characterizing features of coping may change over years.

Circumstances are taxing for families who have a child with the kind of disability that oscillates between appearing and disappearing, and parents of stuttering school-aged children have been experiencing this for several years. Stress is caused not only by the stuttering itself, but also by its unpredictability.

According to Lazarus and Folkman's model of coping, people use two kinds of strategies to cope with stressful situations:

1. Problem- focused coping that is directed at managing the problem causing the distress.
2. Emotion-focused coping that is directed at regulating emotional response to the problem.

Both kinds of strategies are used after cognitive appraisal of the situation: problem-focused strategies are used when the problem is appraised as changeable. Emotion-focused strategies are used when there is an appraisal that nothing can be done to modify the distressing situation. Both kinds of coping strategies are used to different degrees in order to deal with external or internal demands posed by real-life stressful situations.

3.1. What are problem-focused strategies?

These kinds of strategies are similar to problem-solving strategies. They are usually directed towards defining the problem, generating some alternative solutions, weighing costs and benefits, choosing and acting on them.

Problem-focused strategies include not only processes focusing on the environment, but they may be directed inward as well. The latter strategies are directed at motivational or cognitive changes such as shifting levels of aspiration, reducing ego involvement, finding alternative channels of gratification, developing new standards of behavior or learning new skills or procedures.

3.2. What are emotion-focused strategies?

Emotion-focused coping strategies that are directed at *decreasing* emotional distress include avoidance, minimization, distancing, selective attention, positive comparison and wresting positive value from negative events. Sometimes emotion-focused strategies are directed at *increasing* emotional distress because "some individuals need to feel worse before they can feel better" (Lazarus and Folkman 1984). Consequently, they engage in self-blame or self-punishment.

Other emotion-focused strategies lead to changes in the way the problem is construed without changing the objective situation. This is called *reappraisal*. Although reappraisal is a cognitive process it is usually focused on changing emotions, a threat may be diminished by changing the meaning of the situation. For example: "I decided there are more important things to worry about" or "I considered how much worse things could be" (Lazarus and Folkman 1984).

One of this work's objectives is finding out what kinds of strategies are frequently used by parents of school-aged children who have a stutter in order to cope with the problem.

4. How do parents cope with a child who has a disability?

Since there is very little literature dealing with coping of parents who have stuttering children, we tried to find inspiration in literature about families with children who have other kinds of disorders.

When a special needs child is born, it usually violates the balance of the family system and has long term consequences for both the child and the family (Levy-Shiff & Schulman, 1998).

When the family does not discover the child's disability immediately after birth, but rather later on, the effect is similar and many researchers describe it as a crisis (Levy-Shiff & Schulman, 1998).

Theories about this crisis tend to describe a process with stages which are related to typical reactions. During the family's adaptation every stage involves different kinds of parental feelings about the situation. Fortier and Wanlass (1984) offered a 5 stages model families go through:

- 1) **Stage of impact:** characterized by anxiety and shock, fear, concern and disorientation, confusion when getting the message.
- 2) **Stage of denial:** characterized by disbelief, search for help in many places (shopping), feelings alternate between hope, despair and avoidance of feelings. Cognition includes fictionalized explanations, distorted expectations, not hearing.
- 3) **Stage of grief:** anger, helplessness, sense of loss, self pity, self doubt, guilt, sadness, impotence, feeling different, sense of isolation and revival of unresolved feelings. Questioning "how" and "why", death wish toward the child as possible solution, thoughts about what will be in future.
- 4) **Stage of focusing outward:** information seeking, increased friendliness and contact with others, reconsidering options, formulating plans, increased awareness of reality and some feelings of relief and confidence.

5) **Stage of closure:** feeling calm, beginning to meet needs of child and family, emergence of family solidarity as new goals are targeted, increased closeness with similar others. Cognitions deal with acceptance of child and situation.

Many parents report a continuous stress situation which has long term influences. According to Baruchin (Duvdevani, et al., 1998) parents of a child with special needs feel much more stress than parents of other children who are the same mental or chronological age. She found powerful correlation between feeling stress and parents' perception of their functioning: the higher the level of stress parents felt, the less normal they perceived their own functioning. Moreover, the higher the level of stress parents felt, the more they demonstrated negative behavior and speech towards their child.

Parents of special needs children showed a higher level of mental exhaustion in comparison to parents of normal children who are the same chronological or mental age (Viessman 1991 in Duvdevani et al, 1998). The same research showed that mothers of special needs children felt more mental exhaustion than fathers; a fact which is not surprising since the mother is more involved in the daily care of the child and probably has to give up personal and professional development more frequently than fathers.

Nevertheless, there are researchers who emphasize positive coping of parents. As Kelso, French & Fernandez (2005) point out: "While it cannot be disputed that parents of disabled children face a great deal of stress, this stress does not necessarily lead to dysfunction (Beckman 1991).

Outcomes range from successful adaptation to maladaptation. (Foster, Byron and Eiser, 1998 in Kelso et al. 2005). They interviewed parents of children with developmental disabilities and elicited stress sources when raising a child with a disability as well as coping resources accessed by

parents. The most common cited by parents was social networks resources. These included marital relationships, friends, doctors, government disability services, church groups, teachers, babysitters, interim care, support groups, non profit organizations and Education Support Units, Centers and Schools.

There were parents who reported previous exposure to people with disabilities that required use of coping skills as positive in helping them cope. Half of the parents mentioned personality variables as an important factor in coping which included a sense of humor, a day-by-day approach to life, maintaining a positive outlook and the need to be in control. All parents referred to at least one emotion-focused coping strategy such as: relaxing; turning to religion; avoiding the stressful situation; releasing emotions by crying, laughing, humor, acknowledging personal success when raising the child; acceptance; seeking out social support for emotional release and developing as a person. Parents reported use of problem-focused strategies either directed externally (seeking information, negotiation to resolve conflict, learning a new skill etc.) or internally (cognitive reappraisal, reminding oneself how bad it could be etc.). Out of 26 parents in Kelso et al.'s research (2005), 24 noted they were coping well with stressors they faced when raising a child with a disability, which means they were generally successful in maintaining a healthy and positive approach to life. Many parents reported that the transition to "feeling better" took several years. The first two years of the child's life were extremely stressful but they perceived circumstances as getting better as the child developed.

Another positive coping research was conducted by Shu-li Lin (2000). He cites the Resiliency Model of Family Stress, Adjustment and Adaptation which defines family coping as "a specific effort (covert or overt) by individual members in the family or the family function as a whole to

decrease or handle a demand on the family and to acquire resources to manage the situation associated with the demand." In his research he investigated families with children who suffered from CP aged 0-21 years. He found that coping strategies of families changed through the years: Parents of infants and pre-schoolers seemed to use coping behaviors related to increasing knowledge regarding CP and seeking more external resources than families with young adults. Families with school-aged children used more coping behavior related to positive family appraisal and had better positive social interactions than families with young adults. These families appeared to have better family adaptation than families with adolescents and families with young adults. This change in coping strategies over a life time is of interest to us since we are dealing with school-aged children who stutter and their families' strategies are also likely to change over the years - but is it the same change parents of children with other disabilities go through?

5. How can parents or families influence their stuttering child?

5.1 Genetics

According to Yairi (1997) the genetic factor is the most solidly established one in research concerning the family's influence on a child's stuttering.

There is a 42% chance for a stuttering child to have a stuttering parent and more than a 70% chance to have a stuttering member in the extended family (Ambrose, Cox & Yairi, 1997).

It seems that recovery also has to do with genetics. Yairi, Ambrose, Paden and Throneburg (1996) found that chronicity and children's recovery from stuttering were significantly related to the presence of similar trends among relatives. Chronic stuttering relatives either in the

immediate or extended family elevated chances for continuous stuttering of the child, whereas recovered relatives did not.

5.2 Findings about speech rate

There are contrasting findings on this subject matter:

According to Izakson's (2001) findings, speech rate for parents of children who stutter was higher than for parents of fluently speaking children. Supporting this is a series of articles by Meyers and Freeman (1985) who found that mothers of stuttering children tended toward higher speech rates in general even when speaking to children other than their own.

In contrast, Kelly and Conture (1992) did not find any difference in speech rate between parents of children who stuttered and fluent ones.

According to Yairi's review of 50 years of research, no difference was found in speech rate or disfluency of stuttering children's parents compared to fluently speaking children's parents. Miles and Ratner (2001) as well, did not find differences in speech rate between mothers of stuttering and fluent children.

Even if undoubtedly different speech rate had been found, it still would not have proven that it affects the child's stuttering. Yaruse and Conture (1995) found that the severity of stuttering was positively connected with the gap between the parents' and child's speech rate. This suggests that the child-parent speech rate gap may be more influential on stuttering severity than parent speech rate alone.

5.3 Findings about communicative-pragmatic indexes

Meyers and Freeman (as reported by Nippold & Rudzinsky, 1995) found that mothers of both stuttering and fluent children interrupted their children's speech 7 times more in disfluent than fluent situations.

This indicates that a stuttering child, especially in moments of disfluency, has more chances of experiencing speech interruptions.

Kelly and Conture (1992) found that simultaneous speech of mothers to their 4 year olds was higher as stuttering severity was higher. No differences were found in reaction latency and in overall interruptions of speech between groups.

Izakson's (2001) findings that included data on 32 families who have children between 30-50 months of age, showed that parents of the fluently speaking group had more efficient communication on indexes of speech rate, questions, latency and reaction to subject. There were no differences in indexes of listening, turn-taking and direction between groups.

At the same time, she found that parents of stuttering children were more effective in non-verbal indexes than parents of fluent children.

5.4 Findings about linguistic complexity

Kelly (1995) found differences between fathers and mothers in interaction with their stuttering child. Fathers tended to require higher linguistic and cognitive levels of conversation.

Miles and Ratner (2001) deal with Starkweather's theory of stuttering which was called Demands and Capacities. This theory is based on the assumption that semantic and syntactic complex models of parents' language is an impossible challenge for their stuttering children since it is not suited to their cognitive, motor, linguistic and emotional abilities.

The theory emphasizes the gap between the parents' demands and the child's capacities. The gap does not mean the child's capacities are low, but rather shows that the parental demands lack adjustment. .

Even though it is a widespread theory of stuttering development, there are vague findings to reinforce it. One 1986 research found more questions and demands in the speech of mothers of stuttering children than in that of controls', but it was a small sample with too great an age range.

Miles and Ratner (2001) draw attention to a different aspect of looking at parents' speech. In their opinion, we have to take into account the change of speech style as a *result* of stuttering and not only as a stuttering supporting factor.

Kloth, Janssen, Kraaimaat & Bruten (1995) investigated mothers of children at risk for stuttering before onset and a year later, but did not find significant differences in speech rate or communicative style between mothers whose children had stuttered already and mothers whose children had stayed fluent. The only difference found was shorter MLU for mothers who had later stuttering children in comparison to the mothers of children who stayed fluent.

Miles and Ratner (2001) also couldn't find any difference in syntactic complexity between mothers of stuttering and fluent children shortly after onset. They did not find any differences in lexical diversity and rare vocabulary usage, or even in mean length of turn in conversation. Once again this shows no differences in the way parents of the two groups adapted their language to their children's development.

Nippold and Rudzinsky (1995) summarize their review about relationship between parent's speech and the stuttering of their child, acknowledging that until that time there were no consistent findings to support the existence of such relations between children's capacities and parent's demands.

5.5 Findings about parents' attitude towards their stuttering child

Thought and research about parents' attitudes have changed dramatically over the last century. Johnson (1959) believed that "stuttering begins in the parent's ear". He suggested that parental criticism of a child's developmental disfluencies leads to stuttering. In his view, the reason for stuttering was the parents' negative attitude toward their child's normally developing speech.

Glauber (1958) believed that stuttering children have a mother who is a "stutterer" in personality and usually married to an overtly stuttering father. She often marries a passive man and their relationship is sado-masochistic, propelled by the need to control and possess or by a sense of duty and little by positive satisfaction. The father is nearly absent in his father-role. He helps maintain the confusion of the parental roles in the family. Glauber thought that mothers contribute to the initiation of stuttering and fathers contribute to its maintenance.

Wyatt and Herzan (1962) thought stuttering could be traced to a disturbance in the mother-child relationship when the child practices grammatical speech between two and four years of age. She describes conversation "over the child's head" in which the child cannot learn to speak by listening because the words and concepts he hears are beyond his comprehension.

Research on the 1950's and 1960's suggested that parents of stuttering children were more prone to apply pressure and have negative attitudes towards their child than parents of fluent children (Yairi, 1997). They were identified as dominating, over-protective, having high expectations and perfectionists in child education (toilet habits, cleanliness, eating and

speech). In addition, they were characterized as rejecting and having an undesirable evaluation of their child's personality (Yairi, 1997).

Yairi (1997) added that according to his review children who stutter tend to be raised more frequently in less harmonious, more socially withdrawn families, who take less time to enjoy each other's companionship than are non-stuttering children. Inspiration for these ideas was drawn from Andrews and Harris' (1964) findings which suggested that stuttering children tended to come from socially deprived homes more than fluent children.

Glasner (1949) found that school-aged children who stutter are perceived by their mothers as being more sensitive, more susceptible to stress and more behaviorally inhibited than their non-stuttering peers (in Yairi & Ambrose 2005).

Wertheim (1973) found that parental ego dysfunction affects their stuttering child's ego function. She investigated perceptual attitudes of 16 families with 7.5-10.5 year old boys who stutter and 16 families with fluently speaking boys of the same age range. She claims that maternal and paternal constraints found more frequently in families with boys who stutter, encourage the offspring's excessive control over his own behavior and convey the idea that his control is inadequate. An additional finding shows that fathers of the boys who stutter score more often on perception of superior self-regulation and superior degree of competence. In contrast with Glauber's theory of a passive impotent father and a dominating mother, she claims that "by supporting the father's omnipotent self-perception in the framework of the family, the mothers reinforce the salience of the association between being a male and having a superior degree of competence."

She concludes that "the pathogenic impact of parental ego defects on the offspring is not a simple function of each parent's personality but rather

of the resulting balance. This balance was found to provide a highly efficient differentiation between stuttering and non-stuttering offspring." With the same climate of differences between parents, Bernstein-Ratner and Silverman (2000) tell us about findings from the 1960's, according to which, mothers with stuttering children expected lower scholastic achievements and put forward lower standard targets for their child in comparison to control groups. In contrast, fathers tended to over-estimate their child's ability on coordination tasks and linguistic tasks.

With advances in research throughout the years, ideas of differences between parents of stuttering and non-stuttering children in attitudes towards their children were put to the test.

Cox, Seider and Kid (1984) studied subjects from 14 families with several stutterers (5 or more) and subjects from 10 control families with no stutterers to elucidate both genetic and non-genetic factors relevant to stuttering. In order to examine non-genetic hypotheses regarding the etiology of stuttering and environmental factors possibly predisposing stuttering, data was collected using 2 structured case-history interviews and 4 self-report inventories. Pre-natal, developmental, or medical factors did not distinguish stutterers from their non-stuttering family members. In addition, they did not find evidence of differing anxiety levels from among stutterers, their non-stuttering family members, and non-stuttering controls. Familial attitudes toward speech did not differ between non-stuttering family members of stuttering individuals and those of non-stuttering controls. There was no difference in ratings of parental behavior or children's traits that distinguished stutterers from non-stuttering family members.

Bernstein-Ratner and Silverman (2000) raised the possibility that the parents' over-estimation or lower expectations of their stuttering child

may have to do with the parents' beliefs and attitudes, but it also may express parental acquaintance with their children. They put this assumption to the test with children near onset, hypothesizing that a parent that estimates his child's communicative skills incorrectly will have high expectations which do not fit the child's actual abilities. They checked parents' attitudes towards their children's communicative development through questionnaires and the children's actual development through different language tests. They found that parents of stuttering children estimated their child's communicative development as significantly lower than parents of fluent children matched for age and SES.

When testing linguistic skills they found that stuttering children functioned within normal range both as individuals and as a group. Nevertheless, their mean function mark was significantly lower than that of fluent children in some tests and in others, lower with a strong tendency.

They also found that parents of stuttering children answered the questionnaires in a more adaptable way to their child's real development than the fluently speaking children's parents. There was also higher agreement between parents of stuttering children about the developmental level of the child than between the parents of fluent children.

In a preliminary study Nicholas, Yairi, Davis, Mangeldorf, Cook and Hamilton (2006) found that parents of school-aged children who stutter rated them lower than the children's ratings of themselves on a temperament questionnaire. Their parents rated them as (a) being less able to focus and shift their attention, (b) finding it harder to plan and to suppress inappropriate responses, (c) being more shy, and (d) gaining less pleasure from activities involving high intensity or novelty.

Children who stuttered did not estimate themselves differently from children who did not stutter.

The researchers point out that this is not the first time findings show that parents of children who stutter underestimate them, but they do not take into account the real objective abilities of the children since these have not been investigated yet.

Yairi (1997) himself notes that these findings, which rely on studies of parents some years after onset, may reflect changing parental attitudes over the years and their effort to cope with a chronically speech- disabled child. So they may reflect parental burnout.

When it comes to therapy, Conture in Rustin et al (1987) observed that the less objectively the parents are able to describe the problem, the less favorable the prognosis. This means that the parents' ability to describe their child's problem as realistically as possible cannot be underestimated and is an essential tool in therapy. Researchers' points of view about parents' attitude here is not how negative they are but how they portray their child's reality and support therapy. This point of view is less judgmental of parents' personality than the conventional one in the 1950's, 1960's and even the 1970's. It is constructive in looking for the reasons parents develop certain attitudes and how their attitudes are affected by reality.

Looking at the way stuttering influenced parents, Izakson (2001) examined parental burnout and found that fathers of fluent children felt more burnout than fathers of stuttering children. In Contrast, mothers of stuttering children showed more burnout than mothers of fluently speaking children. She poses that mothers usually see their essential role as taking care of their child's health so they may think it's their responsibility to make stuttering fade out of their child's life. When this

attitude is taken too rigidly it doesn't acknowledge the mothers' limited power as a human being, hence ending with burnout feelings.

As Featherstone (1993) claims in her book A Difference in Family:

"usually we have to agree to two kinds of reality, close to each other.

First we have to admit that our child is different from others in a meaningful way. Then we have to admit that in spite the fact we can help we're not able to cure him". Without admitting the second idea excessive burnout is inevitable.

Kigel and Lahat (1987) investigated 43 families with stuttering pre-school and school-aged children. In their opinion the families' reactions to stuttering was equivalent to an unfinished mourning process.

They argue that fluctuation in the stuttering phenomenon prevents stabilization of the emotional reaction. The family experiences an emotional pendulum between hope for fluent speech while denying stuttering on one hand, and despair about the possibility for positive change on the other. Inability to foresee the coming and going of stuttering and to find reason in it sabotages the family's ability to accept the impairment.

They claim to find some resemblance to psychosomatic families described by Minuchin. Those families are characterized by some impairment of the child and an overprotective mother while the father seems somewhat distanced. In the clinic the mother is interested in therapy while the father believes "it will fade away with time". In addition, they found that mothers of stuttering children tend to "translate" their child's needs to the environment: they answer the phone instead of the child or ask the teacher to avoid asking the child questions or to read aloud in class.

They continue describing how sometimes behavior boundaries are not kept by the parents because they want to protect their child from stressful situations. Parents fear that stress will increase disfluency, therefore the child gains secondary rewards, compared to the siblings, because of stuttering. Kigel and Lahat (1987) did get the impression that the father is usually interested in setting necessary boundaries, but the mother's overprotection does not allow for implementation.

30% of the examined cases had traumatic or at risk development such as prenatal distress events, motor developmental delays, speech delays, articulation problems or breathing disturbances. They emphasize that such situations may explain the mothers' overprotection in the first place, which is only reinforced by the stuttering onset.

When one of the parents, frequently the father, was a stutterer himself, they found a tendency 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.

Ramig (1993) shares his clinical experience that parents who stutter themselves may act in two ways: a) overly reactive, concerned and stressed over the child's stuttering problem, or b) minimally reactive, displaying little if any outward concern about their child's disfluent speech. The last group of stuttering parents view their child's stuttering as something that he/she will learn to improve or adjust to.

These parents are those who seem to have come to terms with their own stuttering. Subellok (2005) supports this experience with her findings. In 35% of the 104 families, one of the parents was a stutterer himself. Two major coping styles with the stuttering were revealed in these families: extremely positive namely acceptance, and extremely negative namely non- acceptance of the child's stuttering.

As we have seen so far, parents' attitudes towards their children may be affected by stuttering in many ways and there may be a difference between parents who experienced stuttering themselves and those who did not.

A recent research with mothers of pre-school children by Anderson, Pellowski, Conture, and Kelly (2003) suggests that mothers of pre-schoolers who stutter perceived their children as more apt to exhibit temperamental profiles consisting of hyper vigilance (less distractibility), inadaptability to change and irregular biological functions, when compared to fluently speaking preschoolers. Yairi and Ambrose (2005) report that Conture (2001) and Guitar (1998) hypothesized that children who stutter are born with sensitive temperaments that persist over time and are heightened by the experience of chronic stuttering. Karrass, Walden, Conture, Graham, Arnold, Hartfield, and Schwenk (2006) examined relations between children's emotional reactivity, emotion regulation and stuttering. When compared to their normally fluent peers, children who stutter were significantly more reactive, significantly less able to regulate their emotions, and had significantly poorer attention regulation, even after controlling for gender, age, and language abilities. These results were taken from a questionnaire filled out by parents of pre-school stuttering children.

To summarize the findings reviewed above, research started out by placing a lot of the responsibility on parents' attitudes and personality for the onset and development of stuttering (Glasner 1949; Johnson 1959; Wyatt & Herzan 1962); but over the years continued on to the notion that, for parents, stuttering by itself may pose difficulties of coping with their child rearing and may influence their attitudes and reactions

(Kigel & Lahat 1987; Yairi, 1997; Yairi and Ambrose 2005); and lastly, parents who stutter may cope differently than fluently speaking parents with the stuttering of their child (Kigel & Lahat 1987; Ramig, 1993). Moreover, there may be specific temperamental characteristics which were found in parents' answers to questionnaires (Guitar 1998; Conture 2001; Anderson et al. 2003; Karras et al. 2006) that require specific parental adaptations in order to help their stuttering child, not because of parental failure, but because of their child's special needs.

5.6. Findings about stuttering Children's attitude towards themselves or their stuttering

The self-perception discussed here includes the attitudes, thoughts and feelings stuttering children report towards stuttering, speech situations, their position in peer groups and social and academic achievements. Gildstone (1967) found that high-school stuttering adolescents were less self-accepting than non-stuttering and perceived their parents to be less accepting of them.

De Nill and Brutten (1991) investigated speech associated attitudes of 70 stuttering and 271 non-stuttering children of elementary and middle school-aged children. They found that stuttering children had significantly more negative attitudes towards speech than their non-stuttering peers. Moreover, those speech-related attitudes of stuttering children became more negative with increasing age in contrast to non-stuttering children which became less negative after 9 years of age.

Vanryckeghem and Brutten (1997) who investigated Dutch speaking Belgian school-aged children who stutter, confirmed these findings and added that children who stutter exhibit significantly more negative speech-associated attitude than their peers as early as six years of age which is an earlier age than previously thought.

In a similar research in Japan (Kawai, Nagasawa, Healey & Vanryckeghem, 2006) which compared speech-associated attitudes of elementary school children who stutter and fluently speaking children, once again there were similar findings which showed no age or gender influence on communication attitudes of children who stuttered. Japanese children showed negative communication attitudes even in the first grade regardless of gender, much like Belgian children. Severity did not influence communication attitudes of children who stutter either. Children with mild stuttering showed the same degree of negative communication attitude as those who had very severe stuttering.

A Japanese investigation of factors relating to self-esteem of children who stutter (Nagasawa & Ota, 2005) reached some interesting findings: (1) The children who rated at the highest level of academic or athletic competence had more self-confidence than those who rated at the lowest academic or athletic competence. (2) Among the children who had talked about their stuttering with their parents, the fifth and sixth graders accepted themselves on the same level as the third and fourth graders. Among the children who did not talk about their stuttering with their parents, fifth and sixth graders accepted themselves less than the third and fourth graders did. (3) The parents who talked about their children's stuttering with them did not report a negative perception of stuttering. These findings indicate that negative self-esteem of children who stutter may be influenced by their parents' ability to talk about stuttering.

One of the above mentioned Japanese researchers, Ota Maki (2007a) investigated the factors relating to self-esteem of school-aged children who stutter in a two year longitudinal exploratory investigation. Six 3rd and 4th graders who stutter and who were enrolled in special speech classes in public elementary schools participated in this investigation.

He found that increases in scores children gave themselves on the confidence factor were related to experiences in which the children were acknowledged for their competences. These led to increased self-esteem. An additional finding showed that changes in self-acceptance factor scores children gave themselves were related to children's peer-relations at school homeroom and to home relations.

In another study Ota Maki (2007b) examined whether the self-esteem of children who stutter is related to the communication domain. This is based on a model that holds that self-esteem for individuals is more strongly related to domains considered important for oneself, and less strongly related to domains considered less important for oneself.

A self-perception scale was administered to 338 3rd – 6th grade children who stutter and who were enrolled in special speech classes in public elementary schools, and 692 children who do not stutter. Results were as follows: 1) There were 5 significant predictor variables of the self-esteem of children who stutter: self-evaluation of physical appearance, social acceptance, behavioral conduct, relations-with- parents domain and the importance of the communication domain for oneself.

2) The self-esteem of children who evaluated stuttering negatively was more strongly related to variables of the communication domain than was that of children who did not evaluate stuttering negatively.

3) Children who evaluated stuttering negatively **attached a higher value to the communication domain** than did children who did not evaluate it negatively.

These findings show that self-esteem of children who stutter may be related to their perceptions of stuttering and communication situations in general and not only to their relations with their parents.

Other findings show that children who stutter develop more negative feelings towards speech and social interactions with growing age.

The question remains about the role parents' perception of stuttering play and whether parents' feelings towards stuttering become the child's feelings as well, as Guitar and Peters (1985) claimed.

5.7. Findings about attitudes of children who stutter towards their parents

In the relationship between stuttering children and their parents as mentioned above, Gildstone (1967) found that stuttering children felt their parents were less accepting and more rejecting than the controls. Kinsler (1961) claims that one of the most frequently reported feelings by people who stutter is covert maternal rejection. Overt rejection is less harmful since it gives the child the ability to hate his parents because of their unfairness and to oppose their attitude. When parents don't give love but pretend to act for the child's well being they delegitimize the child's aggression. The child is usually frustrated and has to suppress aggression. Since children learn that speech may be a weapon, they begin to use it for expressing their feelings and stop it partially (unconsciously), practically stuttering.

Schulz (in Wingate 1962) found that people who stutter reported high expectations at home and described their parents as either demanding or irritating.

As opposed to these findings, Yairi and Williams (1971) found that school-aged children who stutter reported their parents were understanding and not critical, at the same level of prevalence as fluent speaking children.

Bourdon and Silber (1970) also failed to find differences between children who stuttered and fluently speaking children in their descriptions of their parents' characteristics. They explain that children who stutter feel a need to protect their parents.

As Shown, children who stutter had a tendency to feel anger and frustration towards their parents on the grounds of rejection and high expectations. This tendency was especially prevalent in the 1960's but was not confirmed in later investigations.

5.8 Where does all that research lead to?

As mentioned earlier, defining stuttering is a complicated mission that usually expresses a specific point of view regarding the etiology, nature of the disorder and therapy (Yairi & Ambrose 2005). Multidimensional approaches to stuttering led clinicians and researchers to perceive emotional and social factors as critical components that influence stuttering behavior and are important factors to consider in therapy (Rustin & Pursure, 1991; Mallard, 1991; Katz-Bernstein, 1992; Yairi, 1997). Since the onset of stuttering is often at pre-school age (Yairi & Ambrose 2005) when child-parents emotional and social interactions are just beginning, there is reason to investigate the parents' perceptions as well as the child's perceptions and the relations between them. Supposing coping is a process (Lazarus and Folkman 1984), families with school-aged children have gained some experience with this process. Taking into account that this age range enables emergence and stabilization of coping strategies and some perspective on the evolution of stuttering and coping with it, there are a few questions posed:

1) Is there any change in the way parents perceive stuttering and cope with it through the years according to their own perspective?

Since we know there is a genetic component in the way a family influences child's stuttering (Yairi, 1997; Ambrose, Cox and Yairi, 1993)

We also ask:

2) How does former stuttering in the family influence parents' coping with the child's stuttering?

Coping with a child's disability necessitates the use of a variety of strategies in face of long term, ongoing stress (Levy-Shiff & Schulman, 1998; Kelso, French & Fernandez, 2005) so it becomes important for us to find:

3) Are there any specific coping strategies concluded from the interview answers and if so, what are they?

And finally, what is the role parents' perception of stuttering plays? Do parents' feelings towards stuttering become the child's feelings as well, as Guitar and Peters claimed (1985)? Thus our last question is formulated:

4) Does parents' perception of stuttering and coping with it influence the child's perception of it and if so, how?

