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*Antioch University, New England*

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Running Head: STUTTERING AND PARENTING

Pebbles Under the Tongue: A Qualitative Investigation of Parents Who Stutter

by

Craig Matthew Kramer

A.A., Queensborough Community College of the City University of New York, 2002

B.A., Hunter College of the City University of New York, 2005

M.A., Adelphi University, 2007

M.S. Antioch University New England, 2012

DISSERTATION

Submitted in partial fulfillment for the degree of  
Doctor of Psychology in the Department of Clinical Psychology  
at Antioch University New England, 2016

Keene, New Hampshire



Department of Clinical Psychology

**DISSERTATION COMMITTEE PAGE**

The undersigned have examined the dissertation entitled:

**PEBBLES UNDER THE TONGUE:  
A QUALITATIVE INVESTIGATION OF PARENTS WHO STUTTER**

presented on May 23, 2016

by

**Craig Matthew Kramer**

Candidate for the degree of Doctor of Psychology  
and hereby certify that it is accepted\*.

Dissertation Committee Chairperson:  
Roger L. Peterson, PhD, ABPP

Dissertation Committee members:  
Gina Pasquale, PsyD  
William Slammon, PhD

**Accepted by the**

Department of Clinical Psychology Chairperson  
George Tremblay, PhD

on **5/23/16**

\* Signatures are on file with the Registrar's Office at Antioch University New England.

## Dedication

I dedicate this research to all the past, current, and future stutterers, who bravely live life without hesitation.

“I’ve stuttered all my days. I guess I’m one of those incurable stutterers. Everyone has his own personal demon and mine is stuttering...I found that once I accepted it as a problem and learned to cope with it by not avoiding or hiding or struggling with it, my demon lost its hold on me.” (Van Riper, n.d., para. 1)

“I am a stutterer. I am not like other people. I must think differently, act differently, live differently—because I stutter. Like other stutterers, like other exiles, I have known all my life a great sorrow and a great hope together, and they have made of me the kind of person that I am. An awkward tongue has molded my life—and I have only one life to live. I share, moreover, the grand assumption that we encounter among those men who are not contemplating suicide, the assumption that life comes first, life is significant, life is precious” (Johnson, 1930, p. 1)

“Before, I had a civil war inside of myself, me and stuttering. Then I was despairing. But now I think stuttering is kind of a gift” (Mitchell, as cited in International Stuttering Association, 2013, p. 8).

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### Abstract

To date, few studies have explored the lived experiences of parents who stutter. Thus, this qualitative study utilized a 15-question, in-depth semi-structured interview to explore how stuttering impacts various parenting roles, functions, activities, and states. Furthermore, this study elucidates how parents who stutter describe and attach meaning to parenting, as well as how they view parental stuttering in terms of disability status. Participants were 10 parents (6 men and 4 women) who self-identified as having a stuttering disorder. All participants were over 18 years of age and had a child between the ages of 5-18. Data was analyzed using an Interpretive Phenomenological Analysis (IPA). Results of the study revealed the following superordinate themes: (a) stuttering symptoms; (b) parental stuttering and positive parenting emotions; (c) parental stuttering, co-parenting, and avoidant behaviors; (d) parental stuttering and verbal discipline; (e) parental stuttering and stigmatization; (f) fear about children stuttering; (g) parental stuttering as it relates to self-identity and disability; and (h) parental stuttering and coping strategies. Within these superordinate themes, the majority of participants reported that parental stuttering exerted both positive and negative influences on affect, cognition, and behavior. Additionally, participants discussed the varied ways in which stigma (societal and self) affected different parenting practices. Furthermore, the majority of participants did not perceive their stuttering to be a disability, nor did they identify with the disability label; a few participants identified a positive self-identity within the context of parental stuttering. All participants reported using coping strategies to manage their stuttering when parenting. Limitations and future implications are discussed.

*Keywords:* disability, stuttering, parenting, communication disorders

Pebbles Under the Tongue: A Qualitative Investigation of Parents Who Stutter

**Chapter 1: Literature Review**

**Problem Statement**

In general, understanding the impact of parenting on children's adjustment has been a central focus in developmental and family psychology (Gottman, Katz, & Hooven, 1996). Within this area of research, there is indisputable evidence that parenting is an essential component for raising children who are psychologically well-adjusted (Shriver & Allen, 2008). Thus, the importance of parenting cannot be underestimated; research has consistently shown that positive parental practices are associated with beneficial child outcomes; whereas, negative parental practices are associated with poor child outcomes. It has been suggested that a parent's love is irreplaceable for a child's well-being (Maata & Uusiautti, 2013). For these reasons, parents are the sole focus of this study.

It is estimated that 8.4 million parents who have a disability have a child under the age of 18 living with them (Drew, 2009). In the United States, the percentage of adult parents with a disability is as follows: 26% have physical disabilities, 24% have a psychiatric disability, 16% have a cognitive disability, and 40% have a sensory disability (Preston, 2010). The percentage of parents with a disability may be even higher than is currently estimated. However, because of different national data sets and varying definitions of the term "disability," it is difficult to accurately assess how many parents truly have a disability (Preston, 2010).

Although the prevalence of disabilities in parents is high, parents with disabilities continue to be primarily ignored by researchers and social policy initiatives (Drew, 2009; Prilleltensky, 2003). Despite the paucity of research, evidence suggests that parents who have a disability experience many difficulties associated with parenting (Preston, 2010). Some problems

faced by parents with disabilities include monitoring, child-care, child-parent bonding, engagement in leisure activities, and decision-making (Barlow, Cullen, Foster, Harrison, & Wade, 1999; Feldman, 1994; Kaiser, Reid, & Boschen, 2012; Murray & Johnston, 2006).

Stuttering classifies as a disability from a legal, scientific, and personal perspective (Parry, 2010; Yaruss & Quesal, 2004). The psychosocial processes of people who stutter (PWS) are complexly related to speech production behavior (Conture, 2004). PWS experience affective (e.g., shame, fear, or humiliation), cognitive (e.g., “No one likes me because I stutter”), and behavioral (e.g., avoidance or isolation) reactions to their speech (stuttering). Affective, cognitive, and behavioral consequences often limit PWS from engaging in various socially related activities, such as domestic life, education, employment, interpersonal interactions and relationships, and community, social, and civil life (Bricker-Katz, Lincoln, & Cumming, 2013; Klompas & Ross, 2004; Yaruss & Quesal, 2004). The limits that stutterers place upon themselves are often socially imposed (social stigma) by the negative evaluation of others (prejudice, stereotypes, and discrimination; Ham, 1990; Przepiorka, Blachnio, St. Louis, & Wozniak, 2013; Rice & Kroll, 1997)

Evidence suggests that parents with disabilities and PWS face many life challenges; however, the association between parenting and stuttering has not been sufficiently studied in stuttering or disabilities research. This is quite surprising, considering the extent to which stuttering may result in some degree of communication-related disability for parents. For example, due to the socially problematic nature of stuttering, parents who stutter may have difficulty with indirect care (e.g., taking children to doctor or school appointments or extracurricular events), co-parenting, verbal discipline, emotional bonding, offering advice, and teaching. Consequently, stuttering may limit parents from engaging in important parenting

practices.

To my knowledge, this is the first study that thoroughly examined stuttering within a parenting context (F. Meyers, personal communication, July 1, 2015; S. Yaruss, personal communication, August 4, 2015). This study sought to understand how stuttering impacts various parenting roles, functions, activities, and states (emotions and cognitions). Furthermore, this study explored how parents who stutter describe and attach meaning to parenting, as well as how they view parental stuttering in terms of disability status. Ten parents (six men and four women) participated in a 15-question, in-depth semi-structured interview (Appendix A). Participants were 18+ years of age, had a child between the ages of 5-18, self-identified as having a stuttering disorder, and expressed a willingness to explore the impact of stuttering on parenting practices and beliefs. Participants' responses were analyzed using an Interpretive Phenomenological Analysis (IPA). Results of the study have practical implications for future research and clinical practice.

### **Significance of Study**

Speech (stuttering) and related communication disorders are understudied when compared to many other disorders (Newbury & Monaco, 2010). This is quite surprising, considering the extent to which communication problems may severely limit a person's ability to function. There is substantial evidence that PWS experience some degree of communication-related disability and a subsequent reduced quality of life (Corcoran & Stewart, 1998; Yaruss & Quesal, 2004). Thus, there is a continued need to examine the lived experiences of PWS. This study adds to the body of literature by seeking to understand how parents who stutter attach meaning and manage various parental roles, functions, activities, and states. Furthermore, this study also elucidates the importance of examining parental stuttering and other

communication-related problems from a disabilities framework; this may prove useful for extending research and social policy initiatives for people with speech and communication-related disabilities.

Most studies examine the link between having children who stutter and parental outcomes. Research has shown that there is an association between parenting a child that stutters and experiencing negative emotions (frustration, self-blame, anxiety; Langevin, Packman, & Onslow, 2010), poor coping strategies (Plexico & Burrus, 2012), and a disrupted parent-child attachment (Lau, Beilby, Byrnes, & Hennessey, 2012). These studies highlight the effect that stuttering has on the parent; however, they only examine the relationship from one direction (i.e., how children's stuttering affects parents). Results of this study clarify the impact of stuttering on various parental roles, functions, activities, and states (emotions and cognitions). Clarifying the experiences of parents who stutter provides fertile ground for future researchers to examine how the challenges associated with parental stuttering may affect children's outcomes.

In addition, gaining insight into how stuttering affects parenting has practical implications for treatment. Understanding the lived experiences of parents who stutter encourages speech-language pathologists, mental health workers, and other professionals to integrate parenting training into stuttering treatment. Results of this study may help professionals adopt a more multidimensional approach to treatment that addresses the various challenges faced by parents who stutter. For example, treatment for parents who stutter involves teaching them coping skills to better manage stuttering symptoms that interfere with parenting.

### **Overview of Stuttering**

#### **Demographics of Stuttering**

Approximately 5% of all children ages 2-5 will go through a period of developmental

stuttering that may last from several weeks to several years (Kaneshiro, 2014). Up to 80% of children will recover (Saltuklaroglu & Kalinowski, 2005), leaving 1% (70 million people) of the population with a persistent developmental stuttering disorder (Kaneshiro, 2014). It is estimated that more than 3 million people stutter in the United States (National Stuttering Association, n.d.a.). Stuttering affects people of all races, ethnicities, languages, socioeconomic statuses, and cultures (Bloodstein & Bernstein, 2008; Ooki, 2011; Tellis, 2008; Yairi & Ambrose, 2013). Gender is one of the strongest predisposing factors for stuttering—approximately 3-4 males stutter for every 1 female (Craig, Tran, Craig, & Peters, 2002).

### **Primary and Secondary Symptoms of Stuttering**

Stuttering is commonly defined as “a communication disorder involving disruptions, or disfluencies in a person’s speech” (National Stuttering Association, n.d.b.). The flow of speech is disrupted by primary stuttering symptoms, such as involuntary syllable repetitions (part, whole, or phrase; “L-L-Let’s go to the store,” or “Let’s-Let’s-Let’s go to the store,” or “Let’s go to-Let’s go to-Let’s go to the store”), prolongations (“LLLLet’s go the store”), and blocking of sounds (no airflow or voice for several seconds; “----Let’s go to the store”; Shipley & McAfee, 2008).

PWS adapt secondary coping behaviors in order to cope with primary stuttering symptoms (Ramig & Dodge, 2009). Secondary coping behaviors fall under two categories: (a) escape and (b) avoidance. Escape behaviors are coping strategies that a stutterer uses to get out of a word once he or she is stuttering. These behaviors include head nods, physical tapping, eye blinks, jaw jerks, facial grimaces, or a rise in voice pitch or loudness (Guitar, 2013; Ramig & Dodge, 2009). Avoidance behaviors (situational [social-interactional] or word [linguistic]) are coping strategies that a stutterer uses to keep away from stuttering. The category of avoidance

behaviors includes attempts to avoid feared words, sounds, or situations. Examples of these behaviors include (a) skipping planned activities, (b) changing appointments or schedules, (c) word substitution, (d) rephrasing words or sentences, or (e) using extraneous words (Guitar, 2013). Although escape and avoidance behaviors are presented as binary classifications, they do not always present themselves as distinct behaviors; in other words, behaviors associated with avoidance may also be used as escape behaviors and vice versa (S. Yaruss, personal communication, February 18, 2015). Stuttering symptoms (primary and secondary) may range from very mild to very severe (very mild, mild, mild-to-moderate, moderate, moderate-to-severe, severe, or very severe; Guitar, 2013).

### **Coping Strategies and Stuttering**

PWS employ a variety of techniques and strategies to cope with primary and secondary symptoms of stuttering (Klompas & Ross, 2004). The most common approaches to stuttering therapy are fluency modification and fluency shaping. Speech modification therapy is primarily aimed at desensitization, acceptances, and motoric techniques (e.g., pausing and phrasing [breaking up sentences or utterances into smaller units] or preparatory set [ease into a word with a slightly prolonged initial sound]). This therapy places a strong emphasis on reducing the self-perceived social and personal consequences of stuttering (e.g., anxiety, fear, shame, or avoidance; Blomgren, Roy, Callister, & Merrill, 2005). The ultimate goal of fluency shaping is to replace stuttering with speech that is more fluent. This is accomplished by teaching PWS different speech techniques (e.g., stretching [lightly stretch the beginning of a sound] or light contact [touching your speech articulators together very gently]) to facilitate a new pattern of speech behavior (Blomgren et al., 2005; Ramig & Dodge, 2009; Spillers, 2001a). It is not uncommon for speech therapists to implement both fluency shaping and fluency modification

techniques into treatment in order to address the superficial symptoms of stuttering as well as the “hidden” attributes of stuttering (Blomgren, 2007).

In recent years, there has been an increasing emphasis on treating PWS from a counseling perspective (psychological/emotional-based interventions). Speech-language pathologists have suggested that certain well-established counseling components should be incorporated into stuttering treatment (e.g., cognitive restructuring, relaxation, mindfulness, or breathing; Menzies, Onslow, Packman & O’Brian, 2009). For example, Menzies et al. (2008) found that cognitive behavioral therapy (CBT; cognitive restructuring, graded exposure, and behavioral experiments) treatment increased participants’ ability to participate in everyday speaking situations, as well as decreased psychological difficulties, anxiety, and avoidance. Furthermore, a group CBT package (psychoeducation, cognitive restructuring, and behavioral experiments) for adults who stuttered led to improvements in everyday functioning, as well as a decrease in anxiety and emotional reactivity to disfluency (Ezrati-Vinacour, Gilboa-Schechtman, Anholt, Weizman, & Hermesh, 2007).

### **Negative Consequences Associated with Stuttering**

Effective communication is vital for people of all ages (Craig & Tran, 2006) and is an integral part of so many aspects of life (Yarrus & Quesal, 2004). Talking and speaking fluently and effectively to others is a highly valued skill that has many important ramifications (Bricker-Katz, Lincoln, & McCabe, 2009). Efficient and successful communication is likely to enhance independence, participation in daily activities, and social and vocational relationships (Lubinski & Welland, 1997). Therefore, it is reasonable to speculate that PWS will have qualitatively different life experiences when compared to people without an ongoing communication difficulty (Crichton-Smith, 2002).

Past literature has focused on understanding the observable characteristics and features (prolongations, blocks, and syllable repetitions) of stuttering. However, there has been enormous strides in understanding the underlying consequences associated with disfluent speech (stuttering; Yaruss & Quesal, 2004; Van Riper, 1982). Much of the current research shows that PWS face more negative affective, behavioral, cognitive, and social (stigma) consequences when compared to their fluent peers (Craig, Blumgart, & Tran, 2009; Tran, Blumgart, & Craig, 2011). These negative consequences are due to difficulty in communicating and expressing speech clearly in various speaking situations such as public speaking, speaking to unfamiliar people, speaking about an unfamiliar topic, speaking to authority figures, speaking to one or more person(s), and starting and sustaining a conversation (Spencer, Packman, Onslow, & Ferguson, 2009; Yaruss & Quesal, 2004). As such, PWS express communication problems in many areas of activity and participation, including domestic life, education, employment, interpersonal interactions and relationships, and community, social, and civil life (Bricker-Katz et al., 2013; Klompas & Ross, 2004; Yaruss & Quesal, 2004).

On average, severe stutterers exhibit greater negative consequences when compared to mild or moderate stutterers (James, Brumfitt, & Cudd, 1999; Koedoot, Bouwmans, Franken, & Stolk, 2011); however, evidence suggests that mild to severe stutterers exhibit similar negative outcomes. For example, Blumgart, Tran, and Craig (2010) found that mild stutterers were just as likely to have elevated social and trait anxiety when compared to moderate or severe stutterers. Furthermore, mild stutterers present similar negative consequences (affective, behavioral, and cognitive) to those with a more severe stuttering problem (Andrade, Sassi, Juste, & Ercolin, 2008). Another study found that PWS experienced significant psychosocial conflict regardless of stuttering severity (Mulcahy, Hennessey, Beilby, & Byrnes, 2008).

The degree of fluency impairment (severity) is not always predictive of negative outcomes. Stuttering severity is highly variable within and across individuals and speaking situations and contexts (Logan & Willis, 2011; Packman, Code, & Onslow, 2007). PWS can have vastly different life experiences and speaking difficulties (Yaruss, 2007; Yaruss & Quesal, 2004). For instance, a severe stutterer may experience minimal disfluency and no negative consequences when talking to a family member; however, they may experience major disfluency and substantial negative consequences when talking to an authority figure (e.g., teacher, boss, or doctor); or, they may experience moderate disfluency and moderate negative consequences when interacting with a boyfriend or girlfriend. Furthermore, coping strategies play an important role in determining stuttering severity and negative consequences (Blomgren, 2013; Craig, Blumgart, & Tran, 2011). For example, severe stutters may experience minimal negative consequences if they have learned to use appropriate coping strategies (e.g., social support, self-acceptance, cognitive restructuring, relaxation, or speech therapy) to manage their stuttering. Conversely, someone who stutters mildly may experience significant negative consequences if they are unable to appropriately manage (e.g., withdrawal, isolation, avoidance, or escape) their stuttering (Yaruss & Quesal, 2004).

### **Secondary Coping Behaviors**

PWS use secondary coping behaviors to manage symptoms associated with disfluent speech, as well as to cope with the social and emotional consequences related to stuttering (Corcoran & Stewart, 1998; Ramig & Dodge, 2009). Avoidant behaviors (linguistic and social-interactional) often constitute the largest group of secondary coping behaviors for PWS (Spillers, 2001b). PWS will often use avoidance during moments of anticipatory anxiety related to feared sounds, words, or situations (Lavid, 2003; Moss, 2013). The experience of fear is often

rooted in feelings of helplessness, shame, and humiliation associated with stuttering (Corcoran & Stewart, 1998).

PWS use linguistic and social-interactional secondary coping behaviors to avoid stuttering. Linguistic coping strategies are ways of manipulating discourse and language to enhance fluency (Daniels, Gabel, & Hughes, 2012). Examples include starters (“Um, uh, can we go to the store?”), interjections (“Can we go to the um, uh, store?”), circumlocutions (talking around/skipping a word; “I want to go to that place, ya know, to the store,” instead of “I want to go to the store”), and word substitutions (replacing the word “store” with a potentially easier word; “Lets to go the market.”). Social-interactional coping strategies are ways of manipulating social routines and participation with others (Daniels et al., 2012). Examples include not attending a doctor appointment, picking an activity that involves less talking, using a friend to talk at a social gathering, or using nonverbal signals or writing instead of speaking (Daniels et al., 2012).

Studies have shown that PWS use different linguistic and social-interactional coping strategies to manage their stuttering. For example, Corcoran and Stewart (1998) found that PWS avoided certain situations such as talking to their children or choosing a certain career. A study by Perez, Doig-Acuna, and Starrels (2015) found that PWS avoided healthcare interactions (missed phone calls and/or medical appointments) because of stuttering; others relied on a third party to navigate the medical system. Other studies have shown that PWS employed a variety of strategies (e.g., avoidance of speaking situations, limiting speaking, selecting different words, changing syntax, word substitution, changing, or skipping words, writing assigned oral book reports) to manage their stuttering in the school and work setting (Bricker-Katz et al., 2013; Daniels et al., 2012). A study by Klompas and Ross (2004) found that South African participants

used a diverse set of coping strategies (e.g., changing words or phrases, avoiding certain words, or avoiding certain situations) to manage their stuttering.

### **Affective**

The surface features of stuttering are most discernible to an outside observer (Blomgren, 2013). However, stuttering is more than its surface manifestations, and constitutes many affective experiences that are hidden below the surface (Beilby, Byrnes, & Young, 2012; Blomgren, 2013). PWS often experience anxiety-related symptoms when placed in social situations that elicit fear and embarrassment (Craig & Tran, 2006, 2014). Research has shown that PWS have greater levels of trait and state social anxiety when compared to people who did not stutter (Blumgart, et al., 2010; Craig & Tran 2014; Craig, Hancock, Tran, & Craig, 2003; Ezrati-Vinacour & Levin, 2004). PWS also manifest specific fears (e.g., public speaking, saying stupid things in a group, asking questions in a group, business meetings, and social gatherings), thus placing them at risk for developing a generalized form of social phobia (Blumgart et al., 2010). It has been suggested that anxiety maintains stuttering symptoms and behaviors (Iverach & Rapee, 2014). Furthermore, PWS have reported feelings of depression (Tran et al., 2011), frustration and anger (Klompas & Ross, 2004), dread and guilt (Manning & Dillolo, 2005), and helplessness and shame (Corcoran & Stewart, 1998).

### **Cognitive**

Many PWS harbor unhelpful thoughts and beliefs (cognitions) related to their stuttering. These cognitions are rooted in the threat of being negatively evaluated by others and the belief that others will judge a person harshly for stuttering (Bricker-Katz et al., 2009; St. Clare et al., 2009). To assess unhelpful beliefs and thoughts in PWS, researchers developed the Unhelpful Thoughts and Beliefs about Stuttering Scale. They found that those who stutter are

more prone than those who do not stutter to report unhelpful beliefs and thoughts such as “People will doubt my ability because I stutter” or “No one could love a stutterer” (St. Clare et al., 2009). PWS also spend a considerable amount of time thinking about whether or not they are going to stutter, how they could circumvent stuttering, how they could cover up the fact that they stutter, and what they could do to lessen the effects of stuttering on their life (Plexico, Manning, & Levitt, 2009). Furthermore, PWS may hold negative self-evaluations about themselves in response to their stuttering (Yaruss & Quesal, 2004).

### **Social Stigma**

PWS experience public stigma in the form of negative stereotypes, prejudice, and discrimination (Boyle, 2015; Ham, 1990; Przepiorka et al., 2013; Rice & Kroll, 1997). Much of the research suggests that listeners’ hold various misconceptions about PWS (Craig, Tran, & Craig, 2003; Hughes, Gabel, Irani, & Schlagheck, 2010). People who do not stutter (PWDNS) tend to assign undesirable characteristics to PWS such as being shy, anxious, self-conscious, lacking confidence, more poorly adjusted, and less adequate (Craig et al., 2003; Ham, 1990). In addition, PWDNS report the belief that stuttering affected career opportunities, and believed that 20 careers were inappropriate choices for PWS (Gabel, Blood, Tellis, & Althouse, 2004). A qualitative-based study revealed that PWS reported stereotypes such as being stupid, introverted, not very intelligent, weird, and having something wrong with them (Klompas & Ross, 2004). Misconceptions can lead to self-stigmatization (internalize negative societal views), which in turn, can negatively impact the quality of life of PWS (Boyle, 2015; Bricker-Katz et al., 2009; Logan & O’Connor, 2012). Self-stigma in PWS is related to significantly higher levels of anxiety, depression, and self-rated speech disruption and significantly lower levels of hope, quality of empowerment, quality of life, and social support (Boyle, 2015).

### **Conclusion about Stuttering**

Verbal communication is an essential part of social life. People who have an ongoing communication-related disability (stuttering) may have difficulty navigating a social world that is primarily organized around verbal fluency. The degree of difficulty experienced by PWS is often dependent on the severity of the stutter; however, given the variability of disfluency (stuttering) across different social contexts, mild to severe stutterers may experience similar negative consequences in response to their speech. These negative consequences include environmental limits, linguistic difficulties, social stigmatization, limitations in communication activities, restricted participation in daily life, and negative behavioral, affective, and cognitive reactions (Yaruss & Quesal, 2004, 2006). As a result, many PWS experience some degree of communication-related disability, which often leads to extensive personal and social limitations and a reduced quality of life (Yaruss & Quesal, 2004). For many PWS, these experiences last a lifetime (Blomgren, 2013).

Hill et al. (2005) recommend that researchers examine the existing literature to inform research questions and interview protocols. Thus, to truly understand the rich personal and social world of parents who stutter, a semi-structured interview was created that captures the core experiences, features, and symptoms (linguistic/verbal problems, environmental difficulties, restricted/limited participation in daily life and communication activities, coping strategies, and affective, behavioral [secondary coping], cognitive, and social [stigma] reactions) of PWS. Thus, the semi-structured interview reflects—either directly or indirectly—many of the difficulties that PWS face on a daily basis. Furthermore, given the highly contextual nature of stuttering across different contexts (places, people, and situations), this study may include PWS who identify as having a very mild to a very severe stuttering disorder. This will provide a more realistic account

of the life experiences of parents who stutter.

## **Parenting**

### **Overview of Parenting**

Parenting is a “complex topic that can encompass a wide range of skills, behaviors, attitudes, cognitions, and emotions” (Shriver & Allen, 2008, p. 27). Much of parental involvement includes developing and maintaining a strong parent-child relationship (Hughes, 2009). This relationship (parent-child) often occurs within the context of effective parental communication (Hughes, 2009). Research has consistently shown that effective communication between parents and children is associated with positive child outcomes (Davidson & Cardemil, 2009; Levin, Dallago, & Currie, 2012).

An important component of parental communication is verbal exchanges or conversations (spoken language) with children (Hughes, 2009). Much of the research has shown that parental communication via spoken language has positive implications for children’s outcomes (Meins, Fernyhough, Fradley, & Tuckey, 2001; Taumoepeau & Ruffman, 2006). Verbal exchanges are important because they “take the parent and child beyond the here and now, to memories, plans for the future, and generalizations about events, beliefs, and values” (Hughes, 2009, p. 108). Furthermore, verbal communication allows parents and children to share, to enjoy each other, and to communicate interest to each other (Hughes, 2009). According to Bornstein, Hahn, and Haynes (2011), “language is the invisible work of parenting and is a principal means of child instruction and scaffolding, as well as a vital ingredient of social interaction, socialization, and the parent-child bond” (p. 650).

The way parents communicate with their children is also heavily influenced by behavioral, affective, and cognitive states. Parents’ cognitions are an integral part of parenting

because “they generate, organize, and shape, as well as mediate the effectiveness of, parenting practices (Bornstein, et al., 2011, p. 670). Furthermore, parental beliefs (cognitions) are related to successful caregiving, investment in childrearing, and satisfaction gained from parenting (Bornstein et al., 2011). Parental emotions also play an important role in parenting. A strong parent-child attachment is contingent on the parents’ ability to teach their children how to manage their emotions, as well as the parents’ own ability to manage and express their emotions (Greenberg, 2015). Children fare better across a broad range of domains (e.g., social skills, more positive emotions, better academic performance) when their parents used an emotion-coaching philosophy when compared to an emotion-dismissing philosophy (Gottman, 1997).

Cognitive and affective states are strongly implicated in determining effective parenting behaviors (Deater-Deckard, 2014; Snyder, Cramer, Afrank, & Patterson, 2005). Parenting behaviors are the tangible everyday childrearing behaviors that parents engage in when they are with their children (Bornstein et al., 2011). According to Greenberg (2015), “parenting behaviors directed toward the child during daily interaction are the proximal and most powerful processes in socialization” (p. 197). It has been consistently demonstrated that positive parenting behaviors are strongly associated with child well-being (Bronte-Tinkew, Moore, & Carrano, 2006; Pettit, Laird, Dodge, Bates, & Criss, 2001). Some parenting behaviors that are consistently studied in the parenting literature and are found to promote positive child development are indirect care (fulfilling social and community responsibilities for children; doctor appointments, talking to teachers, etc.), co-parenting, verbal discipline, emotional bonding, offering advice, and teaching (Gottman et al., 1996; Hughes, 2009; Kotila & Kamp Dush, 2012; McDowell, Parke, & Wang, 2003; Teubert & Piquart, 2010; Ward & Zabriskie, 2011). It is important to note that parenting behaviors encompass an extremely broad range of roles, functions, and activities. However,

examining an exhaustive list of parenting behaviors is beyond the scope of this study.

Parental communication is an important factor in determining a positive parent-child relationship and beneficial outcomes for children. Effective communication between parents and children encompass a wide range of parenting behaviors, skills, attitudes, emotions, cognitions, and verbal conversations (spoken language). Due to the difficulties with verbal communication, it is reasonable to assume that stuttering symptoms and associated consequences (e.g., linguistic and verbal difficulties, and negative affective, behavioral, cognitive, or social consequences) may impact parental communication in a variety of parenting contexts. Thus, this study sought to understand how parents who stutter manage and attach meaning to various parental roles, functions, activities, and states (emotions and cognitions).

### **Parenting and Disabilities**

According to the World Health Organization (WHO; 2015), disability is an umbrella term for an impairment in body function and structure; difficulty encountered by an individual in executing a task or action (activity limitation); and participation restriction in any life situation (Yaruss & Quesal, 2004). The International Classification of Functioning, Disability and Health (ICF) is a classification system that focuses on the definition, and measurement and policy formulations for health and disability (WHO, 2015; Yaruss & Quesal, 2004). The ICF is a biopsychosocial model of disability, which consists of two components: (a) functioning and disability (body functions [voice/speech], body structures [anatomical structures], and activities and participation [tasks/actions and life situations]), and (b) contextual factors (environmental [relationships and social supports], and personal [affective, behavioral, and cognitive reactions]; Yaruss & Quesal, 2004). Thus, the ICF is a useful tool for elucidating both the social and personal experiences of living with a disability.

Disabilities encompass a broad range of disorders and diseases, and may be congenital or adventitious, stable, progressive or varying (Preston, 2010). In 2010, 56.7 million people had a communicative (speech, hearing, or seeing), mental (cognitive, mental, or emotional), or physical disability (wheelchairs, crane, or walker; Brault, 2012). About 14.9 million people experienced some difficulty with seeing, hearing or having their speech understood; about 2.8 million people reported difficulty with speech, of which 523,000 reported a severe disability (Brault, 2012). It is not uncommon for people to have a combination of various disabilities (Brault, 2012).

It is estimated that 18.4 million adults with a disability have a child under the age of 18 living with them (Drew, 2009). Parental disabilities can be physical, systemic, cognitive, visual, auditory, developmental, or psychiatric (Kirshbaum & Olkin 2002). Similar to abled-bodied parents, parents with disabilities experience great joys and challenges when becoming a parent (Kaiser et al., 2012). However, when compared to abled-bodied parents, many parents with disabilities experience significant day-to-day challenges associated with various parental practices (Kaiser et al., 2012; Preston, 2010). The following paragraphs briefly highlight some of the parenting challenges associated with parental disabilities.

Qualitative methodologies are useful approaches for capturing the numerous parenting challenges experienced by parents with a disability. For example, three studies found that parents with arthritis and a spinal cord injury experienced negative emotions (frustration, exhaustion, anxiety, guilt, and helplessness) and negative cognitions (“I can’t protect my child”) in response to parenting with a disability (Barlow et al., 1999; Kaiser et al., 2012; Prilleltensky, 2003). It was not uncommon for negative consequences (affective and cognitive) to interfere with various parental roles and tasks (Barlow et al., 1999; Kaiser et al., 2012). Another qualitative-based

study collected the personal experiences of six mothers with different disabilities (four were in wheelchairs, one was blind, and one had a speech disability) and found that mother experienced various problems with parenting, including activities of daily living (e.g., taking children to YMCA), direct parenting behaviors (e.g., discipline or play), and complications with spouses (Kocher, 1994). A qualitative study by Prilleltensky (2003) found that parents with a physical disability experienced difficulty with child rearing (physical) tasks, lack of social support, difficulties engaging in co-parenting responsibilities, and feelings of frustration and fatigue.

Furthermore, qualitative and quantitative studies have found that parental disabilities interfere with problem solving skills (intellectual disabilities; Feldman, 1994), poor monitoring and decision-making (attention-deficit/hyperactivity disorder; Murray & Johnston, 2006), and emotional bonding (serious mental illness; Montgomery, Tompkins, Forchuk, & French, 2006). Furthermore, parents with disabilities are subjected to the skeptical beliefs of others (social stigma) regarding their ability to care for their children (Prilleltensky, 2003). They often face criticism regarding incompetency and assumptions of parentification (Kaiser et al., 2012; Montgomery et al., 2006).

**Disability, parenting, and stuttering.** Yaruss and Quesal (2004) utilized the ICF framework to demonstrate the complex nature of stuttering in terms of disability and functioning. Recent evidence suggests neuroanatomical structures may contribute to the development of stuttering (body structure; Ingham, Grafton, Bothe, & Ingham, 2012); furthermore, PWS have problems related to the fluency, rhythm, and speed of speech (body functions; Yaruss, 2007). In addition, PWS have problems completing tasks or being involved in different life situations due to difficulties with starting or sustaining conversations (activity/participation; Yaruss & Quesal, 2004). Reactions from others, including stereotypes and prejudice, societal norms and attitudes,

and reduced social support (environmental factors; Blumgart, Tran, & Craig, 2014; Boyle, 2015; Yaruss & Quesal, 2004), contribute to the maintenance and exacerbation of stuttering. Personal reactions (affective, behavioral, and cognitive) may determine whether PWS experience negative consequences associated with their speech (personal factors; Yaruss & Quesal, 2004).

Utilizing the ICF framework, the above classification system demonstrates that stuttering may be classified as a disability. Although there is limited research on parental stuttering, two qualitative studies briefly examined parenting and stuttering within several broad domains of functioning. For example, one participant succinctly explained the negative impact that stuttering had on parenting: “That’s where it [stuttering] has had more of an effect. I definitely did not talk to them as much as I should have . . . I definitely felt that my children were embarrassed that I stuttered and ashamed of me” (Corcoran & Stewart, 1998, p. 256).

Another study (Boberg & Boberg, 1990) interviewed 15 wives to determine how they were affected by their spouses’ stuttering. Participants’ (wives) responses revealed several difficulties associated with various aspects of parenting. Some difficulties included fear of not being able to call for help during a child emergency; choosing a child’s name that does not begin with a feared sound; worry that parental authority would be undermined because of stuttering; anxious about having a child who stuttered; and an inability to read a bedtime story or communicate freely with their children. Although limited in scope, both qualitative studies highlight the disabling aspects (verbal difficulties, avoidance/restricted participation in activities and life [behavioral], shame [social stigma], poor coping strategies, and embarrassment and anxiety [affective]) experienced by parents who stutter.

Parents with disabilities face many challenges associated with various aspects of parenting. However, despite such knowledge, there is a paucity of research in the disabilities

literature that examines the lived experiences of parents with a stuttering disorder or other communication-related problems. This is an indication that stuttering is not often identified as a disability (St. Pierre, 2012). A major reason for this assumption is that PWS are expected to perform on the same terms as able-bodied people. This may be the case because a stutterer's disability is not absolute. PWS are fluent in specific contexts and, therefore, are expected to continually communicate in the same manner as fluent people. As such, PWS are "caught in the indefinite territory between disability and ability" (St. Pierre, 2012, p. 17). Despite societal expectations, there is ample evidence that stuttering—from a legal, scientific, and personal perspective—classifies as a disability. Specifically, there is some evidence that parental stuttering is disabling in many ways (see Boberg & Boberg, 1990; Corcoran & Stewart). Thus, subsuming stuttering under a disabilities framework extends the literature on parents with disabilities by including the life experiences of parents who stutter.

### **Conclusion: Disability, Parenting, and Stuttering**

There is strong evidence that the impact of stuttering is disabling and reduces the quality of life for PWS. Furthermore, it has been demonstrated that parents with disabilities face many challenges associated with parenting. Yet, there is a paucity of research within the speech-language and parental disabilities literature that explores the unique, lived experiences of parents who stutter. This study adds to the body of literature in two ways: (a) first, it explores how parents who stutter describe and attach meaning to various parental roles, functions, activities, and states (this provides important information on how parents who stutter make sense of their personal and social worlds within a parenting context), and (b) second, it highlights the importance of examining parental stuttering and other communication-related problems from a disabilities framework.

## **Chapter 2: Methods**

### **Major Characteristics of Interpretive Phenomenological Analysis**

The primary aim of IPA is to understand how participants make sense of particular experiences, events, and states (Smith & Osborn, 2003). IPA utilizes three theoretical perspectives: phenomenology, hermeneutics, and idiographic. The phenomenological perspective involves a detailed examination of the unique, lived experiences of peoples social and personal world (Smith & Osborn, 2003). The hermeneutic perspective seeks to interpret the experience of participants (Bricker-Katz, et al., 2013). Thus, the researcher plays an active and dynamic role in trying to make sense of the lived experiences of participants (Smith & Osborn, 2003). In other words, “The participant is trying to make sense of their personal and social world; the researcher is trying to make sense of the participant trying to make sense of their personal and social world” (double hermeneutic; Smith, 2004, p. 40). The idiographic perspective relies on a small, homogenous sample size (Smith & Osborn, 2003) in order to analyze each case at an individual level (Smith & Osborn, 2007).

### **Rational of Interpretive Phenomenological Analysis**

First, a major shortcoming in the stuttering field is an overemphasis placed on experimental research designs (Tetnowski & Damico, 2001). Quantitative methodologies have been criticized for failing to consider stuttering as a multidimensional disorder. According to Tetnowski and Damico (2004), the “experimental context often loses the complexity and dynamism of an authentic communicative context” (p. 18). To address this methodological shortcoming, an IPA approach was chosen for this study because it allows parents who stutter to “assign their own meanings to events and engage in their own construction of self and social identity” (Stoudt & Ouellette, 2004, p. 180). Thus, a phenomenological approach elucidated the

complex, multifaceted world of parents who stutter.

Second, IPA “has a theoretical commitment to the person as a cognitive, linguistic, affective and physical being and assumes a chain of connection between people’s talk and their thinking and emotional state” (Smith & Osborn, 2003, p. 54). This theoretical commitment aligns with the view that stuttering is the result of several interconnecting components: (a) linguistic, (b) physical, (c) affective, (d) cognitive, (e) social, and (f) behavioral states (Spencer et al., 2009; Yaruss & Quesal, 2004). Therefore, an IPA approach provided important information for understanding how different parental factors (linguistic, physical, affective, cognitive, etc.) associated with stuttering impacts parental practices and beliefs.

Third, IPA places a strong emphasis on understanding the individual in a social and personal world (Smith & Osborn, 2003). A salient feature of PWS is various personal reactions in different social contexts (Blomgren, 2013). For example, personal reactions, such as primary (syllable repetition, blocks, etc.) and secondary (behavioral avoidance) stuttering symptoms, may change from moment-to-moment depending on the immediate environment (social context [people, places, situation]; Blomgren, 2013). Thus, IPA is a useful approach for this study because it elucidated how parents who stutter navigate different parental practices within various social and personal contexts (symbolic interactionism; Smith & Osborn, 2003).

### **Sampling Selection and Recruitment, and Inclusion/Exclusion Criteria**

A purposive sampling technique was used to recruit participants. This sampling technique is a useful strategy because it allowed the researcher to select participants “in order to illuminate a particular research question, and to develop a full and interesting understanding of the data” (Brocki & Wearden, 2006, p. 95). Participants were recruited in four ways: (a) direct invitation (invited accessibility; Nosek, Banaji, & Greenwald, 2002) of eligible participants via Facebook,

(b) the National Stuttering Association (NSA) disseminated the study to the NSA parents Facebook page and to support groups, (c) a speech-language pathologist posted the study to the American Institute of Stuttering (AIS) alumni Facebook page, and (d) snowball sampling technique. Recruitment letters and a flyer (participant recruitment letter [Appendix B], recruitment letter to clinicians or organizations [Appendix C], and a recruitment flyer [Appendix D]) were used to obtain participants.

This study used a homogenous, small sample size (Smith & Osborn, 2003) in order to focus on a detailed analysis of each case (Smith & Osborn, 2007). Smith, Flowers, and Larkin (2009) suggest a sample size between 4-12 participants. I interviewed 10 participants who met the following inclusion criteria: (a) 18+ years of age, (b) self-identify as having a stuttering disorder, (c) have a child between 5-18 years of age, and (d) express a willingness to explore the impact of stuttering on parenting. Exclusion criteria included: (a) 17 years of age or under, (b) unable to speak English, (c) having a child younger than 5 or older than 18 years of age, or (d) have a neurodegenerative disorder (e.g., Alzheimer's, Parkinson's, Multiple Sclerosis, Huntington's, or Amyotrophic Lateral Sclerosis).

### **Procedure**

I received approval to conduct the study from the Institutional Review Board at Antioch University New England and the NSA. Participants were interviewed by phone or email to ensure that they were eligible to participate. If eligible, participants and I decided on a specific time and location to meet (in-person, by Skype, or by telephone); location of interview depended on proximity (if participant lives in a separate state), convenience, privacy, and comfort level of participants. Participants who agreed to participate signed an informed consent document (Appendix E). Before the interview began, I engaged participants in general conversation to

establish rapport. I ensured that all participants understood the informed consent document. Participants completed a 15-question demographic questionnaire (Appendix F). I then read participants an interview script (Appendix G), in order to ensure that they understood the research focus and process, and then conducted a 15-question, in-depth semi-structured interview. Semi-structured interviews took approximately 26-65 minutes to complete. All interviews were audiotaped. At the end of the interview, participants were asked to forward my information to other potential participants (snowball sampling technique). Participants were informed that they have the right to decline identifying additional participants. All participants were debriefed at the end of the study.

### **Data Collection and Analysis**

Semi-structured interviews are the preferred method of data collection for IPA (Smith & Osborn, 2003). In general, semi-structured interviews are non-directive, and consist of six to ten questions that are framed broadly and openly (Brocki & Wearden, 2006; Smith & Osborn, 2003; Smith et al., 2009). The semi-structured interview is used to guide the interview process rather than dictate it (Smith & Osborn, 2003). As such, the interviewer follows the participants' interests or concerns (Smith & Osborn, 2003) and utilizes probes and prompts to enter more deeply into participants' personal and social world (Smith & Osborn, 2003). A 15-question, in-depth semi-structured interview was used to facilitate data collection, in order to discover sub-themes and superordinate themes associated with parenting and stuttering. The questions are as follows:

1. Please describe the ways in which your stutter presents.
2. What emotions associated with your stuttering have influenced your parenting?  
Explain.

3. What thoughts associated with your stuttering have influenced your parenting?  
Explain.
4. When has stuttering caused you to replace one parenting behavior with another in order to avoid or minimize talking? Explain.
5. How have the perceptions of other people (stereotypes, discrimination, prejudice) in response to your stuttering influenced your parenting? Explain.
6. In what ways has stuttering influenced how you interact with and relate to other people who play an important role in your child's life (e.g., teachers, doctors, coaches, or religious figures, etc.)? Explain
7. In what ways has stuttering influenced how you interact with and relate to other people who play an important role in your child's life (e.g., family members or friends, etc.)?  
Explain
8. How has stuttering influenced the way(s) you verbally discipline your child? Explain
9. How has stuttering influenced your ability to emotionally bond and expressing feelings toward your child? Explain
10. In what ways has your stuttering influenced your ability to offer advice to your child (advice related to moral instruction, relationships [friends, dating], handling conflict, how to get along with others, school advice, etc.)? Explain.
11. How has stuttering symptoms influenced your ability to teach your child something?  
Have there been times when your stuttering has influenced how you teach your child?  
Explain.
12. What coping strategies do you use to manage your stuttering when parenting?  
Explain.

13. What is it like for you being a parent who stutters?
14. How do you view parental stuttering in terms of disability status?

Prompt: Do you view your stuttering as a disability in terms of parenting?

Explain.

15. How do you view parental stuttering and disability in terms of context (i.e., is your stuttering disabling in certain situations, settings, or around certain people?) Explain.

An IPA methodology was used to discover superordinate themes and sub-themes associated with parenting and stuttering. Analysis occurred through six stages: The first step involved listening to the audiotaped interviews and transcribing the client's narratives onto a sheet of paper (Smith & Osborn, 2003). The second step involved an in depth analysis of the case (Smith, Jarman, & Osborn, 1999). This included a line-by-line reading and rereading of the transcript in order to develop a deeper understanding of client's narrative. The left margin was used to make detailed notes about anything interesting or significant the participant is saying. I then returned to the beginning of the transcript to document emerging theme titles in the right margin (Smith et al., 1999). The third step involved writing the emergent themes on a separate sheet and looking for connection between them. Themes that were closely related to each other were clustered together (Quinn & Clare, 2008; now called subthemes). The fourth step involved subsuming cluster of themes under superordinate themes. Superordinate themes are "higher-order" themes that capture the essence of the participants' narrative (Smith & Osborn, 2003). The fifth step involved completing steps 1-4 for each individual case. The sixth step involved analyzing themes from all individual transcripts, and determining which themes cluster together (closely related themes are called sub-themes; Smith et al., 1999). Clusters of sub-themes were subsumed under superordinate themes. This process involved separating sub-

themes from superordinate themes in the individual cases. As such, new subthemes and superordinate themes emerged during this step; this was necessary in order to reflect the experiences of the participants as a whole (Smith et al., 1999).

Thematic analysis followed the suggestions put forth by Hill et al. (2005). The general theme category applied to all 10 participants; themes that emerged from 5 or more cases, but not all cases, were placed in the typical category (5-9); and themes that emerged from fewer than half the cases, but at least two or three cases, were placed in the variant category (2-4). Furthermore, instead of rejecting findings from single case responses, I incorporated these responses into the three other categories (general, typical, or variant). Categories were then modified to account for single case responses. This strategy adheres to Hill et al.'s (2005) suggestion that it is important to capture all of the participants' responses that reflect the phenomena being studied. The above strategy captured a greater number of themes associated with stuttering and parenting. Single case responses were categorized under miscellaneous category.

**Addressing biases.** The researcher can never entirely keep a critical distance from the research process (data collection and analysis), since the interpretations he makes of his surroundings and of himself are determined by his own background, history, beliefs, and opinions (Davidsen, 2013 & Maxwell, 2005, as cited in Daniels, Hagstrom, & Gabel, 2006). Thus, my own history of stuttering contributes a “qualitatively recognizable dynamic to the interview process” (Daniels et al., 2006, p. 206).

Therefore, several safeguards were used in order to minimize introducing bias into data collection and analysis. First, I disclosed my stuttering disorder in the beginning of the interview. Disclosure reduced the likelihood that participants would inquire about the researchers stuttering

history during the course of the interview. Second, I did not discuss intimate aspects of his stuttering disorder with participants. Third, a semi-structured interview was utilized to help guide the interview process. This assisted in adhering to the participants' narratives about their own history. Fourth, I read and reread transcripts multiple times to ensure that interpretations accurately reflected participants' accounts. Fifth, a doctoral-level psychologist (independent rater) analyzed a sample of the results and transcripts. This strategy was used in order to ensure reliability of superordinate themes and sub-themes described in the study. The independent rater determined congruity between transcriptional analysis and results. Sixth, credibility was further established by having participants verify, elaborate, or clarify my researcher's interpretations of their interviews (member-checking; Corcoran & Stewart, 1998; Daniels et al., 2012). Participants were asked to comment on whether superordinate and sub-themes accurately represented their experience of stuttering and parenting. Member-checking is well documented in the stuttering literature (Corcoran & Stewart, 1998), and is recommended when conducting qualitative research (Kornblush, 2015). Five participants determined congruity between transcriptional analysis and a sample of the results.

### **Ethical considerations and confidentiality**

Before conducting the study, Institutional Review Board (IRB) approval was received from Antioch University New England and the NSA. Participants were given an informed consent document to review and sign prior to participation. The informed consent document provided information related to confidentiality and privacy, voluntary participation and withdrawal, procedures of study, and the risks and benefits of the study. Upon completion of data collection, the following steps were followed to ensure confidentiality: (a) no identifying information was linked to the participants' identity in the transcript, (b) interviews were

transcribed in a private room, and (c) all audiotaped interviews were stored on a password protected computer (Cooper, Fleisher, & Cotton, 2012).

## Chapter 3: Results

### Demographics of Participants

Participants were selected using purposive and snowball sampling techniques. Ten adults (six men and four women), ranging from 28 to 50 years of age ( $M = 40$ ), participated in this study. Participants were interviewed in person (3 participants: office, community center, and home), by Skype (4 participants), and by phone (3 participants). Eight participants identified as Caucasian, one identified as African-American, and one identified as Asian-American. Nine participants rated their stuttering severity from very mild-to-moderate (1 = very mild, 3 = mild, 4 = mild-to-moderate, and 5 = moderate). One participant reported that her stuttering was too variable to rate its severity. Nine participants received speech therapy as a child, and one did not. Six participants received speech therapy as an adult, and four did not. No participants were currently receiving speech therapy at the time of the interviews. However, one participant stated that she sporadically attends a stuttering therapy group. Seven participants were currently attending a stuttering support group, and three were not. All participants identified English as their primary language. Participants' professions are listed as follows: (a) construction, (b) (c) financial analyst, (d) speech-language pathologist/professor, (e) human resources, (f) accounting, (g) pediatric dietician, (h) speech-language pathologist, (i) real estate, (j) and speech-language pathologist. Participants' education level ranged from High School to a Doctorate degree.

Participants reported the following demographics for their children: age range was 5-16 ( $M = 9.08$ ). Eight children were identified as Caucasian, one as African-American, and one as Multi-racial. Children' grade level ranged from Preschool to High School. Three children were reported to have a stuttering disorder; one child had apraxia disorder; and eight children did not have any speech-language issues.

### **Superordinate Themes and Themes Sub-Themes**

The primary purpose of this study was to: (a) explore how stuttering impacts various parenting roles, functions, activities, and states (emotions and cognitions), (b) gain a deeper understanding of how parents who stutter describe and attach meaning to parenting within a stuttering context, and (c) explore the connection between parenting, stuttering, and disability status. This was accomplished by identifying superordinate themes and sub-themes associated with stuttering and parenting.

Results of the study revealed the following superordinate themes: (a) stuttering symptoms, (b) parental stuttering and positive parenting emotions, (c) parental stuttering, co-parenting, and avoidant behaviors, (d) parental stuttering and verbal discipline, (e) parental stuttering and stigmatization, (f) fear about children stuttering, (g) parental stuttering as it relates to self-identity and disability, (h) and parental stuttering and coping strategies.

**Superordinate theme 1: Stuttering symptoms.** All ten participants (general theme) disclosed primary and/or secondary stuttering symptoms consistent with a stuttering disorder. Visual and auditory observations made by the researcher confirmed stuttering symptoms disclosed by participants. Participants endorsed the following primary stuttering symptoms: (a) syllable repetitions, (b) blocks, and (c) prolongations. Furthermore, many of the participants reported that secondary coping behaviors (e.g., word substitution, avoidance, and eye shutting) accompanied primary stuttering symptoms. The following excerpts describe participants' stuttering symptoms:

*Participant A:* It looks like I am in thought when I'm blocking (participant tilts head to side to mimic a contemplative stare). I use starters for sentences and use word substitutions frequently.

*Participant B:* Yeah, a lot of it is just facial expressions, like shutting my eyes. That is probably the most common.

*Participant C:* I do have some disfluencies in my speech. I also do some avoidance, so I use some filler words and I use escape behaviors.

*Participant D:* When I have to talk to people that is when it usually comes up; blocks, circumlocutions, use other words, or I tap.

*Participant E:* I would say blocks, and I probably do a lot of repeating of syllables and sounds.

*Participant F:* There is tension in my mouth. I do mostly repetitions, sometimes a block. But I sometimes have a prolonged block, sometimes repetitions, sometimes those quick blocks.

*Participant G:* My stutter usually tends to be sound repetitions and blocks. I really don't have so much prolongations, but some. I tend to have a lot of tension when I stutter or sometimes I'll clench my fists or I'll clench my hands together (participant demonstrates clenching of hands). I also, at times, blink my eyes when I'm trying to get a word out. I tense my lips. I tense my shoulders, my neck. I also tend to avoid at times. I tend to avoid a word or avoid certain situations where I would stutter more. I put in a lot of filler words.

*Participant H:* Pauses, sometimes prolongations of sounds, but I guess those are the main ones, but I'm sure there are still facial contortions that happen."

*Participant I:* I do prolongation and blocks. I do this sound where I click (mimics clicking noise). I lose eye contact. I have just halting blocks primarily.

*Participant J:* It presents as small blocks. At the start of utterances and sometimes forward moving prolongations and repetitions. Sometimes I just inadvertently block

because I did that for many years and I avoided situations or words.

**Superordinate theme 2: Parental stuttering and positive parenting emotions.** Seven participants (typical theme) reported expressing or modeling positive feelings toward their children. These positive feelings included encouragement, compassion, patience, understanding, empathy, and openness. The majority of participants stated that stuttering has contributed to the development of positive feelings. The following excerpts describe participants' accounts of parental stuttering and positive parenting emotions:

*Participant A:* I think that I have more of a capacity to express love and compassion and empathic feelings to them (children) because of stuttering. My kids tend to be more sensitive to the needs of others and more sensitized to will this hurt someone's feelings if I say this or take that action. (Researcher inquires about the connection between positive emotions and parenting). It could possibly make me more protective of the children, more in-tuned, if someone is hurting their feelings, or if they're being emotionally damaged from any situation.

*Participant B:* In the case of my son, it's helped. There was a time when he was stuttering a bit. He would get frustrated about it. He didn't understand it. Definitely, in those moments, it helped because I understand his feelings.

*Participant C:* I'm more affectionate with my son than with my daughter...I think my son is struggling with his speech, and I think I understand what he's going through...Often times I will see that struggle, and I just have to wait (patience).

*Participant F:* Stuttering has made me more of an empathic and patient person. I definitely have a stronger emotional bond with her (child) because we share this challenge (stuttering). I definitely have become a more positive, patient parent because I

want people to have patience with me. So, I try to have patience with my kids when they are talking, especially when they are stuttering. I try to show them patience I'd want shown to me. Do unto others as you want done unto you.

*Participant G:* My stutter has made me into a much more empathic person, a more emotionally aware person, and a more sensitive person. I'm also very aware and sensitive about other people's pain. It's just made me very, very sensitive to others. Our bonding is just fantastic. Me and my son, we just bond. It's been very positive. I'm very sensitive to him. I'm very attuned to him. I know when he's sad. I can tell right away when someone has hurt his feelings. I even know when it's going to be close to that point that if you say one more thing, he's going to start crying. I understand him emotionally. He feels extremely close to me. He feels that I get him.

*Participant H:* The only thing I could say is that I try to be more encouraging because I think that goes a long way. I don't know if I had that as kid. I don't think I had that as a kid with my stuttering. We didn't talk about it much. We didn't talk about it with my parents much. It would have had a more open dialogue about it. I think I try compensate for that. Just reminding them they are doing a great job. We are there for them. I'm there for them. We are all in this together.

*Participant J:* It (stuttering) definitely has made me more open about stuff. I think I'm an open person naturally...I want them (sons) to be in touch with their emotions. I'm pretty open and honest. It makes me vulnerable. I wonder every once in a while if they think that's weird mommy does that (stutter). But I've tried to be so open about it.

### **Superordinate theme 3: Parental stuttering, co-parenting, and avoidant behaviors.**

Seven participants (typical theme) reported using avoidant behavior to avoid or minimize

talking in specific parenting contexts. Within this superordinate theme, two subthemes were identified: Avoidant behavior in the community (e.g., teachers or doctors; 3A) and avoidant behavior with relatives or friends (e.g., cousins, stepmother or children's friends' parents; 3B).

***Sub-theme 3A: Avoidant behavior in the community.*** Seven participants (typical theme) reported experiencing avoidant behavior in the community. Participants' disclosed that they avoided talking to teachers (school setting), doctors, coaches, and religious figures. The following excerpts describe participants' accounts of parental stuttering, co-parenting, and avoidant behavior in the community:

*Participant A:* I was much less likely to talk to them if I would view them as an authority figure. So, I would avoid those. I tried to have excuses not to go to a teacher's conference. When I went to a teacher's conference, I would not say anything. Or, if there was an issue at school, I was much less likely to say anything or to make a phone call. That was very difficult. It was very frustrating because it felt like I was not protecting my child because of stuttering (Participant reported on past behavior).

*Participant C:* When I go to places with my kids, I don't participate as much. I tend to not talk a whole lot. I do tend to limit my conversations a lot, particularly with doctors and teachers. I would say that I do notice myself avoiding and doing a little bit of circumlocutions. Sometimes I do not get to the point soon enough. But that's probably the only way it affects my communication.

*Participant D:* If I am with my wife, I will let her be the main communicator. If she sees me having a hard time, she will interject (when around others).

*Participant G:* I tend to text his teachers more than call them. I've texted his morning teacher... With his Hebrew teacher, I tend to say less overall because I am just nervous

about my stutter. I tend to ask a lot instead of presenting my own thoughts or opinions about what's going on in class. I rely on more what he has to say. I view him as more of the professional than I am, even though I know my son.

*Participant H:* There are still situations in a group situation. Some sort of like big class meeting. I might not, depending on the day, ask something I was curious about. But at the beginning of the year, there will be a big classroom meeting where the teacher meets all the parents. Those situations there may be times when I don't speak up about things. Most of the settings are in a smaller setting, and then I wouldn't hold back.

*Participant I:* With coaches, I'm somewhat vocal. We just make small talk and it's much more casual. It just varies from situation to situation. If you see a coach who looks like a tough guy, looks like he doesn't have enough time to talk, I might hold back a little more.

*Participant J:* I think there is still a hierarchy of what I feel like I can do and what I can't do... There have been things where I could have volunteered to go into to talk to classes about the holidays, or I could have read a book, or I could have chaperoned a big trip. And somehow unconsciously, I think, "Oh, I can't do that." I don't want to embarrass my kids. I don't want to make myself too out there. Even the PTA, I haven't joined that. And I don't necessarily think it's just about stuttering. But I think there is a part of me that thinks that is too high... It's the thought, "There is a limit I can do."

***Sub-theme 3B: Avoidant behavior with relatives or friends.*** Four participants (variant theme) reported experiencing avoidant behavior with relatives or friends. Participants' disclosed that they avoided talking to family members (e.g., step-mother) or children's friends' parents. The following excerpts describe participants' accounts of parental stuttering, co-parenting, and avoidant behavior with relatives or friends:

*Participant A:* These days, no influence whatsoever. Back in my younger days, if there

were a situation where I should have said something to another family member or that said something disparaging to my child or just certain situations you just need to say something to a cousin, to an uncle, at a family reunion, some type of big family gathering, you really need to say something, and I wouldn't. And there were sometimes, I wanted to say something, but I just didn't have a thought because I was afraid that I would stutter (Participant reported on past behavior).

*Participant C:* If my wife is there, she's very sociable. I tend not to be very socialable. I think I sometimes rely on her. She will be the one to voice the opinion about our kids. When I get into a group, I tend to not talk very much. Certainly family is part of that.

*Participant G:* Sometimes my stutter holds me back from sticking up for my son when it comes to other people in his life. My step-mother is just a difficult person to deal with in general. Sometimes I don't like the way she talks to him or she will be like forcing him to give her a hug. I get annoyed at that. I will avoid bringing up the issue partially because I don't want to stutter and then come across as insecure, scared, weak, and intense. So, sometimes, starting a conversation, and then I know I'm going to stutter...I don't want to deal with the whole thing. So, stuttering gets into that. Also, in terms of play dates, I've texted parents, inviting their kids over for a play date over the weekend or asking if my son can come over to them. I've also at times just not called because I was too nervous. I don't have an ongoing relationship with the parents so much. I'm not too sure how much that affects things.

*Participant I:* There are some days when I asked my husband to arrange play dates. I just don't feel like interacting with the parents, especially with those parents I don't know.

**Superordinate theme 4: Parental stuttering and verbal discipline.** Nine (typical theme) participants discussed the influence that stuttering had on verbal discipline. Participants reported a range of experiences regarding stuttering and verbal discipline. These experiences are reflected in the following sub-themes: When I'm angry, stern, or in a heightened state, I don't stutter (4A); stuttering causes emotional consequences when verbally disciplining my children (4B); I am succinct or rely on others when verbally disciplining my children (4C); and I have an open dialogue when verbally disciplining my child (4D).

***Sub-theme 4A: When I'm angry, stern, or in a heightened state, I don't stutter when I have to verbally discipline my children.*** Six participants (typical theme) reported that they do not stutter when they are in a heightened state of arousal. Specifically, the majority of participants' associated emotional arousal with being angry or stern. The following excerpts describe participants' accounts of parental stuttering, verbal discipline, and emotional arousal:

*Participant A:* I would have to go back to my father. My father stutters and if he thought he would stutter on a word, he wouldn't say it. And so I never heard him stutter except for a few times. My father would use the fluency that he would obtain when he was angry. The adrenaline and anger made him fluent. When he was mad, he would save everything up, so I would hear everything I have done over the last three months in a 60-minute time period when he was fluent...I gotta make sure I don't do what my parent did, and use the adrenaline from anger to just say all these thing that I've been holding back. The most important thing for me is to address each issue as it comes rather than wait for a period of fluency, and then talk about everything. I just want to make sure that whether I am having a fluent day or whether my day is more stuttering...that I discipline my children.

*Participant B:* If it's more of a serious discipline, it's not an issue. If I'm being stern, I

don't really stutter.

*Participant E:* When I have to yell, I yell. In fact, usually when I yell I don't stutter at all. I don't use it as an excuse or hindrance... I just don't stutter because I don't think about what I'm saying. I think there must be some chemical reaction where the adrenaline takes over. The adrenaline must do something with your vocal cards. I know a lot of people (who stutter) who said when they yell and scream, they don't stutter.

*Participant F:* I talk. I get the words out. When I'm actually stern, I don't stutter so much.

*Participant H:* In those times I don't think about my stuttering. I think I'm so into what I'm upset about, it doesn't even enter my brain. In truth, stuttering doesn't enter my brain as much as it used to. But, when I am in a heightened state, I couldn't tell you if I was stuttering or not. I'm thinking about other things or trying to get my child to do what they are supposed to do. I'm not thinking about it.

*Participant J:* In the moment of anger, I don't stutter.

***Sub-theme 4B: Stuttering causes emotional consequences when verbally disciplining my children.*** Two participants (variant theme) discussed the emotional consequences of stuttering when parenting. Both participants' acknowledged that they still discipline their children despite struggling with their stuttering; however, they both reported experiencing emotional consequences (e.g., upset, stressed, frustrated) when verbally disciplining their children. The following excerpts describe participants' accounts of parental stuttering, verbal discipline, and emotional consequences:

*Participant I:* It doesn't (stop me from disciplining). I will have such a long block and I'll be stressed and upset, and they will just wait. That has been our household culture. I know that when my daughter was very young, he (husband) was very proactive

educating her about stuttering...I get frustrated with my long blocks, but they are fine.

*Participant J:* I feel very comfortable in my home, so I don't think that prevents me from telling my kids to do their homework or go to their room. It's not the physical act of talking. It's just having a stutter my whole life. I think that having a stutter my whole life and feeling out of control about that. I just don't want to be out of control... I have one (kid) who is really hard and he will just fight. And it's hard for me to not capitulate sometimes...It's exhausting...It's really hard to stay with it and not get emotional...It definitely exhausts me to have arguments.

***Sub-theme 4C: I am succinct or rely on others when verbally disciplining my children.***

Two participants (variant theme) stated that stuttering influenced how they verbally discipline their children. Participants reported being concise during moments of verbal discipline, in order to avoid or minimize the potential of stuttering behavior. One participant stated that he often relies on his partner to do a lot of the verbal disciplining. The following excerpts describe participants' account of parental stuttering, verbal discipline, and being succinct or relying on others:

*Participant B:* If I'm trying to explain a lesson, like you shouldn't do this, and if I'm having a bad speech, sometimes it's frustrating. It's not often, but there have been times, I just kind of summed it up. Maybe I could have explained things a little better to them. At the time, I didn't have the patience.

*Participant D:* I have to be very succinct about verbal discipline. Usually I don't want to stutter the whole time, and then the point gets lost...I am just thinking about identifying what's happening, and making sure my child understands it (Additional response was subsumed under this sub-theme). Participant added: I rely on my partner to do a lot

of the disciplinary type things, especially if it comes to explaining or having to give the “why” for things.

***Sub-theme 4D: I have an open dialogue when verbally disciplining my child.*** One participant (miscellaneous theme) relied on an open dialogue to verbally discipline her child. This dialogue included being verbally and emotionally present with her child. The following excerpt describes the participant’s account of parental stuttering, verbal discipline, and open dialogue:

*Participant G:* I tend to approach things from a very verbal and emotionally aware perspective. So I will even have a talk with him like, “Why did you do that?” If you knew mommy was upset and really hates when you do that, why would you do that right in my face? I’ll talk to him about. Because as a kid I feel like people didn’t give me the time of day or respect of what I had to say. I didn’t give myself that space for a long time because of my stutter. I really make it a point to give him the space to talk. Other parents will throw the kid in the room and lock the door or leave. Just make themselves deaf to their kids cry. I really can’t do that. If he’s having an all-out tantrum, I will put him in his room and say, “When you feel calm, then I will be happy to come and talk to you, but right now you can’t be crying outside in the living room.”

**Superordinate theme 5: Parental stuttering and stigmatization.** Eight participants (typical theme) discussed the intersection between parental stuttering and societal stigma. Participants’ experience of societal stigma—real or imaginary—was connected to the negative misperceptions that people often have about stuttering. Within this superordinate theme, five sub-themes were identified: (a) stigma and effects on parenting behaviors (5A), (b) stigma and motivation to be a better parent (5B), (c) stigma and imagined fears of the future (5C), (d) stigma

sometimes makes parenting difficult (5D), and (e) parenting offers a respite from the stigma of the real world (5E).

***Sub-theme 5A: Stigma and effects on parenting behaviors.*** Five participants (typical theme) discussed the influence of stigma on parenting behaviors (guidance: teaching and offering advice). Participants used their own histories of experiencing stigma to effectively teach and offer advice regarding the acceptance and tolerance of oneself and others. The following excerpts describe participants' account of parental stuttering, stigma, and parenting behaviors (guidance):

*Participant B:* I see things in a different way. I tell my kids in the past that you can't judge someone based upon first impressions. You kind of have to get to know someone. I've tried to teach them that aspect of it. Teaching them to be kinder. Kind of helped me teach them not to judge. There's been times where they said something and I had to remind them, "What if someone thought like that about your dad?" And I give them the explanation of my stuttering. That's the basic lesson: judging and being patient and accepting others.

*Participant F:* I have been in situations where the store clerks have not been nice. They have been rude. They made fun of me. I don't remember if my daughter was with me, but if she was, then that would definitely spur a conversation of we are all different... That when she sees someone in a wheelchair or walker—the same idea that we are all different, but we can all get along.

*Participant G:* First couple of months he went on the bus every morning. He had kids bothering him... There were kids who were pushing him around at school... I said to him "You should just push them back. If a kid pushes you, you should just push them right back." For a while, that was my response and I feel like that relates to my stutter

because there is a certain anger in me on behalf of him. Like, “You’re not going to push me around. You’re not going to push my kid around.” It’s almost like my chance to fight back from when I was young...It’s a little bit of my own projection. If I could go back in time, I’d shove these people. Maybe not physically, but I would talk back, and I would stand up for my right to speak. I would stand up for my right to stutter and not be made fun of....This year I am not telling him to push kids, but he did toughen up from that. He really didn’t push kids, but he felt like he had a backing. We were telling him, “You just shouldn’t take this sitting down.”

*Participant H:* I can see it in the future if she is being put down about something. I can use personal experiences to help her through that....I can’t count on my hands the times I was made fun of for stuttering...I think that I would say “It’s not really you (to daughter). You know how you are.” I tried to instill...Value people that value you. I try to pass that along.

*Participant I:* I try to model patience and empathy if something comes up. I think I feel like I have been judged since I was younger because of my stutter and I know there is more to me and because of those experiences...thinking or looking beyond what is presented to me. It definitely teaches my children to have more empathy and to have patience.

***Sub-theme 5B: Stigma and motivation to be a better parent.*** Two participants (variant theme) discussed the influence of stigma on parental motivation. Both participants stated that the negative misperceptions—real or imaginary—of other people inspired them to be better parents. The following excerpts describe participants’ account of parental stuttering, stigma, and motivation:

*Participant A:* I would always feel like I would have to do more to gain the respect of my children. I would have to be something more than just “me” in order for my children to be proud of me. That beam in their face when they had to introduce their dad. I felt like I had to be something more. I didn’t know what that was and there was a lot of frustration in the “guess work.”... Instead of just asking my children point-blank, “Are you proud of me even though I stutter?” Or, “Are you proud I’m your dad?” I would never ask them. I always guessed that they weren’t.

*Participant D:* Everyone’s response is like concern. Are they smart or are they okay? Always thinking people are judging you...I mean, if anything that just pushes me to go a little harder with my child. I go a little bit harder to go above and beyond as a parent.

***Sub-theme 5C: Stigma and imagined fears of the future.*** Two participants (variant theme) discussed anticipatory feelings of fear and concern related to the stigma of stuttering. Participants’ anticipatory feelings were connected to the imagined possibility of being stigmatized by their children or their children’s friends’ parents. The following excerpts describe participants’ account of parental stuttering, stigma, and the future:

*Participant F:* I think definitely as a parent and as the kids get older and pick up on it, it is something that I’m afraid of. So far, so good. But, she’s 5, so there’s a long way to go, and kids can get meaner as they get older...Deep down I do have this fear. What if they make fun of me? What if their parents don’t want their kids to play with her (child) because I stutter?

*Participant G:* In some ways, I wonder about the future and how I am going to emotionally react when he’s older and I’m stuttering in front of him. I tend to stutter more in front of kids who are older, and I don’t stutter as much in front of young kids.

I'm probably going to stutter in front of him when he's older. I do get concerned about what that will mean and how he will react to me.

***Sub-theme 5D: Stigma sometimes makes parenting difficult.*** Two participants (variant theme) discussed the influence of stigma on parenting behaviors. Each participant discussed the ways in which stigma sometimes made parenting difficult. For example, participant G (two separate responses) discussed the ways in which stigmatization made it difficult for her to communicate with her child and his friends. Participant J reported the way in which stigmatization affected her ability to multi-task as a parent. The following excerpts describe participants' account of parental stuttering, stigma, and difficulties with parenting:

*Participant G:* It's this judgment thing. It happens to be that it hits a certain target in me. Any time anybody looks like they are judging me because of the way that I speak, whether it's a stutter or just what I'm saying, I get very, very sensitive... There is this one friend who comes over and he sometimes makes fun of things that I say... I'm very sensitive when this kid mimics me. It hits a certain sore spot, which comes partially from this stuttering thing. When I speak, people react to me negatively... It affects my parenting because I tend to be much more intense about these friends... For me, it's like, I don't want him coming over any more. He's not a good friend for my son. He's not a good influence for him. I don't want him hanging out with kids like that.

*Participant G:* The thought is, "I don't have time." I don't have time to get my thoughts across. I have to get it across really quickly or someone else will raise their hand or someone will look at me and say, "Oh, she really doesn't know." Or, I just have to get it out or the person is going to look at me strange. That lack of time for myself and that rush thing, sometimes it makes me rush my son... He goes very slow... He just lives in his own

happy world...I will be very pressuring on him, and very impatient. I think a lot of that comes from me not giving myself the space and time to say what I want to say...And I think that's kind of influenced my parenting because I tend to project that onto him. Like, I don't have enough time. You need to get with it. You need to hurry up.

*Participant J:* I think it's an external thing. I think people assume you're nervous all the time. Or, perhaps I'm incapable in some way or I'm anxious. It's mainly about the anxiety. Basically, in my own perception of stuttering, which obviously comes from society, it's very hard to juggle a lot of things at one time. That affects my parenting because I get overwhelmed. Like, you're trying to talk, you're trying to keep the floor, and you're trying to get kids to behave. I sort of feel like I "can't walk and chew gum at the same time," especially if I'm struggling with stuttering.

***Sub-theme 5E: Parenting offers a respite from the stigma of the real world.*** Two participants discussed how parenting offers them a respite from the "real world." Specifically, parents disclosed that they feel judged when speaking in the real world. As such, parenting offers them a respite from the judgments and the misperceptions of others. The following excerpts describe participants' account of parental stuttering, stigma, and a respite from the real world:

*Participant B:* The positive is that it definitely is refreshing (parenting). Because you know, kids don't judge like that. So, it's almost like an escape from the world. I could let my guard down, a bit around them. I really don't have to try as hard—my fluency in general.

*Participant G:* I guess one thing I like to teach him stuff because I feel like I'm very effective when I teach him and I feel he really absorbs it and gets it. For me, it's really nice, because it gives me an outlet because a lot of times, I don't feel like I teach well.

When at school as a speech therapist, I feel extremely stifled by my stuttering. I feel like the kids are looking at me, waiting for me to get the word out. And I feel like they are judging me. And other teachers in the room are listening in. It's just so stifling...So, when it comes to my son, it works. I tend to give a lot of attention to it and a lot of positive energy. I love reading him stories...It's fun and interactive and it's just like natural. I get a lot of enjoyment out of it because I feel so stifled by my stutter in other areas of my life.

**Superordinate theme 6: Fear about children stuttering.** Four participants (variant theme) reported experiencing fear surrounding their children stuttering. The fear of some participants was realistic, since their children had begun to display symptoms of stuttering. For other participants, their fear was rooted in the possibility of their children stuttering. A few participants discussed the connection between fear of their children stuttering and parenting behaviors. The following excerpts describe participants' accounts of parental stuttering and fear of their children stuttering:

*Participant C:* I was even more fearful when my son was born. I know stuttering is genetic and tends to be more in boys. When I find out she was going to be a girl, I was less anxious.

*Participant D:* It's interesting. My biggest fear is that I don't want my daughter to be a stutterer as well. I'm afraid that I don't want to them to pick up any of the traits I have being a stutterer (Researcher inquires about the connection to parenting). That is my only concern. If I see that happening, I want to identify it and correct the behavior. The feeling I would attach to it is that you're very conscience about what you're doing, and what you're saying because you just don't want the child to be able to mimic the behaviors.

*Participant F:* I don't know if stuttering has influenced my parenting, but more the fear of my kids stuttering. When my husband and I were dating, one of his fears was that our children would stutter. Both do, at different degrees and at different times. The physical manifestation of stuttering doesn't affect how I parent necessarily (I inquire about the connection to parenting). I try to be extra careful. Once my older daughter who was 5 started stuttering, I was extra careful about my speech, and to be extra careful not to stutter. I didn't want to make her stutter more. I was more conscience of it.

*Participant H:* My older one was 2 years old. This was just the time I started to face stuttering myself in a more holistic fashion. She started to stutter and everything I read suggested it doesn't start until 2 ½. I was just trying to come to terms with my own stuttering and I heard her. The first time I heard it, it was a block. I didn't react to it well. I must have had fear...Next time it came up, I picked her up, and I made it seem like there was nothing going on. The interesting thing was, even though I was coming to terms with my stuttering the last thing I want is for my child to stutter. I don't want them to go through what I went through. I remember it being a lot of struggle. I kept a lot of it inside and I know my older one would. And it was not a fun way to grow up. There were times when I was a teenager and I had lock jaw.

**Superordinate Theme 7: Parental stuttering as it relates to self-identity and disability.** Five participants (typical theme) provided narratives about their self-identity in relation to stuttering and parenting. One sub-theme was identified: positive self-identity and stuttering, disability, and parenting, which is reflected in three sub-themes: (a) stuttering can sometimes be disabling/challenging when parenting, but ultimately, I am not disabled, nor is it a disability (7B), (b) stuttering is not disabling/challenging when parenting, and I do not consider it

a disability (7C), and (c) stuttering can sometimes be disabling/challenging when parenting, and I consider it to be a disability (7D).

***Sub-theme 7A: Positive self-identity, stuttering, and positive parenting.*** Five participants (typical theme) reported attributes associated with a positive self-identity. Participants also discussed how a positive self-identity contributed to positive parenting practices. Participant responses were coded under this theme if they identified personal attributes associated with a positive self-identity (e.g., unique, different, proud, interesting, or acceptance). The following excerpts describe participants' accounts about parental stuttering, positive self-identity, and positive parenting practices:

*Participant A:* Stuttering makes me a more interesting person. And I see that reflected in my children. Now if I didn't stutter, would I have so many interests, so many activities? I have no idea. We really like a lot of activities and different things. And I find that, and I am not sure if its because its my example or if its just the nature of my children, but they are all like that. They just have so many things that they are interested in. It's not just one certain thing.

*Participant D:* That I am unique. That a lot of people out there are not like me. I'm facing a big challenge head on, but I'm doing parenting well.

*Participant G:* Being a parent who stutters gives me extra joy in parenting. But being a person who stutters has allowed me to explore who I am and strengthen my core identity. And really develop a certain self-esteem that I am worth it, and that it's great to be unique and different, and that has made me a much better parent, and has made me celebrate my kids differences. So, he knows that I love him no matter what. The unconditional acceptance toward him comes from my own work on myself. My own ability to love

myself. To love myself unconditionally regardless of me and my stutter.

*Participant H:* It's who I am. I kind of embrace it now. As a parent who stutters, I think it will be beneficial. I think I'll show my patience and I will understand what my kids are going through no matter what their challenges may be.

*Participant I:* I try to really live my life the best I can without having my stutter impede my lifestyle, and I try to model this to my kids. They see me interacting with parents and they see me having a lot of disfluencies. Just being proud of who you are. I try to model that you set the tone as to how you want to be treated. We tell our kids this all the time; choose your battles. If that's not a good place to be, just walk away.

***Sub-theme 7B: Stuttering can sometimes be disabling/challenging when parenting, but ultimately, I am not disabled, nor is it a disability.*** Six participants (typical theme) discussed the ways in which stuttering was sometimes disabling/challenging in specific parenting contexts (e.g., speaking in large groups or in the community); ultimately, however, within the context of parenting, participants did not consider themselves to have a disability, nor did they believe that they were disabled. In other words, there was a contrast between participants' objective observations ("Stuttering is mildly disabling sometimes" or "Stuttering can sometimes be a challenge") and subjective perceptions of self ("Stuttering is not a disability" or "I am not disabled."). The following excerpts describe participants' accounts of stuttering and disability:

*Participant A:* Unless you have some type of life challenge, then you don't understand how impactful, how devastating those things are. But, disability does not give you an excuse to be selfish with your time, to be selfish with your effort, or to be self-centered. I think that I can use stuttering as an excuse to not be a responsible parent. I would go to the PTA meetings, but I would stutter. I would go to the parent conferences, and I would

stutter. Maybe these are excuses because I really do not want to go or I really don't want to be involved. So I try to be in-tuned with not using stuttering as an excuse to do things I feel like I should do when it comes to my parenting. I think if you want it to be, it certainly can be (a disability). But, not for me.

*Participant D:* It's a challenge, but it's a challenge that can be overcome and fixed.

Having to interact with my child and stuttering and being able to speak clearly is difficult sometimes. But, the stuttering isn't disabling. I don't think I ever had that issue. I don't think it's affected my life like people think it would. I'm very aware of this (stuttering), so it's almost like I'm a lot better at it than I typically am in certain parental settings...As a parent I'm very aware. I'm trying to speak very fluently, and I think I'm a way better stutterer as a parent. I don't think it's disabling at all.

*Participant G:* I think stutter is a little disabling, but I think that's a choice. I think it's just about courage. But I do think at times it might be disabling for me because of the avoidances. I'm scared to call parents at times, the phone calls, and getting into the social aspect of parenting. I feel it's more disabling in terms of their friends and their parents and school. Let's say I have to come to a PTA meeting, I'll feel a lot more shy and less interested in mingling with all the other parents who are talking to each other in school. In terms of parenting my son, just me and him, no, I don't feel it at all...I don't feel it's disabling. I never thought of my stutter to be a disability. I just never put myself into that category. Like, "I'm disabled" in any way.

*Participant H:* It's a hindrance or can be a hindrance in everyday life. It can have adverse effects on how one associates with the world, and part of association could be parenting...Yeah, mildly disabling in those group situations with parents...But,

personally, I don't see it as a disability, especially one-on-one with my kids or family. I don't think its adversely affecting how I am as a parent.

*Participant I:* For me, I would say no (not a disability)...But, it can be challenging. I don't engage as much with parents who I haven't had a positive experience with. If I feel like they've been impatient with me in the past, I try not to interact with them as much...I think it's a matter of choice. I think overall it is not disabling for me because I can talk to those parents who have been impatient with me in the past, but I choose not to because I have a choice of other parents I am good friends with. I think with a disability it's holding you back and you don't have a choice.

*Participant J:* I do think it is very hard being a parent who stutters because of all the challenges. Getting yourself out there. It's not easy. You're thrust upon so many situations...It just harder for me. It's not that I can't do it. I think it's an impairment in these little realms. If I'm in a group or there are kids around and wanting them to respect me, and respect what I have say. Those are more isolated situations...It can be challenging, but not on an everyday basis. So, no, I don't think it's a disability.

***Sub-theme 7C: Stuttering is not disabling/challenging when parenting, and I am not disabled, nor is it a disability.*** Three participants (variant theme) did not discuss or identify any ways in which stuttering may be disabling/challenging when parenting. Furthermore, they did not view themselves to be disabled or to have a disability. The following excerpts describe participants' accounts of stuttering and disability:

*Participant B:* Honestly, that's one of the few things in life where it doesn't even affect it (parenting and stuttering). My kids love me for me. It isn't even an issue...No, I don't (view stuttering as a disability in terms of parenting). If it was severe enough it

might, but I don't at all. Its not disabling to me because I really don't care what other people think about how I'm parenting.

*Participant E:* Even as a parent, it doesn't affect me (stuttering). As a parent, you have to have conversations with your kids teachers, principals, and doctors...,you have to interact. I don't let that bother me. I'll take my kids to the doctor. I'll speak away. Do I call it a disability? No. I say, I stutter. I don't use the word "disability." I don't associate myself with a disability.

*Participant F:* No (its not a disability in terms of parenting). Because I get my point across, I raise my kids how I want to raise them. My stuttering does not stop me from being me or stop me from saying the things I want to say. I've lived in three different communities with in the past eight years as a parent and it has not stopped me from meeting people or setting up play dates or being able to parent for my children. I wouldn't not discipline my kids if we are out because other people would hear me stutter.

***Sub-theme 7D: Stuttering can sometimes be disabling/challenging when parenting, and I consider it to be a disability.*** One participant (miscellaneous theme) considered stuttering to be disabling/challenging when parenting. He also viewed stuttering to be a disability. The following excerpt describes the participant's accounts of stuttering and disability.

*Participant C:* Yes, I think I do (view stuttering as a disability in terms of parenting). It definitely influences my interactions being a parent. It definitely impacts the way I interact and how much I interact. So, I think it definitely has some influence. It's really interesting. I'd say more than half the time it definitely is disabling and it does influence the quantity of quality of communication I have. Once in a while I'm a lot more talkative. Stuttering waxes and wanes, and I am just not as bothered by the stuttering. It's just

better some days. So, I think there are times when I am a lot more talkative. When I am interacting with my kids, I would say that it is not disabling. But when we get together with other people, other families, or other adults, I would definitely say it affects my communication. It is a lot more disabling in those things. I would definitely call it a disability.

**Superordinate theme 8: Parental stuttering and coping strategies.** Ten participants (general theme) reported using coping strategies to manage their stuttering symptoms when parenting. Three participants (participants A, F and J) reported using more than one coping strategy, while seven participants endorsed using only one coping strategy. Participants primarily utilized counseling-based coping strategies to manage their stuttering when parenting. Within this superordinate theme, three sub-themes were identified: (a) counseling-based coping strategies (8A), (b) speech-modification and fluency coping strategies (8B), and (c) linguistic and social-interactional coping strategies (8C). Instead of rejecting single case responses, linguistic coping strategies and social-interactional coping strategies were subsumed under one sub-theme. This strategy was used in order to capture all of the participants' responses. Participants' responses were coded under this theme if they identified a particular behavior or emotion as a coping strategy.

***Sub-theme 8A: Counseling-based coping strategies.*** Seven participants (typical theme) identified using counseling-based coping strategies to manage their stuttering when parenting. Participants' utilized a broad range of counseling-based coping strategies such as deep breathing, relaxations, positive thinking, self-talk, and mindfulness (psychological or emotionally-based coping strategies). The following excerpts describe participants' account of parental stuttering and counseling-based coping strategies.

*Participant A:* Having the right frame of mind. Maintaining that calmness of mind. That's been really the most impactful part of my coping strategies. Developing this calmness of mind. Understanding what it is. I find that my children tend to have this calmness of mind, even my wife does.

*Participant B:* I just try to slow things down a little bit. Breathing helps a lot. Being more thoughtful about what I am saying. Every day I try to do breathing exercises as well. Breathe in through my nose and out through my mouth slowly. It helps me feel more confident as a parent.

*Participant D:* I just kind of think back. I want to be calm. I want to talk as clearly as possible, but I want to put all that nervous energy away and be natural. So, all of that is kind of taking your time and just having a feeling that its going to be okay. Breathing exercises. That's about it. It makes me think very clearly about parenting, and not be nervous, if I was nervous at all. It makes me make better decisions from a good place. It allows you to be a better decision maker.

*Participant E:* I just try to take a deep breath and talk.

*Participant F:* I definitely think positive self-talk. When you're in a position with an authority figure, you're more nervous. I'm not nervous with my kids, so I think I am much more relaxed than if I am with someone who is in an authoritative role. So, I am much more relaxed, yet I try also not to stutter so much because I know that they can't pick up on the stuttering, but subconsciously, I try to make it as fluent as possible. The positive self-talk helps.

*Participant H:* The more you think about if you're going to stutter, it could actually happen. I try to let it flow. I try to be in flow, and not think about how I am speaking. In those situations there might be times where I will have to have like a mini pep talk

(self-talk) in order to get there, and raise my hand during those school meetings (for child).

*Participant J:* I really don't want to stutter in front of all of these kids. You know, if everyone is like, "Oh, X and X's mom is the mom who stutters. What the hell is wrong with her?" The most helpful thing I've been trying to do when it happens is sitting with the feeling and making room for it and breathing in and just saying, "I am feeling shame, it's right there." I'm going to keep it on my lap. It's not in my face. It's on my lap. I have it there and its okay. It's sort of the idea that it's a transient thing.

***Sub-theme 8B: Speech modification and fluency coping strategies.*** Four participants (variant theme) identified using speech modification and speech fluency coping strategies to manage their stuttering when parenting. Participants' utilized a broad range of coping strategies including acceptance, desensitization, and motoric speaking techniques (e.g., prep set, gentle onsets, and pausing and phrasing). The following excerpts describe participants' account of parental stuttering and speech modification and fluency coping strategies.

*Participant F:* I think I may use fluency shaping or fluency modification. Gentle onsets and pull-outs and fluency shaping. Not sure how many techniques there are, but just having complete control of my speech.

*Participant G:* When I am talking to him (child), I really don't stutter. But lets say I am out with him, I tend to proudly stutter. Or, just clean stuttering, where I'm not trying to modify it. And also there is the body language—like eye contact and holding my head up high. Give that confident vibe. I'll look the person in the eye and just stutter it out. If I stutter and it comes out, I'm just going to go with it. It really falls under desensitization strategy. Where you're not modifying anything, you're not making yourself more fluent,

and you're not modifying your speech. You're specifically not doing any of those things. You're just accepting who you are, and letting yourself be who you are without backtracking. Just stutter it out and move along through your stutter and don't backtrack.

*Participant I:* I know in the listserv many people talk a lot more about using different techniques. I don't use that. I try to focus on the content and I try to just move forward with my speech. I'm thinking more about the message, than about the mechanics of my speech. Some of the coping strategies people have used are like breathing techniques or visualization. I don't use those.

*Participant J:* I think if I'm reading out loud, I will definitely use some strategies. I still read to my younger one a lot. I'll try to use certain strategies like stretching into the word, pausing and phrasing, or adding a prep set.

***Sub-theme 8C: Social-interactional and linguistic coping strategies.*** Two participants (variant theme) used social-interactional and linguistic coping strategies to manage difficulties when parenting. Participants' utilized situational avoidance, word substitution, and starters. The following excerpts describe participants' account of parental stuttering and social-interactional and linguistic coping strategies.

*Participant A:* If I start to block, I will have a thoughtful look. I will use word word substitutions or starters. It is my normal pattern of communication when I am parenting.

*Participant C:* Well, sometimes if my wife is present, I kind of know that she will intervene. She's talkative. So I kind of use that sometimes. Certainly, if my wife is there and we have to do a lot of interaction kinds of things, I think I use her. If I'm not doing something because of my speech, it's definitely avoidant.

### Chapter 4: Discussion

One main finding of this dissertation was that stuttering is highly variable within and across individuals and speaking situations. From an affective-experiential perspective, participants reported a range of both positive (e.g., compassion, understanding, and empathy) and negative emotions (e.g., fear, frustration, anxiety and anger) related to parental stuttering. Similarly, participants also disclosed helpful (e.g., positive self-talk) and unhelpful (e.g., “I can’t do that. I don’t want to embarrass my kids”) thoughts related to parental stuttering. Within this context, positive emotions and thoughts were often connected to positive parenting behaviors (e.g., having an open dialogue with child), and negative emotions and thoughts were often related to negative parenting behaviors (e.g., avoidant co-parenting behavior or being succinct when verbally disciplining children).

The majority of participants also discussed the effects of stuttering stigma (stereotypes and prejudices) on various aspects of parenting. Specifically, the stigma of stuttering exerted both positive (e.g., teaching acceptance and tolerance to children) and negative influences (e.g., difficulty interacting with children) on parenting practices. Furthermore, the majority of participants did not identify with the term “disability,” nor did they consider themselves to be disabled; many of these participants discussed how a positive self-identity (e.g., unique, pride, different, or acceptance) contributed to positive parenting practices (e.g., celebration of child’s differences). Additionally, participants reported using a variety of coping strategies (counseling-based coping strategies, speech-modification and fluency coping strategies, and linguistic and social-interactional coping strategies) to manage their stuttering symptoms when parenting.

**Superordinate Theme 1: Stuttering Symptoms**

Although stuttering symptoms vary from person-to-person, all ten participants reported or manifested primary and/or secondary stuttering symptoms. Transcription and observational analysis revealed that many participants experienced syllable repetitions, prolongations, blocks, eye shutting, word substitution, and avoidance, etc. Participants' stuttering symptoms (primary and/or secondary) are consistent with the stuttering symptoms found in the literature (Bricker-Katz et al., 2013; Craig et al., 1996; Daniels et al., 2012). Since participants were required to self-identify as having a stuttering disorder—and not provide justification of a clinical diagnosis—this brief analysis provides support for the inclusion of all participants.

**Superordinate theme 2: Parental Stuttering and Positive Emotions**

Seven participants (A, B, C, F, G, H, and J) reported a range of positive emotions (e.g., compassion, empathy, patience) associated with stuttering and parenting. A number of prominent researchers have demonstrated the important role of parental emotions in positive child development. Parental affect plays a significant role in developing a child's empathy and sense of self, facilitating safety, and improving emotional regulation (Hughes, 2009). The majority of positive child development occurs within the context of a patient, understanding, compassionate, and empathic child-parent relationship (Hughes, 2009). Research has shown a link between positive parenting practices and positive children's outcomes (Eisenberg, 2005). Although this study did not explore the effects of parental stuttering on children, Participant A did report an association between positive parental emotions and his children's development. He stated that his ability to express love, compassion, and empathy toward his children has resulted in them being more sensitive to the needs of others.

Similarly, each participant (A, B, C, F, G, H, and J) stated that stuttering has allowed

them to express positive emotions toward their children. These results are in contrast to other findings, which have found that PWS primarily experience negative emotions. For example, a qualitative study by Klompas and Ross (2004) demonstrated that PWS experienced a broad range of negative feelings such as frustration, anger, embarrassment, stupidity, foolishness, fear, nervousness, and self-blame; only two positive emotions (confidence and a positive attitude) were reported by participants. These results add a refreshingly new perspective regarding the affective-experiential world of PWS.

It is plausible to assert that the context of parenting elicited a different affective response in PWS. A review of the literature (Bricker-Katz et al., 2013; Daniels et al., 2012; Perez et al., 2015) demonstrated that the majority of PWS experience negative emotions (e.g., fear and embarrassment,) within the context of school, work, or other important settings (e.g., medical visit). This may be the case because PWS are more apt to stutter around authority figures than with relatives or friends (Craig & Tran, 2006). The presence of an authority figure—at work, school, or medical setting—may elicit an increase in stuttering behavior and associated negative emotions (Craig & Tran, 2006). Furthermore, many of the above settings (e.g., work, school) occur in a large group setting; PWS often have more difficulty speaking in large groups (Bloodstein, 1995). On the contrary, marriage and family life appear to exert only minimal negative emotions in PWS (Klompas & Ross, 2004). Thus, it is likely that parental authority, coupled with a smaller group setting (parenting and family life), may decrease the likelihood of stuttering and subsequent negative emotions (i.e., parents may feel more relaxed and controlled with the small, more predictable setting of family life).

### **Superordinate theme 3: Parental Stuttering, Co-Parenting, and Avoidant Behaviors**

Six participants (A, C, D, G, H, I, and J) reported using avoidant behaviors to avoid or

minimize talking in specific parenting contexts. Different situational contexts can elicit different problems for PWS. Situations that arouse anxiety around talking can lead to an increase in stuttering severity and subsequent avoidant behavior (Craig & Tran, 2006; James et al., 1999). Often, feelings of anxiety are in response to the fear of being negatively evaluated by others (Bricker-Katz, 2009; St. Clare, 2009). People who stutter spend a significant amount of time “hiding” their stuttering by engaging in a variety of avoidant behaviors (Fogle, 2012).

An integral part of parenting is the ability to interact with different people who play an important role in the child’s life (co-parenting). Parents, to some degree or another, interact and exchange information about their children with spouses, grandparents, and teachers, etc. (Feinberg, 2002; Giarrusso, 1996; Sheldon, 2002). PWS may have difficulty engaging in co-parenting if they are experiencing anxiety and fear surrounding the possibility of stuttering. Participants in this study (6 out of the 10 participants) reported avoidant behavior with a variety of people, including family members (e.g., cousin or step-mother), teachers, doctors, coaches, and children’s friends’ parents.

Participants A, C, D, G, H, and I reported avoidant behavior in the community with a variety of people who are actively engaged in their children’s lives. For example, participant G stated that she prefers to text instead of calling her child’s schoolteachers. Similar to this finding, James et al. (1999) found that PWS had more problems making calls than answering them. Participants A and H both stated that they avoided talking to their children’s schoolteachers (e.g., parent teacher conferences/meetings). Interestingly enough, a retrospective study by Daniels, et al. (2012) found that PWS utilized a variety of avoidant behaviors in the school setting. Furthermore, Participant C stated that he limits his speaking (word avoidance) when talking with his children’s doctors. Perez et al. (2015) demonstrated that chronic discomfort with speaking

caused PWS to avoid healthcare interactions.

The majority of stuttering research has demonstrated that PWS display more avoidant behavior with authority figures (e.g., coaches, teachers, or medical professionals) than with relatives or friends. In this study, four participants (A, C, G and I) manifested avoidant behavior with relatives or their children's friends' parents. For example, participant C stated that his wife is usually the one to voice an opinion about their children when in a large family gatherings. Participant G stated that she avoids talking to her stepmother about issues regarding her child. Similarly, Klompas and Ross (2004) found that PWS sometimes avoided interactions with close family members (spouses or partners).

The literature on stuttering has shown that PWS experience more anxiety and speaking difficulties when talking with an authority figure (Craig & Tran, 2006; Fogle, 2012). Thus, a deeper analysis of the participants' responses revealed that they avoided more when interacting with authority figures (e.g., coaches, doctors, teachers) than with relatives or close friends.

#### **Superordinate theme 4: Parental Stuttering and Verbal Discipline**

Nine participants (A, B, D, E, F, G, H, I, and J) discussed the intersection between parental stuttering and verbal discipline. Verbal discipline is a common practice among parents (Canadian Paediatric Society, 2004). Throughout a child's lifespan (early toddler to adolescence), parents utilize different forms of verbal discipline in order to effectively teach and guide their children (Canadian Paediatric Society, 2004). The main goal of verbal discipline is to foster acceptable and appropriate behavior in children (Canadian Paediatric Society, 2004). Research has demonstrated an association between harsh verbal discipline and negative children's outcomes (e.g., internalizing and externalizing problems; Lansford et al., 2010;

Ming-Te & Kenny, 2013). On the contrary, positive verbal discipline such as empathy, understanding, and compassion, are associated with positive children's outcomes (Hughes, 2009).

Six participants (A, B, E, F, H and J) reported no difficulties with stuttering and verbal discipline. These participants stated that during a heightened state of arousal (e.g., anger or being stern), they do not stutter when disciplining their children. Interestingly enough, participants' reports contradict some of the stuttering research. In general, research has linked stuttering to high-stressed situations and negative emotions (e.g., anger or fear; Alm, 2004). According to Guitar (2013), reduction of negative emotions reduces stuttering severity.

However, according to some researchers (Bloodstein & Bernstein-Ratner, 2008, as cited in Alm, 2004), PWS tend to speak fluently when experiencing strong feelings such as anger, enthusiasm, or fear. Specifically, Bloodstein and Bernstein-Ratner (2008, as cited in Alm, 2004) used a case example to illustrate this phenomenon. They reported that two soldiers in World War II were only able to talk fluently during dangerous situations. Alm's (2004) suggests that stuttering may be reduced during times of intense emotions because the person is focused on the task at hand, thereby suppressing social and personal considerations related to their stuttering. For example, Participant H confirmed the above assertion by stating, "In those times I don't think about my stuttering...I'm so into what I'm upset about, it doesn't even enter my brain (focused on task at hand)...When I am in a heightened state...I'm thinking about other things..."

Furthermore, two participants (I and J) reported experiencing emotional consequences when disciplining their children. The physical struggle of trying to force words and sounds out can be mentally and physical exhausting for PWS (Williams, 2006; Yeoman, 1998). According to Whyte and Kellman (2012), PWS may experience frustration and exhaustion due to their

inability to say what they want to say. Both participants were able to verbally discipline their children; however, they expressed feeling sad, upset, stressed, and exhausted with the process. An unknown author poignantly captured the frustration and exhaustion associated with stuttering. He stated, “By the time I was done with what I was trying to say, the pain in my head and neck... would be so severe that I would need to rest... As I am writing about how badly I used to stutter, it is exhausting (S. L. C., 2014).

Additionally, participants B and D both utilized techniques (e.g., minimizing discourse and relying on others), in order to avoid or minimize talk when verbally disciplining their children. Research has consistently demonstrated that PWS utilize a variety of techniques to “hide” their stuttering (Klompas & Ross, 2004; Perez et al., 2015). Furthermore, Participant G discussed the implications of growing up with a stutter, particularly her experience of feeling silenced. She stated, “Because as a kid I feel like people didn’t give me the time of day or respect what I had to say.” PWS often report feeling silenced. For example, in his autobiography, American journalist, Byron Pitts (2009) states, “I slipped back into my pattern of silence to avoid the shame of stammering and stuttering” (p. 99). Her experience of feeling silenced by others has allowed her to establish an open, honest dialogue with her child. She stated, “I feel like people didn’t give me the time of day or respect what I had to say. I didn’t give myself that space for a long time...I really make it a point to give him the space to talk.”

### **Superordinate theme 5: Parental stuttering and stigmatization**

Eight participants (A, B, D, F, G, H, I, and J) discussed the different ways in which stigmatization influenced parental practices and beliefs. Many PWS experience stigma in the form of stereotypes, prejudice, and discrimination (Boyle, 2015; Craig et al., 2003). The experience of stigma is often rooted in the listeners’ reaction to PWS (Klompas & Ross, 2004). Research has found that listeners hold negative perceptions of PWS (e.g., stereotypes and

discrimination; Ham, 1990; Przepiorka et al., 2013; Rice & Kroll, 1997). When compared to fluent speakers, PWS were thought to be more afraid, tense, anxious, nervous, guarded, avoidant, passive, and sensitive (Kalinowski & Stuart, 1996).

Participants B, F, G, H, and I used autobiographical experiences of stigma to offer advice and teach their children about tolerance and acceptance. For example, participants B, F, and I reported experiencing intolerance and nonacceptance from other people (e.g., being judged or misperceived). As such, these participants found it important to convey a message of tolerance and acceptance toward others. Participants G and H reported similar experiences. However, these participants found it important to convey a message of tolerance and acceptance toward oneself. For example, participant H stated, “You know who you are (to daughter). I try to instill...Value people that value you.” Participant G offered similar guidance to her child, particularly around instances of bullying, i.e., accept who you are as a person, and do not let others push you around.

Furthermore, Participants A and D both discussed how negative societal perceptions influenced their parenting. For example, participant A indirectly reported feeling flawed or defective as a parent. He stated, “I would always feel like I would have to do more to gain the respect of my children. I would have to be something more than just “me” in order for my children to be proud of me.” Similarly, Participant D expressed a negative thought pattern (“Always thinking people are judging you”) about parenting and stuttering. Both participants stated that negative societal perceptions have motivated them to be better parents. For example, Participant D stated, “I go a little bit harder to go above and beyond as a parent.” These findings are consistent with the findings of Kaiser, Reed, and Boschen (2012), who found that mothers with a spinal cord injury constantly felt the need to prove themselves as parents, which inspired them to be “supermoms” (Kaiser et al., 2012).

Research has consistently shown that fear is a primary emotional response in PWS (Corcoran & Steward, 1998). This fear is often rooted in the belief that listeners will react negatively to stuttering behavior (Boyle, 2015; Ham, 1990). It is not uncommon for PWS to experience anticipatory anxiety surrounding the fear of stuttering. Consistent with these findings, Participants F and G both described feeling anticipatory fear about the future. They expressed fear and concern about older children and their children's' friends' parents reacting (listeners reactions) negatively to their stuttering. For example, Participant F stated, "As the kids get older and pick up on it, it is something that I'm afraid of...Kids can get meaner as they get older...Deep down I do have this fear. What if they make fun of me?"

Furthermore, Participants G and J both expressed difficulties with parenting, which appears to be rooted in the negative societal perceptions that others hold about PWS. For example, Participant J stated, "I think people assume you're nervous all the time...In my own perception of stuttering, which obviously comes from society, it's very hard to juggle a lot of things at one time. That affects my parenting because I get overwhelmed." This quote demonstrates that participant J may have internalized the negative societal perceptions of other people (self-stigma; Boyle, 2015). In other words, she may have internalized the belief that PWS are anxious; this internalized belief is then manifested in her inability to multi-task as a parent.

### **Superordinate theme 6: Fear about Children Stuttering**

Four participants (C, D, F and H) reported feeling fear for either current or future symptoms of stuttering in their children. In a qualitative study by Klompas and Ross (2004), one participant reported that he was fearful that his child might stutter; however, this did not prevent him from having children. Furthermore, Boberg and Boberg (1990) reported that many couples were anxious about having children who stuttered. These couples "were extremely sensitive to

any dysfluencies in their children's speech and were determined not to have them suffer the torment they had endured themselves" (Boberg & Boberg, 1990, p. 67). Similarly, participant D displayed extreme sensitivity to any disfluencies manifested by his children. He stated, "That is my only concern. If I see that happening, I want to identify it and correct the behavior... You're very conscience about what you're doing, and what you're saying."

### **Superordinate Theme 7: Parental Stuttering as it relates to Self-identity and Disability**

PWS come to "understand who they are or who they should be... against the backdrop of a powerful social value system (what it means to be "normal" or "abnormal"; Kathard, 2006, p. 80). In other words, the perceptions of other people are powerful motivating factors in determining how PWS see themselves in relation to their external world (Kathard, 2006). As such, it is no surprise that stuttering is predominantly viewed as an impairment or disability (Van Riper, 1982, as cited in Kathard, 2006). According to Starkweather and Givens-Ackerman (1997, as cited in Klompas & Ross, 2004) "speech is so closely related to one's self-identity that to be a 'poor' speaker is like being an incompetent person" (p. 296). Often, the misperceptions of other people, coupled with the social and personal limitations of stuttering, may make it difficult for PWS to form a narrative consistent with a positive self-identity (Daniels & Gabel, 2004, Kathard, 2006).

However, many people with disabilities have provided a narrative that is strikingly different than one generally described. These narratives consist of attributes associated with a positive self-identity (e.g., self-worth, pride, acceptance, unique or different; Dunn & Burcaw, 2013; Klompas & Ross, 2004; Shakespeare, 1996). According to Shakespeare (1996), "the celebration of disability pride is the celebration of difference, and the acceptance of difference (p. 109). A positive self-identity helps people with disabilities "recast their identities as Able"

(Kathard, 2006, p. 80) instead of disabled.

Stuttering plays a primary role in shaping part of a person's identity (Daniels & Gabel, 2004). Five participants (A, D, G, H, and I) in this study identified attributes associated with a positive self-identity (e.g., pride, acceptance, unique, or different). These results are consistent with other qualitative findings. For example, in a study by Klompas and Ross (2004), one participant stated, "Maybe before, till I took pride in being disabled, now I don't give a damn. If you judge me on my disability I feel pride, go beyond the stereotypes, it is the content that matters; I still value and love myself..." (p. 296). Another participant stated, "Absolutely, I have come to terms with it and have accepted the fact that I stutter" (p. 297).

A positive self-identity allowed these five participants (A, D, G, H and I) to "reconstruct and strengthen their self-identity as Able" (Kathard, 2006, p. 85). Being Able was manifested in their ability to be effective and responsible parents. For example, Participant G stated, "Really develop a certain self-esteem that I am worth it, and that it's great to be unique and different...that has made me a much better parent, and has made me celebrate my kids differences." Similarly, Participant A stated, "Stuttering makes me a more interesting person. And I see that reflected in my children...They just have so many things that they are interested in. It's not just one certain thing." The core theme among all five participants was their ability to reconstruct their identity as Able through a process self-acceptance and self-love (e.g., being unique, different, or interesting). These results are consistent with the findings of Kathard (2006), who demonstrated that PWS come to shape their identities as Able through positive experiences (e.g., successful social exchanges) and positive attributes and emotions (e.g., acceptance or pride).

Thus, it is no surprise that these same participants (A, D, G, H, and I, as well as J)

rejected the idea that they were disabled or that stuttering was a disability despite experiencing challenging or disabling moments when parenting. Many people with impairments do not consider themselves to be disabled (French & Swain, 2008). For example, Participant G recognized that stuttering was difficult in certain parenting contexts (e.g., talking to children's friends' parents); however, she did not identify with the disability label. Participant J stated that stuttering causes some problems in group situations when parenting; however, similar to participant G, she did not identify with the disability label. In a qualitative study by Valeras (2010), one participant with a medical impairment stated, "I don't like the *word*. I don't like what it means...I don't think of myself as *disabled*...I don't identify with it" (para. 26).

Participants who rejected the disability label appeared to struggle with trying to "understand themselves as people with both limitations and strengths" (Olney & Kim, 2001, p. 575). Their responses represented an internal struggle that was manifested by contradictions, negations, and sudden shifts in discourse (Olney & Kim, 2001). For example, Participant G stated, "I think stutter is a little disabling...I do think at times it might be disabling for me because of the avoidances...But I don't feel it's disabling...I just never put myself into that category. Like, I'm disabled in any way." Whereas, Participant C was better able to accept his stuttering as a disability. He stated, "When we get together with other people, other families...I would definitely say it affects my communication, and it is a lot more disabling in those things...when I am interacting with my kids, I would say that it is not disabling." Participant C's acceptance of his stuttering as a disability may have been due to his ability to "come to terms with the negative aspect of the disability experience" (Olney & Kim, 2001, p. 575), thereby "defining the self in terms of both limitations and strengths (Livneh & Antonak, 1991, as cited in Olney & Kim, 2001, p. 578). In other words, Participant C recognized that he possesses both

limitations (e.g., difficulty talking with other parents) and strengths (e.g., not disabling with his children) as a parent who stutters.

### **Superordinate Theme 8: Parental Stuttering and Coping Strategies**

Parental coping strategies are an important part of the parenting role. Parents use coping strategies to effectively manage the stressful demands of parenting (Azar & Solomon, 2001), which emanate from a variety of child, parental, and situational stressors (Abidin, 1995). Parents use a variety of coping strategies (e.g., problem-focused, relationship-focused, and emotion-focused) to manage stressful situations when parenting (Mak & Ho, 2007). It is likely that PWS may experience additional stress due to the social and personal difficulties imposed by stuttering. As such, parents who stutter are likely to rely on a variety of coping strategies to manage stressful moments when parenting.

Ten participants reported using a diverse set of coping strategies (secondary coping strategies and speech therapy coping strategies) to manage their stuttering symptoms. This study categorized coping strategies into three sub-themes: counseling-based coping strategies, speech-modification and fluency coping strategies, and linguistic/social-interactional coping strategies. This approach is consistent with the design used by Daniels et al. (2012). In their study, they categorized coping strategies into three major categories: physical coping strategies, linguistic coping strategies, and social-interactional coping strategies. It is important to note that coping strategies in one category may overlap into another category. However, for this study, participants' responses were categorized into distinct groups, in order to demonstrate the broad range of coping strategies used by PWS.

Seven participants used counseling-based coping strategies (emotional and/or psychological) to manage their stuttering when parenting. These coping strategies are consistent

with the burgeoning literature regarding the use of counseling-based coping strategies when working with PWS. A qualitative study revealed that 16 participants found speech therapy to be a positive experience when it addressed social-emotional concerns in addition to speech fluency and speech modification techniques (Daniels et al., 2012). According to Menzies et al. (2009) CBT-based strategies can effectively improve social and emotional difficulties associated with stuttering (e.g., decrease anxiety and social avoidance, and increase participation in everyday speaking situations for PWS). For example, Participant H reported using self-talk and positive thinking to increase his participation in school meetings for his children. Participant J reported using mindfulness and breathing techniques to effectively manage feelings of shame when stuttering in front of her children's friends. Another study found that cognitive-behavioral therapy (psycho-education, relaxation, deep breathing, humming, prolongation, cognitive restructuring, problem-solving strategies and assertiveness) reduced stuttering severity, enhanced assertiveness, decreased dysfunctional attitudes, and improved quality of life for PWS (Reddy, Sharma, & Shivashankar, 2010). Participant D stated that being calm, taking his time, and using breathing exercises improved his parenting by allowing to reduce his nervous energy, think and talk more clearly (reduce stuttering severity), and become a better decision maker as a parent. St. Clare et al. (2009) demonstrated that five days of intensive CBT (cognitive restructuring, graded exposure, behavioral experiments, and attentional training) significantly decreased participants unhelpful thoughts and beliefs linked to stuttering. Participant F reported that using positive self-talk (cognitive restructuring) helped her maintain a relaxed state while talking to authoritative figures and her child.

Four participants reported using speech modification and fluency coping strategies to manage their stuttering symptoms when parenting. For example, Participant G provided a clear

example of how stuttering acceptance (stuttering with no modification) has permitted her to parent in a more efficient manner (in the community with her child). Similarly, participant I reported that accepting her stuttering has allowed her to be a more effective speaker when parenting (i.e., she focuses on the content, not the message delivery). Stuttering acceptance is an integral part of speech-modification programs, and has shown to be an effective coping strategy for managing stuttering symptoms (e.g., reduction in stuttering severity, “normalization” of communication attitudes, and a decrease in their perception of the impact that stuttering has on their life; Tsiamtsiouris & Krieger, 2010). Participants F and J reported using speech fluency shaping coping strategies (e.g., gentle onset and stretching the word) to manage stuttering symptoms when parenting. Speech fluency coping strategies have been shown to be effective in reducing stuttering symptoms and improving the quality of life for PWS (Boberg & Kelly, 1994).

Two participants briefly described using social-interactional coping strategies and linguistic coping strategies (avoidance) to manage their stuttering when parenting. Research has demonstrated that PWS use a variety of avoidant coping strategies to manage their stuttering symptoms in a variety of circumstances (Bricker-Katz et al., 2013; Daniels et al., 2012). Participant C clearly described how he relies on his wife during interactions with others (situational avoidance). Participant A stated that using filler words and substitutions (word avoidance) were a normal part of communication when parenting.

### **Conclusion about Superordinate themes and Sub-themes**

To my knowledge, this is the first study that has thoroughly explored the unique, experiential experiences of parents who stutter. As such, these results offer a new perspective on how PWS navigate different parental roles, functions, and activities (parenting-based behaviors). Furthermore, results also offered new insight into the affective and cognitive world

of parents who stutter. Similar to other qualitative studies, participants' responses captured the highly contextualized nature of stuttering. For example, the majority of participants disclosed a range of affective, cognitive, and behavioral experiences in response to parental stuttering. Furthermore, the majority of participants discussed the impact of stuttering stigma on different parenting behaviors and states (emotions and cognitions). Another major finding was that the majority of participants rejected the disability label. In other words, participants did not identify with the term "disability," nor did they consider themselves to be disabled. This perspective offers a unique glimpse into how PWS (specifically, parents) construct and attach meaning to the term "disability." Additionally, consistent with other studies on stuttering, participants in this study utilized a range of coping strategies to manage their stuttering when parenting.

These results add to the body of stuttering literature by highlighting the impact of stuttering on various parental roles, functions, activities, and states. The following sections will provide a brief overview of: (a) limitations of the study, (b) advancement of theory and research, and (c) clinical practice of speech-language pathology and mental health. These sections will illuminate the continued need to understand the unique, lived experiences of parents who stutter.

### **Limitations of Study**

It is critical to evaluate the inherent limitations in the research methodology and analysis of this study. For example, a small sample size (10 participants) was used to understand the lived experiences of parents who stutter. As such, generalizing the results to the wider population of parents who stutter is limited. Furthermore, the sample did not adequately represent parents who stutter from different racial or ethnic backgrounds. Therefore, it makes it difficult to generalize the results cross-culturally. In addition, I used an IPA approach to analyze data. IPA draws upon the fundamental principles of hermeneutics and theories of interpretation (Smith & Osborn,

2003). In this sense, “IPA researchers attempt to understand what it is like to stand in the shoes of subject” (Pietkiewicz & Smith, 2014, p. 362) by trying to interpret participants personal and social world (Smith & Osborn, 2003). Thus, it is reasonable to assume that the interpretations of the participants’ lived experiences may have been influenced by my background, history, beliefs, and opinions related to his own stuttering disorder (Davidsen, 2013 & Maxwell, 2005, as cited in Daniels, Hagstrom, & Gabel, 2006).

Additionally, the majority of participants in this study reported their stuttering severity as very mild-to-moderate. Furthermore, a majority of the participants were currently attending an NSA stuttering support group. There is a link between support group attendance and lower stuttering severity and an increased quality of life (self-esteem, self-efficacy, and life satisfaction; Boyle, 2013). Therefore, participants’ experiences of parental stuttering may be a reflection of their stuttering severity (mild-to-moderate) and their support group experience. As such, their experiences of stuttering and parenting may not necessarily be representative of people with a more severe stuttering disorder or those who are not members of support groups.

### **Future Implications**

**Advancement of theory and research.** The above research limitations suggest areas for future research. For example, future research may use a mixed-method analysis to further study the lived experiences of parents who stutter. A mixed method approach “capitalizes on the complementary strengths of both quantitative and qualitative research in the same study” (Ponterrotto, Mathew, & Raughley, 2013, p. 48). As such, it may be useful to use quantitative methods to confirm the subjective interpretations and results of qualitative analysis. Furthermore, quantitative methods would bolster the impact of small sample qualitative findings (Ponterrotto et al., 2013). Another avenue of future research may involve replication of this study with

participants' from various ethnic groups. Thus, future research should explore how stuttering influences parental beliefs and practices across various ethnic groups. Additionally, future research may also consider exploring how different levels of stuttering severity (e.g., severe-to-very severe stuttering) and support group attendance contributes to the life experiences of parents who stutter. The majority of participants in this study attend a stuttering support through the NSA; this may have led to a reduction of participants stuttering severity. As such, participants' in this study represent a unique subpopulation of PWS, which may not be representative of the larger stuttering community. Furthermore, future research may want to explore how the challenges associated with parental stuttering affects children's outcomes. For example, is being succinct—in response to parental stuttering—an appropriate parenting technique when verbally disciplining children? While being succinct may alleviate moments of stuttering for the parent, what type of impact is it having on children? Are children able to adequately internalize a succinct moral instruction? These are some questions that future researchers may begin to explore.

**Clinical practice of speech-language pathology and mental health.** Findings from this study demonstrated that stuttering exerted an influence on various parenting roles, functions, activities, and states (cognitions and emotions). Therefore, it is important that speech-language pathologists seek to understand the connection between the clients' subjective experience of stuttering (emotional, behavioral, and cognitive states and stigmatization) and its effects on different parenting practices. For example, speech-language pathologists may help parents better understand how strong emotions associated with their stuttering influences both positive and negative aspects of parenting. This may include helping parents who stutter utilize appropriate coping strategies to better manage negative states (emotions, cognitions, or

behaviors) that lead to parenting difficulties.

When deemed necessary, speech-language pathologists may refer parents who stutter to appropriate mental health services (individual or family/couple psychotherapy). According to Klompas and Ross (2004), “the need to view the person who stutters holistically and first and foremost as a person, should be the cornerstone of therapy” (p. 298). As such, psychotherapists are in a unique position to understand clients from a holistic, multi-faceted perspective. For example, individual psychotherapy may focus on helping clients (parents who stutter) understand the relationship between stuttering and multiple aspects of the self (physical, emotional, mental, cultural, and spiritual) in the context of different parenting roles, functions, activities, and states. This approach may enhance treatment strategies for parents who stutter because it takes into consideration the extent to which different aspects of the self may contribute to parental stuttering.

Additionally, family/couple therapy may help identify family variables (e.g., homeostatic maintainer; individual or social forces that are maintaining a given problem in a family system; Fishman, 1993) that are maintaining or exacerbating the parents stuttering symptoms. For example, in order to avoid or minimize talking, a parent who stutters may have a nonstuttering spouse attend school meetings or doctor appointments. In these examples, the nonstuttering spouse—who is the homeostatic maintainer—is helping maintain the parents stuttering symptoms by contributing to their avoidant behavior. Therefore, family/couple therapy may help identify strategies that allow the nonstuttering spouse to be supportive—instead of enabling—of the client’s speech difficulties when parenting.

### **Reflections**

Perhaps the most poignant finding of this study is the highly contextualized nature of

participants' responses. Participants reported on a range of "psychological experiences tied to stuttering: reports of challenge, triumph, and heartache" (Ginsburg, 2000, p. 389). Despite some roadblocks, all participants were effective, responsible, and loving parents. Another interesting finding was that the majority of participants disclosed that they hardly ever considered the connection between parenting and stuttering. Participants seemed to take great satisfaction in being offered the opportunity to discuss how stuttering impacts various parental roles, functions, activities, and states.

A consistent finding in the stuttering literature is that stuttering is highly variable within and across individuals and speaking situations. Thus, this study adds another complex layer to the already complex nature of stuttering. Unlike other contexts (e.g., work or school), the parenting context appeared to elicit greater variability in participants' responses. This may partially be due to many factors including parental authority, a smaller group setting (e.g., children, wife, relatives), and the satisfaction of parenting. As such, parents were more apt to share a mixture of positive and negative experiences associated with parenting and stuttering.

From time immemorial, the author has been a person who stutters. Similar to the participants in this study, I have contended with many of the experiences that were explicated by participants (not within a parenting context). I felt a strong connection to the participants' struggles and triumphs and believe the participants would agree with something put forth by Wendell Johnson (1930):

An awkward tongue has molded our lives.

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## Appendix A

### Semi-Structured Interview

1. Please describe the ways in which your stutter presents.
2. What emotions associated with your stuttering have influenced your parenting? Explain.
3. What thoughts associated with your stuttering have influenced your parenting? Explain.
4. When has stuttering caused you to replace one parenting behavior with another in order to avoid or minimize talking? Explain.
5. How have the perceptions of other people (stereotypes, discrimination, prejudice) in response to your stuttering influenced your parenting? Explain.
6. In what ways has stuttering influenced how you interact with and relate to other people who play an important role in your child's life (e.g., teachers, doctors, coaches, or religious figures, etc.)? Explain
7. In what ways has stuttering influenced how you interact with and relate to other people who play an important role in your child's life (e.g., family members or friends, etc.)? Explain
8. How has stuttering influenced the way(s) you verbally discipline your child? Explain
9. How has stuttering influenced your ability to emotionally bond and expressing feelings toward your child? Explain
10. In what ways has your stuttering influenced your ability to offer advice to your child (advice related to moral instruction, relationships [friends, dating], handling conflict, how to get along with others, school advice, etc.)? Explain.
11. How has stuttering symptoms influenced your ability to teach your child something? Have there been times when your stuttering has influenced how you teach your child? Explain.
12. What coping strategies do you use to manage your stuttering when parenting? Explain.
13. What is it like for you being a parent who stutters?
14. How do you view parental stuttering in terms of disability status?  
Prompt: Do you view your stuttering as a disability in terms of parenting?  
Explain.
15. How do you view parental stuttering and disability in terms of context, i.e., is your stuttering disabling in certain situations, settings, or around certain people? Explain

## Appendix B

### Participant Recruitment Letter

To whom it may concern,

My name is Craig Kramer, and I am a student in the Department of Clinical Psychology at Antioch University New England. I am writing to invite you to participate in my dissertation research study. The aim of this research study is to understand how stuttering influences your role as a parent. I am also interested in how parents who stutter describe and attach meaning to parenting. The knowledge gained from this study could help you better understand how stuttering impacts your parenting.

You may be eligible to participate if you are:

- 18+ years of age
- self-identify as having a stuttering disorder
- have a child between 5-18 years of age
- have a desire to talk about stuttering and parenting

Taking part in this study involves an individual interview with the researcher that is about 60-90 minutes. Interviews may happen in-person, by Skype, or by telephone. All interviews will be audio-taped. You will be offered a \$30.00 Amazon gift card for your participation.

This study is completely voluntary. You can choose to be in this study or not be in the study. If you take part in the study, you may change your mind at any time, and leave the study. If you withdraw from the study, you may also remove any of your data collected from the study. You also have the right to refuse to answer any question(s). All materials associated with this study will remain private and confidential.

There are two risks associated with taking part in this study. Discussing sensitive information during the interview may cause you to feel some distress, such as sadness or anxiety. These feelings may arise when thinking about or discussing experiences related to parenting and stuttering. You will be allowed to lead the interview at your own pace, in order to minimize any distressing feelings. If needed, I will provide you with a list of mental health referrals to address any distress that you may have experienced during the study. There is also minimal risk that others may find out you have participated in this study. This may happen if someone finds the audiotapes or your identifiable information (name, email address, or phone number). There is a minimal chance this will happen and I will make a great effort to protect your identity.

If you'd like to participate or have any questions about the study, please contact me by phone at XXX-XXX-XXXX or by email at XXX@antioch.edu. If you have additional questions about the study, please contact my dissertation adviser, Roger L. Peterson, Ph.D., ABPP by phone or by email: 603-283-2178 or at rpeterson@antioch.edu.

Thank you for your time and consideration.

Sincerely,

Craig Kramer, M.S., M.A., Antioch University New England

## Appendix C

### Recruitment Letter to Clinicians or Organizations

To whom it may concern,

My name is Craig Kramer, and I am a doctoral candidate in the clinical psychology program at Antioch University New England. I am currently in the process of collecting data for my dissertation study, which is a qualitative study on the lived experiences of parents who stutter. The aim of this study is to understand how stuttering influences different aspects of parenting. I am also interested in how parents who stutter describe and attach meaning to parenting. In order to access participant, I am contacting speech-language pathologists and other professionals in the field of stuttering and asking them to help me identify potential participants for this study.

Participants may be eligible if they are:

- 18+ years of age
- self-identify as having a stuttering disorder
- have a child between 5-18 years of age
- have a desire to talk about stuttering and parenting

Taking part in this study involves an individual semi-structured interview with the researcher that is about 60-90 minutes. Interviews may happen in-person, by Skype, or by telephone. All interviews will be audio-taped. Participants will be offered a \$30.00 Amazon gift card for their participation.

This study is completely voluntary. Participants can choose to be in this study or not be in the study. If participants take part in the study, they may change their mind at any time, and leave the study. If they withdraw from the study, they may also remove any of their data collected from the study. All materials associated with this study will remain private and confidential.

There are two risks associated with taking part in this study. Discussing sensitive information during the interview may cause participants to feel some distress, such as sadness or anxiety. These feelings may arise in participants when thinking about or discussing experiences related to parenting and stuttering. Participants are allowed to lead the interview at their own pace, in order to minimize any distressing feelings. If needed, I will provide participants with a list of mental health referrals to address any distress that they may have experienced during the study. Another risk to participants is threats to anonymity. There is minimal risk that others may find out that participants have participated in this study via audio recordings or identifiable information (name, email, and phone number). I will make a great effort to protect all participants' identity.

I greatly appreciate your willingness to help me recruit participants for this study. I am hoping that participants will find it a meaningful experience to speak about their experience of being a parent who stutters. I am attaching a flyer that you may choose to distribute to your clients that you perceive as most appropriate for this study. Please feel free to contact me with questions or have potential participants contact me if they would like to participate. I may be contacted by phone at XXX-XXX-XXXX or by email at XXX@antioch.edu. If you have additional questions about the study, please contact my dissertation adviser, Roger L. Peterson, Ph.D., ABPP by phone or by email: 603-283-2178 or at rpeterson@antioch.edu.

Thank you for your time and consideration.

Sincerely,

Craig Kramer, M.S., M.A., Antioch University New England

## Appendix D

### Recruitment Flyer

# Attention: All Parents Who Stutter

### About the research study and the researcher

This is a dissertation research study titled *Pebbles Under the Tongue: A Qualitative Investigation of Parents who Stutter*. This research study is aimed at understanding the impact of stuttering on different parenting roles and functions. Craig M. Kramer, M.S., M.A., a doctoral candidate in the clinical psychology program at Antioch University New England, is the primary researcher. Craig will be conducting this research study under the supervision of Roger L. Peterson, Ph.D., ABPP.

### What is Involved?

Participation will involve an individual interview with the researcher that is approximately 60–90 minutes. If eligible to participate, researcher and participant will decide on a specific time and location to meet. Individual interviews may occur in-person, by Skype, or by telephone.

### Eligibility Requirements

- 18+ years of age
- self-identify as having a stuttering disorder
- have a child between 5–18 years of age
- have a desire to talk about stuttering and parenting

### Participation Benefits

Each interviewee will receive a \$30.00 Amazon.com Gift Card

### Contact Us

If you wish to participate in the study, please contact:

**Craig M. Kramer, M.S., M.A.**

*Researcher*

Phone: (XXX) XXX-XXXX

Email: XXX@antioch.edu

If you have additional questions, please contact:

**Roger L. Peterson, Ph.D., ABPP**

*Craig Kramer's Dissertation Advisor*

Phone: (603) 283-2178

Email: rpeterson@antioch.edu

If you have any questions about your rights as a research participant, you may contact:

**Kevin P. Lyness, Ph.D.**

*Chair of the Antioch University New England IRB*

Phone: (603) 283-2149

**Melinda Treadwell**

*Vice President for Academic Affairs*

Phone: (603) 283-2444

Thank you for your consideration

## Appendix E

### Informed Consent Document

I am inviting you to be part of a study on how stuttering affects you as a parent. Please read this form before you agree to join the study. You may ask as many questions as you like to be sure that you understand what this study asks of you.

#### **About me**

My name is Craig Kramer, and I am a doctoral student in clinical psychology at Antioch University New England. This research study is part of my doctoral dissertation. Since I am a student, my professors are helping me with this project.

#### **Purpose of study**

In this study, I will be asking questions about the way that stuttering influences your role as a parent. I am interested in how stuttering affects parenting. I also hope to find out more about the meaning that you find in parenting.

#### **Procedures of study**

You will be interviewed by phone or email to make sure you are eligible to participate. Based on convenience, privacy, location, and comfort level, you and I will pick a place to meet for the interview. Interviews may happen in-person, by Skype, or by telephone. The researcher will review informed consent with you. You are required to sign the informed consent before participation begins. You will then complete a 15-question demographic questionnaire. I will then briefly describe the research process and focus to you. Afterward, you will have a 15-question interview with me. Interviews will be audio-taped. Once the study is complete, you will have one additional chance to meet with me for 1 hour. You may review my written report of your interview, to ensure that you are comfortable with how I report it. If you want, you will be provided a copy of the study.

#### **Risks and Benefits**

Discussing sensitive information during the interview may cause you to feel troubling or upsetting feelings. For example, you may feel sadness or anxiety when you talk about stuttering or your children. Also, you may feel these feelings during or after moments of stuttering. I will follow-up with you after the study is complete. If needed, I will provide you with a list of mental health referrals to address any distress that you may have experienced during the study. There is also minimal risk that others may find out you have participated in this study. This may happen if someone finds the audiotapes or your identifiable information (name, email address, or phone number). There is a minimal chance this will happen and I will make a great effort to protect your identity. Participating in this study may have some benefits for you. This study offers you a chance to talk about stuttering and parenting. This may help you better understand and improve your parenting practices. Another benefit to this study is that you will help build the research on this topic.

#### **Confidentiality**

All identifying information in the study will remain confidential. Research materials (demographic questionnaire, transcribed transcripts, aggregated data, and audio tapes/files) will be coded with a letter (Participant A) to protect your identity. Only the researcher will have access to your name. No identifying information will appear on any documents, and the only people that will have access to your information are my research team and myself. Word-for-word quotes may be included in the study, but will be protected with an identified letter (Participant A). Raw and processed data, identifiable information (name, phone number and email address), and other research material (demographic questionnaire, transcribed transcripts, and, informed consent document) will be locked in a secure file cabinet. Audio

recordings of the interview will be stored on a password-protected computer. Your name, phone number, and email address will be kept during the course of the study, in order to follow-up with you once results are complete. Your identifiable information will not be shared unless you give written permission. Also, I am required by law to contact the appropriate authorities if you are at risk for harming yourself or others, or if you report child or elder abuse. Results of this study may be published in my doctoral dissertation, a professional journal, or presented at professional meetings/conferences. All materials associated with this study will be destroyed when the research study is complete.

### **Participation and Withdrawal**

Your participation in this study is voluntary. You are free to stop the interview at any time and withdraw from participating. You also have the right to refuse to answer any question(s). If you leave the study, you may remove any data that was collected. There is no penalty for leaving the study or refusing to answer any question(s).

### **Alternatives to the Research**

This is not a treatment study. Your alternative is not to participate in this study.

### **Costs**

There is no cost for participating in this study.

### **Compensation:**

You will be offered a \$30.00 Amazon gift card.

### **Questions**

If you have questions about this project, please contact me at XXX-XXX-XXXX. You may also contact my faculty adviser, Roger L. Peterson, Ph.D., ABPP at XXX-XXX-XXXX.

If you have any questions or concerns about your rights as a research participant, please contact: Kevin Lyness, Chair of Antioch University New England Institutional Review Board, at 603-283-2149. You may also contact, Dr. Melinda Treadwell, Vice President of Academic Affairs, at 603-283-2444.

### **Consent statement:**

I have read and agreed to the above information. I understand that participating in this study is voluntary. I have the right to withdraw at any time without penalty. I completely understand the risks involved in this study. I consent to being audio taped during the interview. All of my questions have been answered. I have been given a duplicate copy of this informed consent.

\_\_\_\_\_  
**Signature of participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Participant name (printed)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of researcher**

\_\_\_\_\_  
**Date**

## Appendix F

### Demographic Questionnaire

1. What is your age? \_\_\_\_\_
2. What was your sex at birth? Man \_\_\_\_\_  
Woman \_\_\_\_\_
3. What is your race/ethnicity? Asian American/Asian \_\_\_\_\_  
African American/Black \_\_\_\_\_  
American Indian or Alaskan Native \_\_\_\_\_  
Hispanic/Latina(o) \_\_\_\_\_  
Native American or Pacific Islander \_\_\_\_\_  
Multi-racial \_\_\_\_\_  
White \_\_\_\_\_  
Self-identify (please specify): \_\_\_\_\_
4. What is your highest level of education? General Education Degree (G.E.D) \_\_\_\_\_  
Associates Degree \_\_\_\_\_  
Bachelors Degree \_\_\_\_\_  
Masters Degree \_\_\_\_\_  
Ph.D./Postdoctoral Degree \_\_\_\_\_  
Law Degree \_\_\_\_\_  
Medical Degree \_\_\_\_\_
5. What is your occupation? \_\_\_\_\_
6. What is your primary language? \_\_\_\_\_
7. How would you rate your stuttering severity? Very mild \_\_\_\_\_  
Mild \_\_\_\_\_  
Mild-to-Moderate \_\_\_\_\_  
Moderate \_\_\_\_\_  
Moderate-to-Severe \_\_\_\_\_  
Severe \_\_\_\_\_  
Very Severe \_\_\_\_\_
8. Did you receive speech therapy as a child? Yes \_\_\_\_\_  
No \_\_\_\_\_
9. Did you receive speech therapy as an adult? Yes \_\_\_\_\_  
No \_\_\_\_\_
10. Are you currently receiving speech therapy? Yes \_\_\_\_\_  
No \_\_\_\_\_

11. Do you currently attend a stuttering support group? Yes \_\_\_\_\_  
No \_\_\_\_\_
12. What is your child's age? \_\_\_\_\_
13. What is your child's race/ethnicity?  
Asian American/Asian \_\_\_\_\_  
African American/Black \_\_\_\_\_  
American Indian or Alaskan Native \_\_\_\_\_  
Hispanic/Latina(o) \_\_\_\_\_  
Native American or Pacific Islander \_\_\_\_\_  
Multi-racial \_\_\_\_\_  
White \_\_\_\_\_
14. What grade is your child in? \_\_\_\_\_
15. Does your child stutter? Yes \_\_\_\_\_  
No \_\_\_\_\_

## **Appendix G**

### **Script to Read to Participants Before Semi-Structured Interview**

The main focus of this dissertation is to understand how stuttering impacts your parenting. I will be asking you 14 main questions. During the interview, I may ask you to offer me more information on certain questions. If I ask you this of you, it is up to you how much or how little information you provide to me. You're allowed to refuse to answer any questions that you do not want to. There are no right or wrong answers in the interview. You can tell me about anything you want related to stuttering and parenting. You can tell me about one event or many events. They can be positive or negative and can be from the past or present. It is your choice. If at any time you want to stop the interview, let me know. Do you have any questions before we begin the interview?

## Appendix H

Table 1

*Emergent Topic Grid(s)*

Transcription Letter	A	B	C	D	E	F	G	H	I	J	Total
<b>Superordinate theme 1: Stuttering Symptoms</b>	X	X	X	X	X	X	X	X	X	X	10

Transcription Letter	A	B	C	D	E	F	G	H	I	J	Total
<b>Superordinate theme 2: Parental stuttering and positive parenting emotions</b>	X	X	X			X	X	X		X	7

Transcription Letter	A	B	C	D	E	F	G	H	I	J	Total
<b>Superordinate theme 3: Parental stuttering, co-parenting, and avoidant behaviors</b>	X		X	X			X	X	X	X	7
Sub-theme 3A: Community	X		X	X			X	X	X	X	7
Sub-theme 3B: Relatives and friends	X		X				X		X		4

Transcription Letter	A	B	C	D	E	F	G	H	I	J	Total
<b>Superordinate theme 4: Parental stuttering and verbal discipline</b>	X	X		X	X	X	X	X	X	X	9
Sub-theme 4A: Angry, stern, or in a heightened state, verbal discipline	X	X			X	X		X		X	6

Sub-theme 4B: Stuttering, emotional consequences, verbal discipline									X	X	2
Sub-theme 4C: Succinct or rely on others, verbal discipline		X		X							2
Sub-theme 4D: Open dialogue, verbal discipline							X				1

Transcription Letter	A	B	C	D	E	F	G	H	I	J	Total
<b>Superordinate theme 5: Parental stuttering and stigmatization</b>	X	X		X		X	X	X	X	X	8
Sub-theme 5A: Stigma and parenting behaviors		X				X	X	X	X		5
Sub-theme 5B: Stigma and motivation to be a better parent.	X			X							2
Sub-theme 5C: Stigma and imagined fears of the future						X	X				2
Sub-theme 5D: Stigma sometimes makes parenting difficult							X			X	2
Sub-theme 5E: Parenting offers a respite from the stigma of the real world		X					X				2

