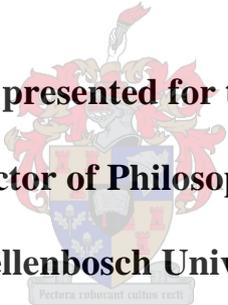


**A PROGRAMME TO ENHANCE RESILIENCE IN FAMILIES IN  
WHICH A CHILD HAS A HEARING LOSS**

**INGRID ANITA AHLERT**

**Dissertation presented for the degree of  
Doctor of Philosophy  
at Stellenbosch University**

The crest of Stellenbosch University is centered behind the text. It features a shield with various symbols, topped by a crown and a banner with the motto "Pectora celsiorant cultus recti".

**Promoter: Prof AP Greeff**

**December 2009**

## **Declaration**

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## SUMMARY

The aim of this study was to identify and enhance specific resilience qualities that help protect and support families in overcoming the adversity of having a child with a hearing impairment. The study was divided into two phases, namely (a) the descriptive phase, which aimed to identify and explore the resilience qualities that foster better adaptation in these families and (b) the intervention phase, which aimed to develop, implement and evaluate an intervention programme that enhances the utilisation of social support, one important resilience quality identified in the descriptive phase of the study.

The study was essentially exploratory and descriptive in nature and was directed at developing scientific knowledge and theory in the field of family resilience. Using the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin & McCubbin, 1996) as the theoretical framework, the resilience process was mapped in terms of stressors, risk and protective factors, and family adaptation.

The 54 participating families in the descriptive phase were identified according to the nature of the crisis (hearing impairment) and the developmental phase of the family. The participants were obtained by means of a non-probability, purposive sampling procedure and were drawn from the black, coloured and white cultural subgroups residing in the Western Cape, South Africa. Both quantitative and qualitative measures were used for data collection. The results were analysed predominantly according to correlation and regression analyses techniques, while the qualitative data was categorised according to themes and frequencies. Results showed that family time and routine, social support, affirming communication, family hardiness, problem-solving skills, religion, a search for meaning and accepting the disability were factors promoting resilience in these families.

A randomised pretest-posttest control group design was applied in the intervention phase of the study. The 31 participants were identified in the initial phase of the study and belonged to the coloured cultural subgroup. Data was again collected using quantitative and qualitative measures and was analysed using repeated measures analysis of variance and grounded theory analysis. The results did not indicate a statistically significant change in the utilisation of social support following the implementation of the workshop. The qualitative data, however, highlighted that the participants reported greater support from the immediate and extended family, increased family time and routine, as well as improved communication and problem-solving skills following the workshop.

The study generally offers valuable knowledge that can be incorporated in psychological and social training programmes, preventative community interventions and therapeutic settings. The positive and pragmatic approach adopted in the study ensures that families are empowered by bringing them hope, helping them develop new competencies and building mutual support. The study has opened various new avenues for future research in the field of family resilience and hearing impairment.

## OPSOMMING

Die doel van hierdie studie was om spesifieke veerkrachtigheidskwaliteite te identifiseer en versterk wat gesinne met 'n kind met 'n gehoorgestremdheid teen teenspoed beskerm en ondersteun. Die studie is in twee verdeel, naamlik (a) die beskrywende fase, met die doel om die veerkrachtigheidskwaliteite wat beter aanpassing in hierdie gesinne gekweek het, te identifiseer en ondersoek, en (b) die intervensiefase, met die doel om 'n intervensieprogram te ontwikkel, implementeer en evalueer wat die gebruik van sosiale ondersteuning, een van die belangrike veerkrachtigheidskwaliteite wat in die beskrywende fase van die studie geïdentifiseer is, te verhoog.

Die studie was in wese ondersoekend en beskrywend van aard en daarop gerig om wetenskaplike kennis en teorie in die veld van gesinsveerkrachtigheid te ontwikkel. Met die gebruik van die Veerkrachtigheidsmodel van Gesinsspanning, Verstelling en Aanpassing (*Resiliency Model of Family Stress, Adjustment and Adaptation*) (McCubbin & McCubbin, 1996) as teoretiese raamwerk, is die veerkrachtigheidsproses uitgestippel in terme van die oorsake van die spanning, risiko- en beskermende faktore, en gesinsaanpassing.

Die 54 gesinne wat aan die beskrywende fase deelgeneem het, is op grond van die aard van die krisis (gehoorgestremdheid) asook die ontwikkelingsfase van die gesin geïdentifiseer. Die deelnemers is deur middel van 'n doelgerigte nie-waarskynlikheidsteekproefnemings-prosedure verwerf vanuit swart, kleurling en blanke gesinne wat in die Wes-Kaap, Suid-Afrika woon. Beide kwantitatiewe en kwalitatiewe metings is vir data-insameling gebruik. Die resultate is hoofsaaklik aan die hand van korrelasie- en regressieontledingstegnieke geanaliseer, terwyl die kwalitatiewe data volgens temas en frekwensies gekategoriseer is. Die resultate het getoon dat gesinstyd en -roetine, sosiale ondersteuning, bevestigende

kommunikasie, gesinsgehardheid, probleemoplossings-vaardighede, geloof, 'n soeke na betekenis en die aanvaarding van die gestremdheid faktore was wat die veerkragtigheid van hierdie gesinne bevorder het.

'n Ewekansige voor- en natoets kontrolegroep-ontwerp is tydens die intervensiefase van die studie toegepas. Die 31 deelnemers is tydens die aanvanklike fase van die studie geïdentifiseer en behoort tot die kleurling kulturele groep. Data is weereens deur middel van kwantitatiewe en kwalitatiewe metings ingesamel en is aan die hand van herhaalde metings-variensieontleding en gegronde teorie-analise geanaliseer. Die resultate het geen statisties beduidende verskil in die gebruik van sosiale ondersteuning ná die implementering van die werkwinkel getoon nie. Die kwalitatiewe data het egter beklemtoon dat deelnemers ná die werkwinkel meer ondersteuning van hulle onmiddellike en uitgebreide familie geniet het, sowel as meer gesinstyd en -roetine, verbeterde kommunikasie en probleemoplossings-vaardighede.

Oor die algemeen bied die studie waardevolle kennis wat by sielkundige en sosiale opleidingsprogramme, voorkomende gemeenskapsingryping en in terapeutiese raamwerke ingelyf kan word. Die positiewe en pragmatiese benadering in die studie verseker dat gesinne bemaagtig word deur hulle hoop te bied, nuwe bekwaamhede te help ontwikkel en wedersydse ondersteuning op te bou. Die studie het talle nuwe weë vir toekomstige navorsing op die gebied van gesinsveerkragtigheid en gehoorgestremdheid gebaan.

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## CHAPTER 1

### INTRODUCTION TO, MOTIVATION FOR AND AIMS OF THE STUDY

#### 1.1. Introduction

When a child is born, the homeostasis in a family is typically disrupted, even more so when the child is disabled. Receiving the diagnosis that your child is hearing impaired inevitably comes as a total shock. Such a diagnosis is also relatively unalterable, and thus the stress experienced by the family is enduring (Jansen, 1994). No families across the world, regardless of their racial, ethnic, cultural and social backgrounds, are immune to the possibility that their child may have a disability or, more specifically, have a hearing impairment. What is certain, however, is that the presence of a child with a hearing impairment can have adverse effects on various domains of family life, including the marital relationship, family socialisation practices and normal family routines (Greeff & Van der Walt, in press; Jackson & Turnbull, 2004).

Research in the past has confirmed that families with a child with a disability are exposed to more stress, conflict, financial burdens and marital distress (Nixon & Cummings, 1999). Three specific issues have also been identified as being particularly different for families who have a child with a hearing impairment:

- 1) Most children (90%) with a hearing impairment are born to hearing parents (Eleweke & Rodda, 2000), almost all who use spoken language as their primary means of communication. This implies that parents cannot communicate effectively with their child.
- 2) When learning about the hearing impairment, parents face additional challenges, such as understanding the impact of the hearing impairment, finding appropriate services

and support for their child, and developing strategies for communicating with their child (Kurtzer-White & Luterman, 2003).

- 3) A variety of professionals such as audiologists enter the family's life, changing the boundaries of the family and offering information and advice that may undermine the parents' authority (Luckner & Velaski, 2004).

For decades, the dominant perspective was that families have a difficult time adjusting to the presence of a child with a hearing impairment (Luckner & Velaski, 2004). Much attention was given to pathology, with the image of these families being one of sorrow, depression and emotional turmoil. Research in the family field in the past has typically focused on these negative aspects of family functioning, reiterating the families' failures and pathologies (Walsh, 1996).

In recent years, however, studies have found that despite the many challenges faced by families with children with a hearing impairment, some cope remarkably well with this non-normative crisis and are even able to adjust (Hartshorne, 2002; Moores, Jatho & Dunn, 2001). The question thus arises as to what are the key family processes that empower the families to overcome the adversity and to be resilient. Knowledge in this field is still relatively limited and a number of authors (e.g. Hawley & DeHaan, 1996; McCubbin & Patterson, 1982; McCubbin, Thompson & McCubbin, 1996) have emphasised that research about successful adaptation in these high-risk families would strengthen the conceptual bases required to frame both curative and preventative interventions for the future. It is against this background that it was deemed relevant and necessary to conduct a study on family resilience, with a specific focus on families who have a child with a hearing impairment.

In order to orientate the reader with regard to the study, a few relevant terms will first be defined and discussed, followed by the motivation for and aims and contextualisation of the study.

## **1.2. Terminological considerations**

### 1.2.1 Family resilience

The concept of resilience and the study thereof emerged from the stress and coping theory in the field of individual developmental psychology (Garmezy, 1991; Hawley, 2000; Rutter, 1999). As research extended to multiple adverse conditions, a gradual relational awareness began to surface which led to the concept of family resilience.

Resilience is described as being the ability to bounce back after being exposed to hardships or stressful life events (Hawley, 2000). It refers to (a) those key processes that assist families in coping more effectively, and emerge stronger, from crises; (b) the ability to withstand and grow under stressful situations; (c) a process of adaptation with an emphasis on strengths and resources, rather than on pathology (Hawley, 2000; Hawley & DeHaan, 1996; Walsh, 1996). Resilience does not imply that a family will move through the crisis related to a child's hearing impairment unscathed, but rather that the family will integrate the experience into its identity in order to return to a level of functioning at or above the pre-crisis level (Walsh, 2002). Resilience will thus be conceptualised in this study as the ability to overcome and recover from adversity. It will be regarded as a process that culminates in adaptation. Since the focus is on family resilience, the family as a social system will be defined below.

### 1.2.2 The family as a social system

Defining contemporary families is complex and multifaceted, since large variability is seen in family structures and cultures (Patterson, 2002; Walsh, 2002). In South African layman's

terms, the concept of family is associated with genetic and biological ties, and the parent-child dyad (Odendal, Schoonees, Swanepoel, Du Toit & Booysen, 1994). Patterson (2002) defines a family as two or more individuals with a certain pattern and relationship between them.

Despite being a difficult concept to define, families fulfil important functions irrespective of their structure and culture, namely they provide membership, economic support, socialisation, nurturance and protection to vulnerable members (Bubolz, 2001; Patterson, 2002). These family functions are especially important in the 21<sup>st</sup> century, which is being described as the era of family transformation and stress (McCubbin, McCubbin, Thompson, Han & Chad, 1997). The concept of the 'normal' family (i.e. the intact nuclear family, where the father is the breadwinner and the mother the supportive housewife) has undergone a redefinition. The conventional view of a family consisting of two parents with a couple of healthy, perfect children is clearly a fiction. Recent political, social and economic transformations in South Africa have resulted in many different family structures and ways of family life. Changing values, political events, modernisation and globalisation have contributed to the diverse family forms seen in our country today (Smith, 2006). These include dual-earner two parent families, single-parent households, interracial marriages, stepfamilies, homosexual couples, as well as cohabiting couples with or without children (McCubbin *et al.*, 1997; Patterson, 2002). These changes have exposed families to new challenges, such as having to juggle workplace, household, parenting and eldercare demands. Greater economic independence for some families has resulted in less dependence on their extended families, while poorer conditions force other families to unite for the sake of survival (Smith, 2006). Society expects the family to be competent in the face of all of these challenges and therefore it is important that those factors that allow families to rise above their adversity and to survive their respective hardships are identified and enhanced (Walsh, 2003).

Definitions of a hearing impairment are provided in the section below, as this is the specific crisis faced by the families in this study.

### 1.2.3 Hearing impairment

A broad variety of definitions and classifications of hearing impairment are still in use today (Duijvestijn, Anteunis, Hendriks & Manni, 1999). Hearing impairment is, however, usually described by measures of hearing, such as loss of sensitivity and loss of acuity. When defined medically, hearing loss is categorised at levels from slight to profound. For the purpose of this study, hearing impairment will be used as a generic term to refer to all levels of hearing loss, from mild to profound.

Since no one has adequately defined the parameters of a hearing impairment, it is extremely difficult to estimate the prevalence of hearing impairments (Schröder, 2004). Out of the total population in South Africa, 20.1% reported to have a hearing impairment, which makes it the third highest reported disability (Statistics South Africa, 2001). Despite this relatively high incidence, only limited services are available for this clinical population in South Africa (Deaf Federation of South Africa, 2003). It is evident that the uniqueness of the South African situation as a developing country requires local research endeavours and intervention plans to improve the services available to families and children affected by a hearing impairment.

## **1.3 Motivation for the study**

Research regarding the study of adaptation in families with children with a disability is important for a very specific reason, namely to guide interventions that aim to prevent or reduce the stress experienced by families following the diagnosis. Research has shown that promoting and building upon the families' existing strengths and coping strategies is an

important component of a comprehensive support system offered to families with a member with a disability (Dunst, Trivette & Mott, 1994; Hanline & Daley, 1992). King, King, Rosenbaum and Goffin (1999) and Farrell, Elliott and Ison (2004) found that services will be most beneficial for parents when they are delivered in a family-centred manner and address issues such as the availability of social support, concerns about the family's functioning, and child behaviour problems. These interventions should ideally commence immediately after the identification (Kargin, 2004), but this is seldom the case in South Africa due to a lack of staff, poor service facilities and poor access to health-care services.

Therefore, in order to address the call for (a) early, family-centred interventions that, focus on supporting and strengthening families' existing coping strategies, and (b) South African research that provides an empirical basis to understanding the coping strategies of families with a child with a hearing impairment, the current study focused on identifying specific attributes that differentiate resilient families with a child with a hearing impairment from the vulnerable families, and to then build on the protective mechanisms underlying the adaptive attributes.

The family resilience approach, grounded in family systems theory, was used as a theoretical basis to understand the processes, factors and dynamics that influence the outcome of how a child's hearing impairment impacts on the family. The study was essentially exploratory and descriptive in nature and directed at understanding resilience in families with a child with a hearing impairment in the South African context. More specifically, the study focused on the resilience of families from the white, coloured and black<sup>1</sup> cultural subgroups who have a child with a hearing impairment and live in the Western Cape, South Africa. The inclusion of

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<sup>1</sup> The use of terms white, coloured and black participants could be viewed as controversial, but the terms will be used descriptively and in the context as explained.

the different racial families would break the long tradition of psychology to disregard culture and ethnicity and to generalise the data obtained from white middle-class participants to other population groups found in South Africa (Smith, 2006). The research questions and specific aims of the study were:

#### Main research questions

- What are the specific resilience qualities that help protect and support culturally diverse South African families, living in the Western Cape, in overcoming the adversity of having a child with a hearing impairment in their family?
- Can the identified resilience qualities be enhanced in these families?

#### Primary aims:

- To identify and explore qualities associated with resilience in families with a child with a hearing impairment.
- To develop and implement a programme that enhances one specific resilience quality identified to foster better adaptation in families with a child with a hearing impairment.
- To evaluate the effectiveness of the intervention.

### **1.4 Contextualisation of the study**

The structure of the dissertation is as follows: In Chapter 2 an overview of family resilience is presented as a theoretical background to the study. Empirical findings regarding resilience are discussed, followed by a description of the evolution of the various family resilience models.

The chapter concludes with a motivation as to why the Resiliency Model was selected and deemed the most suitable model for the present study.

As a clinical backdrop to the problem under investigation, Chapter 3 provides a description of hearing impairment and the impact it may have on the family. Hearing impairment and related concepts are defined, followed by a description of the prevalence, classification, causes, and amplification methods available to the person with a hearing impairment. The chapter then highlights the impact that a hearing impairment may have on a family by explaining it according to the Resiliency Model.

In Chapter 4 the problem is formulated and the specific aims of the study are stated. This is followed by a discussion on the methods used in the research, namely the design, the composition of the sample, the measures used and procedure followed in the data collection, the ethical considerations, and the statistical analysis conducted to analyse the data. Chapter 5 reports on the results of the statistical analyses, followed by a comprehensive discussion of the findings.

In Chapter 6 the intervention phase of the study is introduced. The theoretical frameworks guiding programme development are discussed, followed by a step-by-step description of how the social support programme was developed, implemented and evaluated. The reader is informed about the context; programme ideas, aims and objectives; the format, structure and content of sessions; techniques used; participant and facilitator roles; ethical considerations taken into account; budget preparations; and ultimately evaluating the programme and communicating the results.

The design and methodology used for the intervention phase of the study are presented in Chapter 7. First the specific aims are discussed, followed by a description of the research design, the composition of the sample, the measures used to gain data, the procedure followed in data collection, the ethical considerations, and the statistical measures used to

analyse the data. Chapter 8 reports on the results of the statistical analyses and a comprehensive discussion regarding the findings is provided.

The final chapter provides a discussion of the conclusions and limitations inherent in the study, and suggestions for possible future research are presented.

## CHAPTER 2

### FAMILY RESILIENCE

#### A THEORETICAL BACKGROUND

##### **2.1 Chapter preview**

This chapter will first explore the family as a social system and then highlight the concept of family resilience and the evolution of the Resiliency Model of Family Stress, Adjustment and Adaptation, which forms the theoretical foundation for the present study. The relevance of this model in the South African context will be discussed and empirical findings will be explored.

##### **2.2 Introduction**

Researchers and society at large have a long history of focusing on pathology, trying to identify and explain the causes of diseases and disorders. Over the past 20 years, however, increasing evidence has shown that specifically families can survive and thrive from adversity (Walsh, 2003). As a result, research in the field of family therapy has redirected its focus from family deficits towards family strengths, and has attempted to explain why families that are exposed to hardships emerge resilient. Assessment and interventions have, and continuously endeavour to, identify how existing and potential strengths and resources in the family can be enhanced while the problems are being addressed (Walsh, 1996).

The family resilience approach is increasingly gaining support amongst researchers because it fits into the salutogenic paradigm. Within this approach, families are seen as challenged rather than damaged and as able to endure and recover from crises or persistent stressors (Walsh, 1996). A resilient approach is especially suitable for the 21<sup>st</sup> century, where the world and family life are changing at such a rapid pace. Families are dealing with many

disruptions, uncertainties and losses due to social and economic upheavals. The traditional family is no longer the norm, and therefore no single model of family health fits all families. Families need to be able to approach the challenges and demands placed on them with mutual support, flexibility and innovation in order to cope (Walsh, 1996). The following section will focus on the development of resilience and the models used to identify the resilience factors in families.

## **2.3 Theory and empirical findings on resilience**

### 2.3.1 The individualistic tradition and resilience

The concept of resilience and the study thereof emerged from the theory of stress and coping in the field of individual developmental psychology (Garmezy, 1991; Hawley, 2000; Rutter, 1999). Most of the studies tried to identify how some children of mentally ill parents were able to overcome the early experiences of maltreatment and ultimately lead functional lives (Walsh, 1996). In the 1980's it became apparent that the same adversity could lead to different outcomes, i.e. while some children's lives were shattered, others overcame the same situation and led productive lives (Garmezy, 1991; Masten, 1994; Rutter, 1999; Walsh, 2003). As a result, an interest emerged in studying wellness and strengths.

Antonovsky (1987) introduced the concept of salutogenesis and other researchers tried to identify personality traits that enable some individuals to cope and be resilient, despite being exposed to hardship (Antonovsky, 1979; Dohrenwend & Dohrenwend, 1981; Lazarus, 1991). Although the initial studies focussed primarily on individuals and were concerned with personality traits as well as cognitive and intrapersonal processes, the studies also emphasised that the individual was located within the systems of the nuclear family, extended family and broader community (Smith, 2006; Wolin & Wolin, 1993).

A gradual relational awareness thus began to surface and families began to be viewed as a protective factor for individuals potentially at risk (Hawley, 2000). Despite this view, the individual remained the unit of analysis, with the family variables being viewed as correlates to resilience (Hawley). Slowly, as research extended to multiple adverse conditions, and the impact on family and sociocultural influences were increasingly noted, family researchers progressively began to question the role the family plays in assisting individual members to be resilient (Garmezy, 1991; Rutter, 1999; Werner, 1993). This then led to the concept of family resilience.

### 2.3.2 The concept of family resilience

The shift towards family resilience has not been easy. Many debates took place whether resilience can be conceived as a family-level construct rather than a collection of resiliencies held by individual family members. As a result, there are currently at least two approaches with regard to resilience and families (Hawley & DeHaan, 1996). On the one hand, resilience is seen as an individual factor, with the family serving as a protective or risk factor, while on the other hand it is seen as a systemic quality shared by the whole family unit (Hawley & DeHaan). The latter view, namely that resilience is viewed as a family-level construct, is becoming increasingly popular. A basic premise in this systemic view is that crises have an impact on the whole family and not just on individual family members. The family is thus viewed as an identity itself, with the individuals merely being components of the family (Van Breda, 2001). This systemic view will also be adopted in the current study, i.e. the family as a whole will be the unit of analysis.

Researchers such as McCubbin and McCubbin (1988) and Walsh (1996) have refined the theory of family-level resilience and have ensured that considerable progress has been made

in family resilience research. Such developments are very important given the many challenges and changes that contemporary families face today.

McCubbin and McCubbin (1988) defined family resilience as “characteristics, dimensions and properties of families which help families be resistant to disruption in the face of change and adaptive in the face of crisis situations” (p. 247). McCubbin and McCubbin (1996, p.5) further stated that

family resilience can be defined as the positive behavioural patterns and functional competence individuals and the family unit demonstrate under stressful or adverse circumstances, which determine the family’s ability to recover by maintaining its integrity as a unit while insuring, and where necessary restoring, the well-being of family members and the family unit as a whole.

According to Walsh (1996, p. 263), “family resilience refers to those key processes that enable families to cope more effectively and emerge harder from crises or persistent stresses, whether from within or from outside the family”.

Hawley and DeHaan (1996, p. 293) stated that:

... family resilience describes the path a family follows as it adapts and prospers in the face of stress, both in the present and over time. Resilient families positively respond to these conditions in unique ways, depending on the context, developmental level, the interactive combination of risk and protective factors, and the family’s shared outlook.

Hawley and DeHaan (1996) stressed the importance of viewing family resilience as a developmental construct, linking it to the path a family follows over time as it adapts to

stressful situations. This corresponds to Walsh's (1996) view that resilience is unique and a process, with many different pathways.

All of the above definitions of family resilience focus on several key elements. Firstly, resilience occurs when the family faces hardship. Secondly, resilience is reflected in the manner in which the family reacts to the hardship. Thirdly, resilience refers to the ability to bounce back or return to a level of functioning at or above the pre-crisis level. Fourthly, resilience is viewed in terms of strengths rather than deficits. Fifthly, resilience is dynamic and refers to a path that families follow over time in response to a hardship. Finally, the path that the family follows will be unique and will differ according to the particular stressor (Hawley & DeHaan, 1996; Walsh, 1996).

The concept of family resilience builds on the vast research that has already been conducted on family stress. The research on stress and coping led to a clearer understanding of the family as a system and how that system suffers under stress (Van Breda, 2001). Over time, the family stress literature started to highlight that families do cope in the face of adversity and draw on their strengths to adapt. These findings then gave rise to the exploration of stressors/risk and protective factors, and the construction of the family resilience models.

### 2.3.3 Empirical exploration of stressors/risk and protective factors

Stressors/risk factors, whether biological, social, economic or psychosocial, increase the likelihood of family problems developing (McCubbin *et al.*, 1997). Research on family stress has classified stress into being normative (expected stressors, e.g. parenthood) and non-normative (unexpected stressors, e.g. illness) (Jansen, 1994). Studies conducted by Larson, Wilson and Beley (1994) and Voyandoff and Donnelly (1988) found non-normative stressors, such as job insecurity or job loss, to have an effect on the marital relationship and the

family's problem-solving skills. Studies on the influence of a child's chronic illness on the family have indicated twice the risk for psychological and behavioural problems in the child and an increased risk for family problems (Lavigne & Faier-Routman, 1992; Wallander & Varni, 1998). In another study on medically ill children living at home, in 75% of the families one or both parents reported psychiatric problems on a standard symptom inventory (Patterson, Leonard & Titus, 1992).

There is a divide in the literature on how severe a risk must be before the outcome of the family's efforts to adapt are seen as evidence of resilience (Patterson, 2000). On the one hand, Masten and Coatsworth (1998) define significant stress as resulting from: (a) a high risk status as a result of continuous exposure to adverse conditions, e.g. poverty; (b) exposure to a traumatic event, e.g. war; or (c) a combination of the two. From this perspective, however, only very few families could be seen as being resilient. A different perspective suggests that any family that functions effectively can be viewed as resilient (Walsh, 1998). Even minor events can generate severe stress and demand major changes.

The key to understanding family resilience is the identification of protective factors. Protective factors are resources or attributes of the individual and environment that buffer the effects of a stressful situation on a person (Patterson, 2000). Protective factors thus increase the family's chances to adapt successfully after a crisis and can stem from the individual family members, from the family as a unit or from the community.

Studies on protective factors were initially conducted mostly from an individual perspective, where the family was potentially viewed as a risk factor. Wolin and Wolin (1993) studied individuals that overcame the adversity of alcoholism and mental illness in their family of origin and concluded that individual characteristics such as insight, independence, initiative

and humour were significant protective factors. Garmezy (1984) also researched protective factors in children and found interpersonal factors, such as someone taking a strong interest in the child, and personal characteristics, such as an easy temperament, as contributing to the children's resilience.

Studies were then broadened to investigate the impact of social support. Walsh (1996) found that families that are able to develop and use social support are more resistant to major crises and are also better able to recover. The importance of support from family members was highlighted by Barnard (1994), Hawley and DeHaan (1996) and Walsh (1998). Other researchers emphasised the importance of social support from friends (Hawley & DeHaan, 1996).

A common thread in current studies is to view the family as a protective factor (Hawley, 2000). The importance of protective factors varies according to the family's life cycle stage, race, culture and ethnicity (McCubbin, 1995; Patterson, 2002). The most prominent protective factors that have been found to be important across all stages of the family life cycle are: family celebrations, family hardiness, family time, family routines and family traditions (McCubbin *et al.*, 1997). Family accord and support networks have been found to be particularly important for the families in the current study, as they were in the childbearing/school-going age stage (McCubbin *et al.*, 1997). Gordon Rouse, Longo and Trickett (2000) identified emotional support between family members, clear boundaries and rules, and frequent contact between members as protective factors that contribute to resilience in families. McCubbin *et al.* (1997) identified the following ten general protective factors based on their review of the cumulative work done to date: family problem-solving communication, equality, spirituality, flexibility, truthfulness, hope, family hardiness, family

time and routines, social support and health. Many of these factors have been incorporated in the resilience models and will be discussed in greater detail below.

#### 2.3.4 The evolution of the family resilience models

Family resilience models were developed in an attempt to discover what behaviours, patterns and interactions within the family system and within the community could explain the different outcomes in families following their exposure to adversity. Initially, even the resilience models followed a pathological stance, trying to identify family risk factors rather than strengths. However, with the shift towards prevention and family preservation, theories were developed and research was conducted that revealed and supported the family's own abilities and strengths. Research is still being conducted to support and expand on these findings. The discussion below will highlight how the resilience models have evolved over time.

##### 2.3.4.1 Hill's ABCX Model

Much of the research on family stress since the 1970's has been based on Hill's (1949) ABCX model of family stress and crisis management. Although other, more sophisticated models have evolved since then, Hill's model remains the prototype (Van Breda, 2001). Hill (1949) developed the model to explain why families who are confronted with the same stressors vary in their ability to adapt (Hawley, 2000). According to Hill's ABCX model, the ability of a family to cope with a potential crisis situation (X) is dependent on the interaction between three factors: Factor A (the stressor), Factor B (the family's resources or strengths) and Factor C (the family's interpretation of the stressor event) (McKenry & Price, 1994). Factors B and C lie within the family itself and must be seen in terms of the family's values and structures, while Factor A lies outside the family and is an element of the event itself. In short, the model states that a stressor event (A) interacts with the family's resources (B) and

the interpretation or definition that the family gives to the event (C) to produce the crisis (X). The model thus suggests that a family's adaptation to a crisis is shaped by the interaction between the family's resources and perceptions.

The ABCX model suggested that families encounter several stages when faced with a stressor event, namely: (a) a period of disorganisation, which may be characterised by increased conflict, a search for solutions, and feelings of anger, confusion and resentment; (b) a period of recovery, during which the family members discover means of adjusting to the crisis, and (c) a period of reorganisation, in which the family reconstructs itself either at, above or below its pre-crisis level of functioning (De Haan, Hawley & Deal, 2002; Hawley, 2000). Although families will vary in the length of time it takes them to progress through this process, the model postulates that most families will pass through a similar process when confronted with a crisis.

#### 2.3.4.2 Double ABCX Model

McCubbin and Patterson (1983a) developed the Double ABCX Model in 1983 after identifying various deficits in Hill's ABCX Model and recognising the need to consider a family's response to stressors over time. According to McCubbin and McCubbin (1996, p.5), the Double ABCX Model "emphasises the factors, particularly coping and social support, which facilitate family adaptation to a crisis situation". While the ABCX Model focuses on two aspects, namely (a) the factors which precede the crisis and determine the capacity of the family to cope, and (b) the extent to which the outcome is a crisis, the Double ABCX Model explores what happens to the family after the crisis, how they adapt (Clark, 1999; Van Breda, 2001).

In order to accommodate this new perspective, Hill's ABCX Model was reformulated by dividing it into two phases and adding four post-crisis factors. The first phase of the model involves the initial adjustment of the family to the stressor event, while the second phase involves the family's adaptation following the crisis. The four post-crisis factors added to the model include the following: a) pile-up of stressors (aA), resources (bB), perceptions (cC) and bonadaptation or maladaptation (xX) (McCubbin & McCubbin, 1996). According to the Double ABCX Model, most families recover from a crisis (x), but some may experience an ongoing pile-up of stressors (aA). This can either lead to bonadaptation or maladaptation (xX), depending on the family's resources (bB), perceptions (cC) of the crisis (x) and pile-up of demands (aA). The shifting of the view from crisis to adaptation in the Double ABCX Model reflected the evolvement of the resilience orientation in family stress researchers.

#### 2.3.4.3 The Family Adjustment and Adaptation Response Model (FAAR)

The FAAR model evolved as a natural extension of the Double ABCX, with an emphasis on describing the processes involved in the "family's efforts to balance demands and resources in order to achieve a level of adjustment or adaptation" (McCubbin & McCubbin, 1996, p.5). Like the Double ABCX Model, the FAAR Model also encompasses the adjustment and adaptation phase. The FAAR Model, however, acknowledges that families go through three stages of adaptation: resistance, restructuring and consolidation (McCubbin & Patterson, 1983a). When families are exposed to a stressor, they typically tend to resist making any changes or adjustment, thereby precipitating a state of maladjustment that leads to a family crisis (resistance or adjustment phase). The crisis increases the demand on the family for change, and restructuring begins. Demands are, however, not always met or well managed and the family becomes disorganised (restructuring or Level 1 of adaptation phase). Further changes then need to be made to ensure stability and coherence, as well as member-to-family and family-to-community balance (consolidation or Level 2 of the adaptation phase).

#### 2.3.4.4 Typology Model of Family Adjustment and Adaptation

In 1989, McCubbin and McCubbin (1989) expanded on the Double ABCX Model and introduced the Typology Model of Family Adjustment and Adaptation. This model was introduced to emphasise the importance that the family's established patterns of functioning and their level of appraisal play in buffering against family dysfunction and promoting adaptation and recovery (McCubbin & McCubbin, 1996). The model also describes the family's response to stressful life events in terms of the adjustment phase and adaptation phase, but a few changes were made to the model, namely, (a) family vulnerability (V) due to the pile-up of demands was added in both the adjustment and adaptation phase; (b) the importance of the family life cycle stage was acknowledged in understanding vulnerability and resilience; and (c) family schema were included as another level of family appraisal (CCC), emphasising the importance of the family's shared views, values and beliefs (McCubbin & McCubbin, 1996). The model allows one to explore what family types, strengths and resources are needed, or created, in order to effectively deal with family reorganisation and systemic change during normative and unforeseen events (Jansen, 1994).

#### 2.3.4.5 Resiliency Model of Family Stress, Adjustment and Adaptation

The Resiliency Model of Family Stress, Adjustment and Adaptation (referred to as the Resiliency Model from here on), which was developed in 1993, is the most recent, expanded version of both the FAAR Model and the Double ABCX Model. The model is supported by a number of underlying assumptions. The main assumption is that all families will be faced with adversity and change at some point in their life cycle (Jonker & Greeff, in press). Another assumption is that families strive for balance and harmony during times of stress (McCubbin & McCubbin, 1996). Change, however, inevitably brings about an imbalance and disharmony in the family system (Van Breda, 2001). Typically, four domains of family functioning are affected when exposed to stressors, namely: (a) interpersonal relationships;

(b) structure and function; (c) development, well-being, spirituality; and (d) community relationships (McCubbin & McCubbin, 1996). “These four domains, together with the desired balance and harmony, thus occupy the centre of the resilience circle ...” (Van Breda, 2001, p.112).

As discussed previously, resilience refers to a process in which protective factors play a role in reaching adaptation despite severe risk and hardship (Hawley, 2000; Hawley & DeHaan, 1996; Walsh, 1996). Since resilience as a process is a difficult and complex construct to measure, its operationalisation for research purposes is also difficult (Hawley, 2000). The Resiliency Model, however, enables the measurement of the resilience process by mapping it in terms of stressors and risks, protective factors and adaptation (Smith, 2006). In this study, resilience will thus be measured in terms of the family’s adaptation to the child’s hearing impairment.

Since this model forms the theoretical foundation for this study, it will be discussed in greater detail in terms of the adjustment and adaptation phases.

#### 2.3.4.5.1 The adjustment phase

“Family adjustment refers to the outcome of a family’s efforts to deal with a specific and relatively minor stressor” (Van Breda, 2001, p. 112). Any stressor event creates difficulties that must be managed by the family unit (McCubbin, 1995). Families usually try to cope with the stressor by maintaining the status quo, with minimal disruption to their established patterns of functioning.

The extent to which the family would adjust to a stressor is determined by the interaction of the following components (see Figure 1): the severity of the stressor, the vulnerability of the family (which is shaped by the pile-up of stressors), the family’s established patterns of

functioning, their appraisal of the stressor, their resistance resources and their problem-solving skills (McCubbin & McCubbin, 1996). The outcomes of the family's efforts to cope may vary along a continuum from positive bonadjustment to the other extreme, namely maladjustment (McCubbin & McCubbin, 1996).

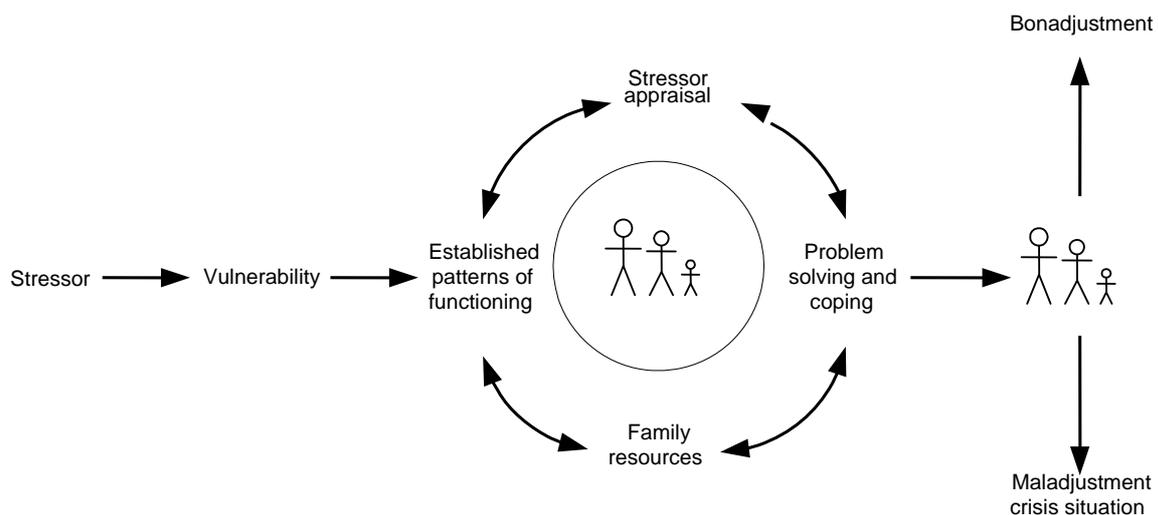


Figure 1. Adjustment phase of the Resiliency Model of Family Stress, Adjustment and Adaptation (adapted from McCubbin & McCubbin, 1996).

Families faced with the diagnosis of a child's hearing impairment are required to adjust in order to incorporate the impact of such a stressor into their family life. A discussion will thus follow on each of the specific components involved in the adjustment process (with reference to Figure 1).

#### The stressor (A)

“A stressor is a demand placed on the family that produces, or has the potential of producing changes in the family system” (McCubbin & McCubbin, 1996, p.17). Hill (cited in McCubbin & Patterson, 1983b) identified four main categories of stressors: (a) accession, which involves family structural change due to a member being added (e.g. birth of a child); (b) dismemberment, which involves family structural change due to the loss of a family

member (e.g. a child's death); (c) loss of morale and unity (e.g. alcoholism, substance abuse); and (d) structural and self-confidence changes within the family (e.g. desertion, divorce). The severity of the stressor is ultimately determined by the degree to which it threatens the family's stability, disrupts the system as a unit, and/or exhausts the family's resources (McCubbin & McCubbin, 1996).

Family stress has been classified into two categories, namely normative (which refers to expected stressors over the life span, e.g. parenthood) and non-normative (referring to unexpected stressors, e.g. illness). Normative family demands are generally not seen as being a significant risk for a family, but can become one if the timing of the change does not correspond with societal expectations, e.g. teenage pregnancy (Patterson, 2000). Such an event could trigger additional risks, thereby setting a risk process in motion. Generally speaking, however, most families are able to manage normative demands successfully.

On the other hand, non-normative demands, which are unexpected and often traumatic, are likely to lead to significant risk (Patterson, 2002). In non-normative stressor events, the adaptation may be more difficult because the event was not anticipated by society and therefore there are fewer guidelines to direct the family's response (Jansen, 1994). According to Hetherington (1984), non-normative stress has a way of pushing a family to the extremes of adaptation - either they become more competent or they deteriorate in their competence.

The way in which a family subjectively perceives the stressors shapes how they will cope, and influences their behaviour and subsequently the outcome (Patterson, 2002). The family's subjective appraisal and shared meanings of the stressor help it to define the situation, and thereby to reduce ambiguity and uncertainty. If families have successfully managed

normative demands in the past, they will be able to build their resilience and create a pattern of family adaptation.

#### Family vulnerability (V)

Family vulnerability refers to “the interpersonal and organisational condition of the family system” (McCubbin & McCubbin, 1996, p.17). It indicates how susceptible a family is to a specific stressor. The family’s vulnerability can range on a continuum from high to low and is determined by the accumulation of demands, as well as by the normative stressors associated with the family’s current life cycle stage. Since the pile-up of stressors varies across the life cycle of the family, the family’s vulnerability will also vary across the life cycle (Van Breda, 2001). This implies that a particular stressor will therefore be more or less threatening to the family at different times.

#### Family typology of established patterns of functioning (T)

“A family typology is defined by a set of attributes or clusters of behaviours that explain how the family system typically operates or behaves” (McCubbin & McCubbin, 1996, p. 18). A family typology thus refers to the family’s predictable pattern of behaviour, which develops over the course of the family’s life cycle. According to McCubbin and colleagues, the family’s reaction to stress can be predicted once it has an established typology (Van Breda, 2001). The family’s typology plays a critical role in facilitating the development, reinstatement and/or preservation of balance and harmony.

McCubbin and Thompson (1991) identified four family typologies, namely regenerative, resilient, rhythmic and traditionalistic. The term ‘resilient’ families has recently been replaced with the term ‘versatile families’ in order to allow for a more diverse grouping of typologies under this term (Van Breda, 2001). The four family types describe the family’s

integrity, unity, changeability, predictability and rituals along two dimensions, which have been dichotomised into high and low (McCubbin *et al.*, 1996). Marsh *et al.* (1996) analysed the Regenerative family typology in terms of hardiness and coherence, the Versatile family in terms of family flexibility and bonding, the Rhythmic family in terms of family time and routines, and the Traditionalist family in terms of family celebrations and family traditions. Families can range from being low on both dimensions to being high on both dimensions. Regenerative families have been found to be the most effective in managing normative and non-normative stressors. In addition, research has shown that the Regenerative family type is most strongly correlated with family, marital and community satisfaction, as well as general family well-being (Van Breda, 2001).

#### Family resistance resources (B)

The family's resistance resources have been described by McCubbin and McCubbin (1996, p.19) as

... a family's ability and capabilities to address and manage the stressor and its demands and to maintain and promote harmony and balance in an effort to avoid a crisis, or disharmony and imbalance, and substantial changes in or deterioration in the family's established patterns of functioning.

Resources play an important role in determining the family's ability to meet the demands and needs arising from the stressor event. The resistance resources in the adjustment phase are intended to avoid a crisis from developing and to ensure minimal change to the family system. The resources may be individual, family or community based. Individual resources include the personal resources of family members, such as self-esteem and independence. Family resources comprise the systemic characteristics of the family that contribute to the structure and organisation of the family, while community resources include the social

support received from the extended family, friends, professionals and agencies outside the immediate family (Jansen, 1994). Resources tend to vary across the family's life cycle and from culture to culture. According to various researchers, however, the most critical family resistance resources include social support, economic stability, cohesiveness, flexibility, hardiness, shared spiritual beliefs, open communication, traditions, celebrations, routines and organisation (Olson *et al.*, 1983).

#### Family appraisal of the stressor (C)

The family's appraisal of the stressor is the "family's definition of the seriousness of a stressor and its related hardships" (McCubbin & McCubbin, 1996, p. 19). A stressor can be defined as being catastrophic, manageable or even irrelevant. Hill (cited in Burr, 1973/1982, p. 8) stated that there are three types of definitions, namely (1) those formulated by an unbiased observer, (2) those formulated by the community or society within which the family lives, and (3) those formulated by the family itself. The subjective meaning that the family attaches to the stressor event is the most important in influencing the family's response to it. Whether a stressor event ultimately leads to a crisis or breakdown in the family, therefore, depends on the family's explanation of why it occurred and what can be done to improve the situation.

#### Family problem solving and coping (PSC)

The problem solving and coping component in the adjustment phase indicates the "family's management of stress and distress through the use of its abilities and skills to manage or eliminate a stressor and related hardships" (McCubbin & McCubbin, 1996, p. 20). In other words, problem solving refers to the family's ability to break the stressors into manageable portions, to identify alternative ways of dealing with the problem, to initiate action, and to communicate effectively in order to maintain or restore harmony and balance within the

family system. Coping, on the other hand, refers to the family's strategies and behaviours, which are intended to (a) maintain or strengthen the family, (b) activate the family and community resources, and (c) embark on efforts to resolve the challenge (McCubbin & McCubbin, 1996).

#### Family bonadjustment, maladjustment and crises (X)

Most stressors do not create major hardships. Bonadjustment occurs when the family moves through a stressful situation with relative ease and only minor changes are made in the family system in order to promote balance and harmony. Such a positive adjustment is possible if the stressor is not too great and/or if the family is not too vulnerable and/or if the family has a helpful typology, good resources, a positive appraisal and good problem solving and coping skills (McCubbin & McCubbin, 1996; Van Breda, 2001).

However, if the stressor is severe, families may not achieve balance and harmony with the minor changes made to the system. They may then experience a state of maladjustment, which requires that major changes are made within the family in order to cope with the situation. This maladjustment may result in a family crisis (McCubbin & McCubbin, 1996). Researchers, however, have pointed out that a crisis should not automatically be seen as being negative (Van Breda, 2001). A crisis merely symbolises "a continuous condition of disruptiveness, disorganisation, or incapacitation in the family social system" (McCubbin & McCubbin, 1996, p.22). Often such a disruption is necessary to initiate family change. Families may even occasionally knowingly produce crises in order to bring about the necessary changes required to develop as a family unit. This movement to initiate change, and in which the family alters its resources, appraisals, problem-solving and coping strategies, marks the beginning of the adaptation phase in the Resiliency Model of Family Stress, Adjustment and Adaptation.

#### 2.3.4.5.2 The adaptation phase

“Family adaptation refers to the outcome of a family’s efforts to deal with prolonged, severe and multiple stressors” (Van Breda, 2001, p. 121). A disability such as a hearing impairment introduces families to lifelong stress, demands and challenges. Families may struggle to incorporate the disability and its implications into their family life and, as a result, become maladapted. Families in such a crisis need to realise that their ability to gain some form of stability depends on the degree to which they can adjust their roles, rules, patterns of interaction, boundaries and relationships with the community (McCubbin & McCubbin, 1988). A discussion on the adaptation phase will follow below (with reference to Figure 2).

Families experience a crisis (X), namely a disruption of their homeostasis, as a result of their maladjustment to a stressful situation (e.g. diagnosis of a child’s hearing impairment). The family’s situation is exacerbated by the pile-up of demands (AA), which may weaken the family’s ability to adapt to the crisis. The pile-up of demands increases the vulnerability (V) of the family. Families then typically take on the challenge to change in order to achieve a level of adaptation (XX) characterised by balance and harmony. How successful the adaptation is, is determined by the interaction of the family’s newly instituted patterns of functioning (TT) and the adjustment, maintenance or revitalisation of their existing patterns of functioning, their internal resources (BB), their network of social support (BBB), their appraisal of the stressor (C), situation (CC) and schema (CCC) and, finally, their problem-solving and coping abilities (PSC). According to McCubbin and McCubbin (1996, p.26), the family “engages in a dynamic relational process over time, introducing changes directed at restoring and maintaining family harmony and balance within the family system as well as in the family’s relationship to the larger community and environment”. When families’ efforts at change are unsuccessful, the maladaptation causes the family to return to a crisis situation and the family must again move through the entire process of adaptation.

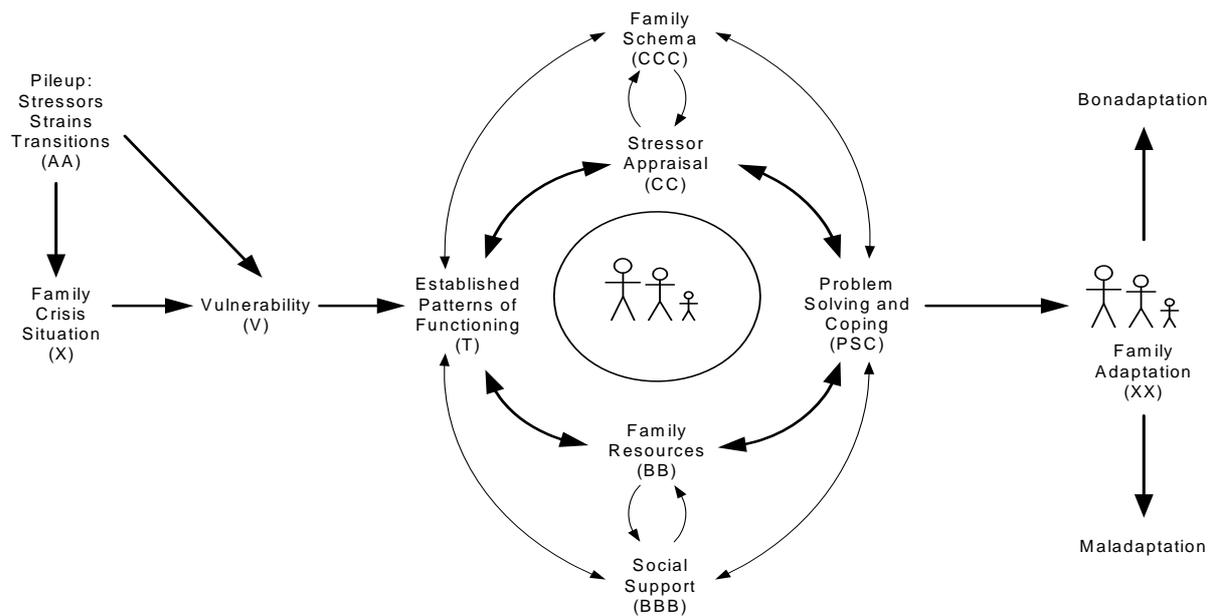


Figure 2. Adaptation phase of the Resiliency Model of Family Stress, Adjustment and Adaptation (adapted from McCubbin & McCubbin, 1996).

Below is a discussion of the specific components involved in the adaptation phase.

### Family adaptation (XX)

Family adaptation refers to the outcome of the family's efforts to bring about change in response to the crisis situation. The family makes "an effort to achieve a balance fit at the member-to-family and the family-to-community levels" (McCubbin & Patterson, 1983a, p. 20). Member-to-family fit entails whether the family unit can meet the demands of the individual family members, or whether the family members can meet the demands of the family unit. The family-to-community fit entails whether the community can meet the demands of the family, or whether the family can meet the demands of the community (Van Breda, 2001). Imbalance between demand and capability may result in family stress and may create the need to reorganise the family system.

Adaptation can range from bonadaptation (healthy adaptation) to maladaptation (unhealthy adaptation). Bonadaptation has been achieved when the family has integrated the demands of the stressor into its functioning, balance and harmony have been restored, and the individual-to-family and family-to-community fit is balanced (McCubbin & McCubbin, 1996; Van Breda, 2001). Family maladaptation is characterised by a continued disharmony and imbalance in family functioning, with deterioration in the family's integrity, health and development, and possible loss of independence (McCubbin & Patterson, 1983a).

McCubbin and Patterson (1983b) emphasised that, in adaptation, a level of functioning should be established that promotes the development of both the family as a whole and each of the individual family members. Fit and balance, as well as intrafamilial and environmental resources, are the key to successful adaptation (McCubbin & Patterson, 1983a; Walsh, 1996).

#### Pile-up of demands (AA)

The stressor event (A) is a life event that produces or has the potential to produce change in the family system (McCubbin & McCubbin, 1996). The change may have an impact on the family's roles, boundaries, rules or decision-making patterns (McCubbin, 1995). Such a change decreases familiarity and increases uncertainty in the family, thereby generating additional stress. The family thus needs to deal with a number of stressors at the same time (Clark, 1999). Past research has shown that it is particularly important to take the pile-up of demands into consideration in families who care for a child with a physical disability such as a hearing impairment (McCubbin & McCubbin, 1996).

There are nine general categories of stressors contributing to the pile-up of demands in the family system, namely (1) the initial stressors and its hardships (e.g. the birth of a child with a hearing impairment, which can be accompanied by financial needs, increased strains due to

caregiving, uncertainty surrounding the diagnosis, treatment and prognosis); (2) normative transitions (e.g. child starting school), which can coincide with but be independent of the initial stressor; (3) prior strains (e.g. marital problems prior to the birth), which are not resolved but can be exacerbated when the family faces new challenges; (4) unexpected situational demands and contextual difficulties (e.g. lack of adequate child care, crime); (5) the consequences of family efforts to cope (e.g. increased anger and resentment as a result of role overload); (6) intrafamilial and social ambiguity due to lack of social and community guidelines for families so that they do not know how they should respond to the stressor and what support is available; (7) newly instituted patterns of family functioning, which may demand additional changes, thereby creating additional stress; (8) newly instituted patterns of functioning that are in conflict or incongruent with the family's beliefs, values and/or rules; and (9) old established patterns of functioning that are in conflict with new patterns of functioning (McCubbin, 1995; McCubbin & McCubbin, 1996). Ultimately, the severity of the stressor is determined by how much it threatens the family's stability and how the demands compare to the family's resources and capabilities.

#### Family types (T) and newly instituted patterns of functioning (TT)

As mentioned previously, a family's adaptation to a crisis is influenced by its typical patterns of functioning. According to Van Breda (2001), four family typologies or patterns of behaviour have been identified in the adaptation phase of the Resiliency Model. A brief discussion of these follows below.

- Weakening in and/or inadequate family patterns of functioning (T). An inadequate typology is a large contributor to why some families enter a state of maladjustment. A family's pattern of functioning may also weaken while they are trying unsuccessfully to adjust.

- Retained patterns of functioning (T). The family enters the adaptation process with intact patterns of functioning. While some of these patterns may facilitate the bonadaptation process, others may continue to be pathogenic and lead to maladjustment.
- Restored patterns of functioning (T). The crisis may reactivate and/or restore previous patterns of functioning that the family once possessed but lost over time.
- Newly instituted patterns of functioning (TT). In general, the adaptation phase requires that the family makes changes to the family system and these changes result in new patterns of functioning, which in turn may promote bonadaptation.

#### Family resources (BB)

A resilience resource is a “characteristic, trait or competency found in the individual, family or community which facilitates adaptation” (McCubbin & McCubbin, 1996, p. 35). Families under stress are often required to develop new resources in order to cope with the pile-up of stressors and demands (Van Breda, 2001). The individual family members, the family as a unit and the community are all potential sources of resources (Clark, 1999). Personal resources include the individual’s intelligence, knowledge, personality, physical and emotional health, self-esteem, sense of coherence, sense of mastery and ethnic identity. Resources of the family system include, for example, cohesion, adaptability, open communication, mutual support and problem-solving ability, while community resources include professional services, clubs and organisations (McCubbin & McCubbin, 1996). Resilience resources in the adaptation phase are aimed at helping the family achieve balance and harmony after making the necessary changes to the family system.

### Social support (BBB)

McCubbin and McCubbin (1996) defined social support or community resources as including “all persons and institutions that the family and family members may use to manage a crisis situation” (p. 35). Supports can come from informal (e.g. family members, friends) or formal sources (e.g. schools, churches). Cobb’s (1976) definition of social support is most frequently used in the Resiliency Model. According to Cobb, social support refers to information that is exchanged at the interpersonal level and provides emotional, esteem and network support. Emotional support allows individual family members to feel loved and cared for, while esteem support lets family members believe that they are respected and valued, and network support lets the family members believe that they belong to a network of communication that reflects mutual support and understanding. McCubbin and colleagues have added an additional two forms of support, namely appraisal support (which is feedback that allows the individual to assess how well he/she is coping with life’s tasks) and altruistic support (which refers to information received in the form of goodwill from others for having given something of oneself) (McCubbin & McCubbin, 1989). Much of the research on social support uses these terms interchangeably. All researchers, however, believe that the number of people that one can rely on for support is predictive of well-being, irrespective of the nature of the support (Van Breda, 2001).

### Family appraisal processes (C – CCCCC)

With the evolution of the resilience models, work on the family appraisal processes has been especially prominent. The family’s perception of the pile-up of demands, of the available resources and of what action needs to be taken in order to cope is a critical factor in predicting the family’s adaptation (McCubbin & Patterson, 1983a). Levels of appraisal have been added to Hill’s original C factor to demonstrate how numerous appraisals emerge during the adjustment, and especially the adaptation, phase. Depending on the nature of the stressor,

different levels of family appraisal will be activated. Lower severity stressors may, for example, only activate the first two levels, while severe stressors may activate all five levels (Van Breda, 2001). The various levels will be discussed in greater detail below.

- Family schema: Level 5 (CCCCC)

Family schema describes a family's shared values, goals, priorities, rules and expectations. The schema is created over time and shapes the family's unique character and framework by which incoming experiences are evaluated. McCubbin and McCubbin (1993) suggest that a strong family schema is one of the key elements found in resilient families. Families with a healthy schema generally adopt a realistic view of life, accept less than perfect solutions to a problem, and are confident in their own ability to overcome adversity (Hawley, 2000).

The family schema plays an important role in helping families give meaning to stressful events. Family stories or shared understandings of the situation help facilitate the family's adaptation to the situation. Order, balance and harmony are promoted within the family by allowing the development of congruence between the family's meanings and their patterns of functioning.

A family's ethnic or cultural beliefs are stored in the family schema. The family's culture fundamentally influences the family's sense of coherence and paradigms, which in turn all help the family to give meaning to the stressful situation and shape their process of adaptation (McCubbin & McCubbin, 1996).

Although a family's schema is generally seen as a relatively stable construct, under drastic circumstances it may be reshaped in order to cope with the crisis (McCubbin, Thompson, Thompson, Elver & McCubbin, 1998). When faced with a disability stressor such as hearing

impairment, the family appraises its past and future in order to give meaning to the disability and the changes that may result from such a diagnosis (Thiel, 2005).

- Family coherence: Level 4 (CCCC)

Family coherence is a global concept that measures the extent to which families feel certain that the outcome of a situation will be in their favour (Hawley, 2000). Although family sense of coherence and family schema seem closely related, research has shown that family schema influences a family's sense of coherence (McCubbin *et al.*, 1998). Family coherence is a dispositional world view that expresses the family's feelings of the world as being comprehensible, manageable and meaningful. When a world view is shattered by a stressor, such as having a child with a disability, the family's ability to cope, heal and grow often involves reconstructing their view of the world in order to make sense of the occurrence (Patterson, 2002).

Antonovsky and Sourani (1988) found that families with a strong sense of coherence are able to adapt more easily after a crisis and tend to attain a higher level of reorganisation after the event. In addition, research has also shown that a family's sense of coherence is a good predictor of the family's sense of well-being (Anderson, 1998).

- Family paradigms: Level 3 (CCC)

A family paradigm is a model of shared expectations and rules that are implemented by the family to guide their development of specific patterns of functioning around specific domains of family life (e.g. work, child rearing, religion). The family paradigm is a lower order appraisal that is more related to daily living and consciousness. It is similar to the notion of 'family identity' and related to specific functions and patterns (Van Breda, 2001).

- Situational appraisal: Level 2 (CC)

Situational appraisal involves the family's shared assessment of the stressor, the hardships resulting from the stressor, and the demands placed on the family to change their patterns of functioning (McCubbin & McCubbin, 1996).

- Stressor appraisal: Level 1 (C)

Stressor appraisal represents the family's definition of the stressor and how severe they perceive it to be. It is important to give meaning to the stressor because it sheds light on the issues the family faces, suggests potential solutions to the problem, makes the emotional strain more manageable and empowers the family to re-establish its balance and harmony (Clark, 1999). Families can either see their situation as hopeless and unmanageable, or they can accept it and view it as a challenge. The more the family feels in control, the more likely it is that the family will be resilient (Drapenau, Samson & Saint-Jaques, 1999).

#### Family problem solving and coping (PSC)

Family problem solving and coping includes any covert or overt efforts made by the family to manage a demand placed on them. The coping efforts may occur on an individual or at a family system level. Problem solving and coping may be directed at reducing or eliminating stress, acquiring resources, managing tension within the family, and shaping the appraisal of the stressor (Danielson, Hamel-Bissell & Winstead-Fry, 1993).

The evolution of the Resiliency Model and the work of McCubbin and McCubbin have been discussed in great depth. Walsh (2003) has also been a prominent figure in the study of family resilience and developed the latest family resilience framework, which will be discussed briefly below.

#### 2.3.4.6 Walsh's Family Resilience Framework

Walsh's (2003) family resilience framework aims to identify those key family processes that tend to reduce stress and vulnerability, promote growth, and empower families to overcome the adverse hardships that they may be exposed to. Walsh (2003) stated that family belief systems, organisation patterns and communication processes are the three key domains of family functioning that influence family resilience.

Family belief systems shape how the family views a crisis and helps members to make meaning of the situation. The attached meaning, in turn, has an impact on whether the family copes or not (Hawley, 2000). Family belief systems in general facilitate a positive outlook and offer spiritual support (Walsh, 2003). When faced with a crisis, families do best when helped to gain a sense of coherence (Walsh, 2003). Families are then able to redefine their situation as manageable, meaningful and comprehensible and are able to normalise and contextualise their distress. According to McCubbin and McCubbin (1996), this is facilitated by the family's existing family schema. Family schema contains the shared values, beliefs and expectations of the family, which help the family make meaning of the situation (McCubbin & McCubbin, 1996). Shared faith is able to give the family a framework for finding meaning and perspective. Bennett and DeLuca (1996), Greeff and Van der Walt (in press), as well as Gillard (2002), have found that religious beliefs can be particularly supportive as well as an important resilience factor for families with a child with a disability.

Family organisation refers to the family's flexibility, connectedness, and social and economic resources (Walsh, 2003). In times of stress, families need to activate their resources, buffer stress and reorganise themselves in order to meet the challenges (Walsh, 1998). Flexibility is a core process in resilience (McCubbin *et al.*, 1997). Families who are flexible are able to change when necessary and are just as able to maintain their stability through their existing

patterns of functioning (Walsh, 1998). Connectedness among family members allows for mutual support and collaboration (Thiel, 2005). Kin and social networks are vital in times of trouble because they can offer practical and emotional support (McCubbin *et al.*, 1997; Suarez & Baker, 1997; Walsh, 1998). Families who are isolated typically struggle to deal with a crisis, while resilient families have been found to reach out to others in times of need. Connectedness among family members is also vital, as it enhances support and cooperation, while also respecting differences, boundaries and autonomy (Thiel, 2005).

The final domain of functioning affecting family resilience is communication, which includes clarity, open emotional expression and collaborative problem solving (Walsh, 1998). Communication has been described as being the backbone of a family (Freeman, Dieterich & Rak, 2002). In times of crisis, it is crucial to clarify the stressful situation as much as possible in order to enhance the decision-making process and to facilitate a shared understanding among family members (Orr, Cameron & Day, 1991; Walsh, 1998). Communication helps bring clarity to the family's situation in that it facilitates the process of making meaning of the experience of illness (Walsh, 2003). When communication is vague, the result could well be confusion and misunderstanding (Walsh, 1998). A crisis can arouse a wide range of feelings and, when emotions are intense, conflict is likely to erupt. Expressing emotions is important in dealing with a prolonged ordeal such as hearing impairment, because bottling up the emotions could obstruct the communication process (Walsh, 1998). Communication also enhances problem solving by way of open disagreement and problem-solving skills (Thiel, 2005). Collaborative problem solving and creative brainstorming open up new possibilities for overcoming the crisis and allow the family to become proactive rather than crisis-reactive (Frey, Greenberg & Fewell, 1989; Taanila, Syrjälä, Kokkonen & Järvelin, 2002; Walsh, 2003). Avoiding problems could lead to unresolved issues becoming even more disruptive in the long term.

According to Walsh (2003), resilience does not mean that the family recovers from the crisis unscathed. The family's structure and functioning may very well have changed, but the resilience process involved effectively working through the hardship, learning from it, and integrating the experience into the family's life story. This emphasises the view that instead of referring to resilience as 'bouncing back', a more appropriate metaphor would be 'bouncing forward' (Walsh, 2003). The family made changes in order to meet the challenges and to grow and re-establish balance and harmony within the system.

A discussion will follow on why the Resiliency Model of McCubbin and McCubbin (1996) was deemed the most relevant for the current study.

#### **2.4 Motivation for selecting the Resiliency Model for the present study**

The family resilience framework is increasingly being used by clinicians and researchers because it offers a means of empirically measuring the outcome of the resilience process. Resilience, as mentioned previously, is a complex construct to measure and the Resiliency Model allows researchers to operationalise the measurement of resilience in terms of stressors and risk, protective factors and adaptation (Smith, 2006). Through this process, specific independent variables that are associated with family adaptation can be measured. The Resiliency Model also suits the current trend of focusing on strengths rather than deficits, and supports the perspective of family resilience as a process (Walsh, 1996; 2002). The Model has been applied to different cultural settings, which is important for a culturally diverse country such as South Africa (Greeff & Van der Merwe, 2004; Smith, 2006). Research in the current study could therefore incorporate different cultural groupings. In addition, the Resiliency Model, based in the salutogenic paradigm, was deemed suitable to guide the development of a programme for families with a child with a hearing impairment, because current early intervention practices call for strength-based models of family support (Judge,

1998). It is important that families are empowered to use their existing and new coping strategies to build on their strengths and to facilitate the adaptation process. According to Judge (1998), such interventions form an important component of comprehensive support for families with a member with a disability.

There has been growing interest in family stress and coping among South African researchers, and the Resiliency Model is increasingly being used by researchers interested in disabilities (Jansen, 1994). As early as 1989, Van Rooyen (1989) undertook a study on the parents of autistic and mentally retarded children. Jansen (1991; 1994) followed suit by conducting a study on families with children with physically disabilities. Studies then also focused on families with children with learning disabilities (Turk, 1991), children with allergies (Wiehann, 1991), children with diabetes (Corna, 1992), children with hearing impairment (Markman, 1992) and children with visual impairment (Zimmerman, 1993). All the studies showed that parents with children with disabilities experience significantly more stress than parents who do not have a child with a disability. Greeff and Van der Walt (in press) focused on resilience in families with an autistic child, while Gillard (2002) conducted a study in Belgium to identify the resilience characteristics in families living with a child with a disability.

Unfortunately, with the exception of three projects (Der Kinderen & Greeff, 2003; Greeff & Human, 2004; Greeff & Van der Merwe, 2004), no other published South African research on family resilience is available. However, numerous additional studies have been conducted at the University of Stellenbosch under the promotion of Professor AP Greeff at the honours, master's and doctoral level (e.g. Jonker & Greeff, in press; Smith, 2006; Thiel, 2005). The current study falls under the larger initiative of the Department of Psychology, University of Stellenbosch and aims to expand on existing family resilience research by focusing on

families with a child with a hearing impairment and include families from diverse cultural settings.

## **2.5 Conclusion**

Family resilience has increasingly gained support in the field of family therapy. A resilient approach is especially suitable in present times, where family life is changing at such a rapid pace and families are confronted by various hardships and disruptions. The Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin & McCubbin, 1996) was found to provide the most suitable theoretical framework for the current study. The model enables the measurement of the resilience process by mapping the process in terms of stressors and risk, protective factors and adaptation. In this way, key processes can be identified and enhanced. These will assist families in making the necessary changes when faced with a crisis. This, in turn, will help the family to grow, meet the challenges, and re-establish balance and harmony within the family system.

The literature review in Chapter 3 will focus specifically on hearing impairment, what impact such a disability can have on the family, and what resilience factors are required to promote effective family functioning.

## **CHAPTER 3**

### **LITERATURE OVERVIEW**

#### **HEARING IMPAIRMENT AND FAMILY RESILIENCE**

##### **3.1 Chapter preview**

The purpose of this chapter is to present an overview of hearing impairment in children as a clinical background to the focus of this study, and then to highlight the impact of this disability on the family. The present chapter opens with a brief definition of disability and hearing impairment, followed by the incidence of disabilities and hearing impairment in South Africa, the types and causes of hearing impairment, and the amplification and methods of communication available to these children. A discussion will then follow on the Resiliency Model and which factors have been found to help families to adjust and cope with their child's disability.

##### **3.2 Introduction**

The diagnosis of a disability such as a hearing impairment results in a crisis and potentially affects the family on many levels. These levels include the behavioural level (e.g. physically taking care of the child), the affective level (e.g. working through the feelings of grief, anger, guilt, helplessness), the physical or sensory level (e.g. the somatic symptoms), the interpersonal level (e.g. supporting family members) and the cognitive level (e.g. understanding the diagnosis and its implications) (Fortier & Wanlass, 1984). In order to understand hearing impairment it may be helpful to take a brief look at the definitions of disability and impairments.

### 3.3 Definition of disability and related terms

Disability, impairment and handicap are contested and complicated terms as a result of multiple definitions and theoretical arguments on their meaning (Henderson, 2006). The debate still continues but, in order to ensure a structured approach, the definitions provided by the International Classification of Impairments, Disabilities and Handicaps (ICIDH) will be adopted in this study. The definitions look as follows:

- *Disability*: “A restriction or inability to perform an activity in the manner or within the range considered normal for a human being...” (Barbotte, Guillemin, Chau & Group 2001, p. 1047).
- *Impairment*: “Any loss or abnormality of psychological, physiological or anatomical structure or function” (Henderson, 2006, p. 920).
- *Handicap*: “The disadvantage(s) resulting from impairment or disability” (Henderson, 2006, p. 920). The term handicap was used during the twentieth century, but has since been rejected as offensive due to its association that people with impairments only make a living by begging (Amundson, 2006).

The term disability will be adopted as an umbrella term in this study, with the term impairment referring specifically to a hearing impairment.

### 3.4 Definition of hearing impairment

Generally the terms deaf, Deaf and hard-of-hearing are used to refer to individuals who have a hearing impairment or auditory disability. According to the Concise Oxford Dictionary (Allen, 1990), the term deaf refers to “individuals who are wholly or partly without hearing” (p. 296), while the term Deaf refers to individuals who identify with and participate in the language, culture and community of deaf people (The Canadian Hearing Society, 2004). The

term hard-of-hearing refers to individuals who have a mild to moderate hearing impairment and can use their hearing for communication purposes (Northern & Downs, 2002). The children in the current study suffered from a moderate to profound hearing impairment and either used signing or spoken language to communicate. The group was therefore heterogeneous and the researcher will use the term hearing impairment as a generic term.

It is difficult to define hearing impairment per se, as the implications of the sensory disability vary from child to child (Schröder, 2004). The definitions and classifications also vary according to the purpose for which they were developed, e.g. medical, educational or psychological. Usually, however, a hearing impairment is described by measures of the degree or severity of the loss, and the type of pathology present (Northern & Downs, 2002).

The following classification is used in South Africa (Keith, 1996):

Table 1

*Guidelines Used to Describe the Degrees of Hearing Impairment*

Degree of hearing impairment	Grade of impairment
-10 to 15 dB	Normal
16 to 25 dB	Slight
26 to 40 dB	Mild
41 to 55 dB	Moderate
55 to 71 dB	Moderate - severe
71 to 90 dB	Severe
91 dB +	Profound

It is important to note that no two individuals have the same pattern of hearing, even if they fall within the same category. Other factors, such as the age of diagnosis, co-operation of caretakers in the treatment programme, proper use of hearing aids, the level of noise in daily

life, visual and other impairments, intellectual abilities and the social-emotional development of the child, all influence the impact the hearing impairment has on the child and its family (Markman, 1992; Schröder, 2004). However, despite the individual variations in the classification, the above-mentioned criteria have been found to be useful for social, educational and medical purposes (Keith, 1996).

### **3.5 Incidence of disabilities and hearing impairment in South Africa**

South African statistics regarding people with a disability appear to be unreliable and outdated. The unreliability of the statistics on hearing impairment may be attributed partly to the fact that there are many unidentified deaf people, especially in rural areas. In addition, South Africa has a lack of assessment centres (audiology clinics) required for identification and intervention. Figures received from specific disability federations, such as DEAFSA (Deaf Federation of South Africa) and the Federation for the Blind, differ from those received from Statistics South Africa. During the 2001 census, 5% (2 255 982) of the total population (44 819 778) reported having some kind of disability. Table 2 provides a summary of the types of disabilities in South Africa according to gender (Statistics South Africa, 2001).

Table 2

*Percentage of People with a Disability by Type of Disability and Gender (Statistics South Africa, 2001)*

Type of disability	Male %	Female %	Total %
Sight	28.3	35.6	32.1
Physical	30.7	28.6	29.6
Hearing	19.4	20.7	20.1
Emotional	17.3	14.3	15.7
Intellectual	13.5	11.3	12.4
Communication	7.2	5.8	6.5

The high incidence of sight and physical disabilities should be interpreted with caution because of the easy identification of these impairments compared to other disabilities. In addition, cultural perspectives, socio-economic and demographic factors, and willingness to report accurately may have impeded the data collection (Statistics South Africa, 2001). Out of the total population of South Africa, 20.1% reported to have a hearing impairment, which makes it the third highest reported disability. Table 3 below represents a breakdown of the people with a hearing impairment in South Africa according to their cultural group.

Table 3

*Percentage of People with a Disability Affected by a Hearing Impairment According to Cultural Group (Statistics South Africa, 2001)*

Type of disability	White %	African %	Coloured %	Indian/Asian %
Hearing	26.1	19.7	18.2	16.2

From Table 3 it seems that the highest incidence of hearing impairments is reported by the white cultural subgroup (26.1%), followed by the African- (19.7%), Coloured- (18.2%) and Indian/Asian (16.2%) cultural subgroups. DEAFSA work around a figure of approximately

500 000 people as Deaf and still makes use of the prevalence figures from the World Health Organization, namely that approximately 1% of the population is Deaf and another 3% have a hearing impairment (A. Botes, personal communication, September 21, 2007).

When focusing specifically on the Western Cape, South Africa, from where the sample was drawn for the current study, a total of 186 850 people with disabilities were reported out of a population of 4 524 335 (Statistics South Africa, 2001). Of this group, the coloured cultural subgroup reported the highest incidence of disabilities (99 598), followed by the black- (46 019), white- (39 820) and Indian (1 412) cultural subgroups (Statistics South Africa, 2001). The table below provides a summary of these findings.

Table 4

*Number of People with Disabilities in the Western Cape by Population Group (Statistics South Africa, 2001)*

Population group	Total population	With disabilities	Percentage %
Total	4 524 335	186 850	4.1
Black	1 207 429	46 019	3.8
Coloured	2 438 976	99 598	4.1
Indian/Asian	45 030	1 412	3.1
White	832 901	39 820	4.8

In the Western Cape, 5.2% of 0- to 9- year-old children have disabilities (Statistics South Africa, 2001). Unfortunately, no breakdown was available with regard to the specific disabilities they have.

The lack of sufficient and accurate data on people with disabilities may be due to the different definitions that exist regarding disabilities, different survey methods used to collect data, negative attitudes towards people with disabilities and poor service infrastructure for people

with disabilities, which prevent the collection of data (Statistics South Africa, 2001). What is certain is that people with disabilities are often ignored and, as a result, a significant amount of human potential goes untapped. This, in turn, impacts negatively on the economic and social development of the country.

Focus will now be placed specifically on hearing impairments to highlight why such a disability may have a significant impact on the functioning of families.

### **3.6 Types of hearing impairment**

The various causes of hearing impairment all affect different parts of the ear and hearing mechanism. Hearing impairments have thus been categorised according to the site of the lesion and are distinguished as sensorineural, conductive, or mixed (Schirmer, 2001; Woodson, 2001).

#### **3.6.1 Sensorineural hearing impairment**

Most permanent childhood hearing impairments are sensorineural (Flexer, 1999). This type of hearing impairment is usually present at the time of birth and entails that the damage to the hearing system lies within the cochlea, in the inner ear. Generally the loss is profound and the distortion of the sound cannot be improved with amplification (Schirmer, 2001).

#### **3.6.2 Conductive hearing impairment**

Conductive hearing impairment is the most common type of hearing impairment found in children and often goes undetected (Bennetts & Flynn, 2002). The damage occurs in the outer or middle ear, where sound is amplified and transmitted to the cochlea. Hearing impairment is usually mild to moderate and an individual's sensitivity to all sound is reduced (Stewart & Adams, 1997). Most conductive hearing impairments require medical treatment for hearing to return to normal.

### 3.6.3 Mixed hearing impairment

When a conductive hearing impairment is superimposed on a sensorineural hearing impairment, the resulting hearing problem is known as a mixed hearing impairment. This loss is quite uncommon among children (Schröder, 2004).

## 3.7 Causes of hearing impairment

Since hearing is a complex process, it follows that identifying the causes of a hearing impairment is also complicated. If a specific cause has been identified, then predictions can be made as to whether the hearing impairment may deteriorate. In addition, it may also explain the attitude the parents have towards their child's disability (Newton & Stokes, 1999). Markman (1992) found that, where the cause is unknown, parents suffer from greater anxiety and guilt feelings. Unfortunately, for many children with a permanent hearing impairment, no cause can be found.

A child's hearing impairment can be inherited (genetic) or acquired (environmental). Available research has led to the proposal that genetic and environmental factors may often interact to cause a hearing impairment (Arnos, Israel, Devlin & Wilson, 1996). The common trend is to divide the causes of hearing impairment into three categories, namely prenatal, perinatal and postnatal. It is estimated that half of all childhood deafness can be attributed to hereditary causes (Northern & Downs, 2002). Hearing impairments can also result from sexually transmitted diseases, viral infections such as Rubella contracted during pregnancy, or from certain medications taken during pregnancy (Chase, Hall III & Werkhaven, 1996; Schirmer, 2001). Difficulties during birth or soon after birth can also lead to a hearing impairment, e.g. prematurity, jaundice or lack of oxygen (Newton & Stokes, 1999). Meningitis, otitis media, measles, mumps and head injuries are some of the diseases and other problems that children can contract themselves with hearing impairment as a possible

consequence (Newton & Stokes, 1999). According to the World Health Organization (2009) there are a number of preventable causes of hearing impairment in middle-income countries such as South Africa. These include middle ear infections, excessive noise, inappropriate use of certain drugs, complications during childbirth, and vaccine-preventable infections such as measles, mumps, meningitis and rubella (World Health Organization, 2009). It can be hypothesised that many children in South Africa are at risk of suffering from a hearing impairment due to the high incidence of physical abuse and violence, cold and often wet winters in the Western Cape, and a high incidence of sexually transmitted diseases and AIDS.

### **3.8 Co-morbidity of hearing impairment with other medical conditions**

Researchers have found that many cases of deafness carry with them the possibility of damage to other sensory systems and/or neurological damage (Marschark, 1993). Approximately 30% of children with hearing impairment have a disability in addition to a hearing impairment (Fortnum, Marshall & Summerfield, 2002). Common co-occurring conditions include mental retardation, significant visual impairment, asthma, arthritis, heart trouble, learning difficulties, attention deficit disorders, emotional or behavioural problems, cerebral palsy and orthopaedic problems (Flexer, 1994; Northern & Downs, 2002; Tye-Murray, 1998).

### **3.9 Types of amplification**

The aim in providing amplification for a child with a hearing impairment is that sound must be amplified to a level that provides the child with access to as much of the speech signal as possible (Smith, 1997). Various types of amplification systems are available, and fitting the correct one for each child involves teamwork from professionals and parents.

The first option for amplification would be a hearing aid. Various types are available (e.g. ear-level hearing aids, body-type hearing aids, extended-frequency hearing aids or bone-conduction hearing aids) and the one to be used should be chosen according to the child's individual needs. Tremendous technological advances in hearing aids over the past three decades, have led to improved fitting, comfort and instrument performance (Northern & Downs, 2002).

Another option for amplification is the cochlear implant. This is an electronic device that performs the function of the damaged or absent hair cells within the cochlea by providing electrical stimulation to the remaining nerve fibres. The damaged ear is thus bypassed and the auditory nerve is stimulated directly. For a child to be considered a candidate for a cochlear implant, the child must have a reasonable chance to perform better with a cochlear implant than with any present sensory aid (Schröder, 2004).

### **3.10 Methods of learning language**

One of the most difficult decisions parents have to make once their child has been diagnosed with a hearing impairment is the choice of communication. There are, broadly speaking, three communication approaches, which differ significantly in what they entail and in their overall objectives.

1. Auditory-oral approach: the goal of this approach is communication through speech (Lynas, 1999). This implies that the deaf children's residual hearing is exploited by amplification so that the auditory processing parts of the brain can be activated and language can develop.

2. Total communication approach: the basic premise of this approach is to use all methods of communication, namely sign, gestures, finger spelling, speech, hearing, lip movements and

facial expression (Lynas, 1999; Northern & Downs, 2002). The aim is to support audition and speech with visual communication to ensure easy, two-way communication between the child and significant others.

3. Bilingualism: this approach emphasises sign language used by people having a hearing impairment within their own group.

Regardless of whether the parents decide to adopt the oral approach, sign language or total communication, they will have to learn new ways of interacting with their child (Luckner & Velaski, 2004). A hearing impairment, in the context of the hearing family, attacks the backbone of the family structure, namely communication. Everyday parenting activities may be very challenging if all members do not have access to a shared language (Evans, 1995; Freeman *et al.*, 2002).

### **3.11 Hearing impairment: An explanation according to the Resiliency Model**

The family was chosen as the unit of analysis in the current study because previous research has shown that the family is the most important unit when conducting research on children with disabilities (Akamatsu, Hobfoll & Crowther, 1992). The trend in family research is to conceptualise the family as a system (Minuchin, 1974). This approach has also been adopted in the Resiliency Model, where the view is that a crisis has an impact on the whole family. When the family is perceived as a system, the units do not function in isolation, but interact both within and between systems so that changes in one unit will have an impact on all the other units. The presence of a child with a hearing impairment within a family, therefore, does not only have implications for that specific member, but also has implications for the functioning of the entire family.

As previously discussed, the Resiliency Model describes a family's response to life changes and major stressors in two phases, namely family adjustment and family adaptation. As was noted in Chapter 2, family adjustment is a more short-term response by families to manage less severe stressors and transitions. The process involves slight changes in the family pattern of functioning and may even be adequate. When the demands placed on the family by the stressor event cannot be resolved by the use of present resources and coping strategies, a state of family crisis arises. The family is in a state of disintegration and needs to change in order to create stability in its ways of functioning. This marks the beginning of the family adaptation stage, in which the family alters its capabilities, roles, routines, resources, appraisals and coping strategies to meet the demands placed on it. It can be assumed that most, if not all, families will struggle to adjust to the diagnosis of a hearing impairment and the demands of having a child with a disability may exceed the family's current capabilities, resulting in initial maladjustment and a crisis. The family then enters the adaptation phase of the Resiliency Model in order to re-establish its equilibrium and to function at or above its previous level of functioning.

Following a strengths-based paradigm in this study, the discussion below will only briefly focus on the crisis that may result due to the diagnosis of a child's hearing impairment, before highlighting the specific factors that previous studies have found to assist families in the adaptation process.

### 3.11.1 Family crisis (X)

Parenting a child with a disability may be defined as a chronically stressful situation (Margalit & Ankonina, 1991). The time immediately after the diagnosis is perceived as the most stressful for parents and is a time when they experience the greatest loss of quality of life (Burger, Spahn, Richter & Eissele, 2005). The extent to which the diagnosis will put the

family in disequilibrium will depend on factors such as the severity of the hearing impairment, the age of the child at diagnosis, the family's ethnicity, religious and cultural background, the hearing status of the parents, the education of the parents, the marital relationship, the mode of communication used, the proficiency of the partner's in the child's communication mode, the available resources, and the family's access to social support and parenting models (Jackson & Turnbull, 2004; Markman, 1992; Trachtenberg & Batshaw, 1997). What is certain is that living with a child with a hearing impairment is not easy and can initially be daunting. There are practical and emotional issues that families will need to resolve before they can function as effectively, or even better, than before.

### 3.11.2 Pile-up of demands (AA) and family vulnerability (V)

After the diagnosis of a child's hearing impairment (i.e. the stressor/crisis situation), families are exposed to new stressors every day, which result in the pile-up of demands and increase the impact of the stressor on the family. Research has shown that the diagnosis of a child's chronic illness and the ongoing strains of caring for the child could pose significant risks for future family problems (Patterson, 2002). Family routines and rituals are disrupted, which in turn may threaten the family's development, maturation and stability (Steinglass, 1998). According to Steinglass (1998), it is not uncommon that the child's impairment could trigger a chain of other stressors, which move the family into high-risk status.

Having a child with a hearing impairment automatically results in increased duties to treat and care for the child. In addition to the normative and non-normative stressors that the family faces, visits will have to be made to various professionals, clinics and hospitals, all of which take up extra time and increase the financial burden on the family. Parents may be unsure of how to discipline their child and may constantly have to explain their child's hearing impairment and unique needs to friends, acquaintances and strangers. The daily

caregiving demands may lead to physical and emotional exhaustion and limited time for social activities. This, in turn, may contribute to additional stressors, such as compromised parenting and/or increased marital dissatisfaction and conflict (Patterson, 2002). In their review of studies conducted on stress and coping in families with a child with a disability, Knussen and Sloper (1992) identified that other family problems, such as illness, work issues, moving house and the school problems of other children, may also increase the burden on the family.

Calderon, Bargones and Sidman (1998) conducted a study that involved 28 families who had a child aged 42 to 87 months with a hearing impairment. The aim was to understand the role, success and limitations of early intervention programmes. Parents were interviewed, completed questionnaires and had to make a video of their interaction with their child. Calderon *et al.* (1998) found that two-thirds of the participants experienced additional stress related to life events such as divorce, birth of an additional child, unemployment and illness. All these additional stressors may increase the vulnerability of the family. It is thus important that families are empowered to cope with the additional demands in order to lower their vulnerability (Knussen & Sloper, 1992).

### 3.11.3 Family types (T) and newly instituted patterns of functioning (TT)

A family's adaptation is influenced by its typical pattern of functioning (refer to Chapter 2, p. 31). Focus is placed on the family's coherence, flexibility, bonding, family time and routines, celebrations and traditions (McCubbin & McCubbin, 1988). Taanila *et al.* (2002) interviewed the parents of eight children (aged eight to 10 years) with a physical and/or intellectual disability on two occasions to identify what coping strategies they used and how the families with good and poor coping capacities differed. The researchers found that family cohesion and feelings of togetherness and co-operation, as well as time spent doing something

together, are very important for families with a child with a physical and/or intellectual impairment (Taanila *et al.*, 2002). These aspects have an important function in creating continuity and stability within the family system (McCubbin & McCubbin, 1988). Families with a child with a hearing impairment should therefore be encouraged to have rituals, routines and traditions that promote family cohesion and bonding.

#### 3.11.4 Family resources (BB) and social support (BBB)

When confronted with a crisis such as a hearing impairment, families attempt to strengthen existing resources or even acquire new resources in order to meet the demands placed on them. Resources typically come from three sources, namely an individual family member, the family as a unit, and the community (see Chapter 2, p. 32). These resources will firstly be discussed, before discussing the role of social support in enhancing family adaptation.

##### Individual, family and community resources

The families in the present study were all in the childbearing and school-age life cycle stage. According to McCubbin and McCubbin (1988), the following resources are seen as critical strengths for families in this stage: (a) balanced interrelationship among family members; (b) good marital communication; (c) a shared orientation to child rearing; (d) satisfaction with family life; (e) financial management skills; (f) satisfaction with quality of life; (g) family celebrations; (h) family time and routines; (i) family hardiness; and (j) family traditions.

Much research has been conducted to identify significant resources that enhance family adjustment in families with a child with a disability. Yau and Li-Tsang (1999), for example, found personal resources, a strong marital relationship and positive characteristics of the child with a disability as vital factors that promote family adaptation. Knussen and Sloper (1992) identified (a) socio-economic or material resources, such as good finances and

employment; (b) personality variables, such as locus of control, neuroticism and self-esteem; (c) relationships within the family and social network; and (d) service response as important categories of resources. Bennett and DeLuca (1996) conducted a study that involved in-depth interviews with 12 parents (11 mothers, one father) who had a child, aged between 15 months and 30 years with a disability. The study investigated the informal resources that parents use across the family life cycle. They found that family and friends, parent groups, helping professionals and religious beliefs can be particularly supportive for families with a child with a disability (Bennett & DeLuca, 1996).

The wide range of resources is often divided into protective and recovery factors. McCubbin *et al.* (1996) identified the following important family protective factors: celebrations, routines, time spent together as a family, family traditions, strength of the family, open communication, harmony, adaptive personalities, good financial control, supportive social networks, good physical health of family members, and shared values. Important recovery factors are family coherence (Lavee, McCubbin & Patterson, 1985; McCubbin, 1979), redefining the situation so as to make it appear more manageable to the family (McCubbin *et al.*, 1996; Richmond & Christensen, 2000) and communication (Hawley & DeHaan, 1996; McCubbin *et al.*, 1996). When McCubbin *et al.* (1997) focused specifically on the families of children with cystic fibrosis they identified the following recovery resources as assisting in the adaptation process: (a) family integration, i.e. parents' efforts to keep the family together and to maintain an optimistic outlook; (b) family support and esteem building, i.e. parents' efforts to get support from the community and friends and to develop their self-confidence; (c) family recreation orientation, control and organisation, i.e. participating in various recreational and sport activities; and (d) family optimism and mastery. Patterson (1991) identified nine coping strategies that seem to be specifically protective for these families: (a) balancing the illness with other family needs; (b) maintaining clear family boundaries; (c)

developing communication competence; (d) attributing positive meanings to the situation; (e) maintaining family flexibility; (f) maintaining a commitment to the family as a unit; (g) engaging in active coping efforts; (h) maintaining social integration; and (i) developing collaborative relationships with professionals.

Studies on family characteristics such as socioeconomic standing and family compositions, as well as on child variables such as severity of the disability and age of the child, have generally been inconclusive (Calderon & Greenberg, 1999; Jansen, 1994; Scorgie, Wilgosh & McDonald, 1998).

### Social support

It is widely believed that social support is a significant factor that mediates stress and promotes coping in families with a child with a disability (Frost Olsen *et al.*, 1999). One of the main tasks of those involved in the care of people with disabilities is to develop support systems that help families mobilise their personal resources (Jansen, 1994). Suarez and Baker (1997) believe that by introducing parents with a child with a disability to supportive resources, one catalyses the process of normalising adjustment problems and stress. Sources of support can be vast, e.g. grandparents, extended family, friends, church, schools and professionals (Richmond & Christensen, 2000).

Greeff and Van der Walt (in press) researched resilience factors in families with a child with autism and found social support and the mobilisation of community resources to be important for growth and healing. Gillard (2002) also found social support to be an important factor in their study of families with a child with a disability. Judge (1998) studied 69 parents (mostly mothers, 88%) of children with disabilities from the ages of birth to five years. Each family was involved in one of eight different kinds of intervention programmes developed for

children with disabilities or those at risk for developmental delays. The results indicated that the use of social support is highly associated with family coping.

Parents' efforts at seeking emotional and informational social support were found to be predictive of family strengths (Judge, 1998). Taanila *et al.* (2002) found the help and support from formal services to be very important for families with children with impairments. Parents seem to find training courses particularly supportive and helpful and appreciate the exchange of experiences with other parents who have had similar experiences (Taanila *et al.*, 2002). Hintermair (2000) conducted a survey that focused on how families communicate and socialise with other parents who have a child with a hearing impairment. A total of 317 parents completed the Parenting Stress Index and a questionnaire on the child's hearing impairment. The results showed that parents who frequently met with other parents with a child with a hearing impairment showed a strong sense of competence and a warm, trusting, accepting relationship with their child with a disability (Hintermair, 2000).

Calderon and Greenberg (1999) and Quittner, Glueckauf & Jackson (1990) identified social support as being an important predictor of maternal adjustment when having a child with a hearing impairment. According to Calderon and Greenberg's (1999) review of the literature, several studies have found that greater marital satisfaction is related to higher levels of life satisfaction and lower levels of parental stress in families with a child with a hearing impairment. Several studies have also demonstrated the importance of extended family and formal support (e.g. support groups or professionals) to maternal and family adjustment in families with children with special needs (Gringlas & Weinraub, 1995; Honig & Winger, 1997). Morton (2000) conducted an informal survey on 11 parents (nine mothers, two fathers) of young deaf children between 13 months and four years old. The children were enrolled in a state-sponsored early intervention programme for deaf children. The survey was

distributed during one of the ongoing monthly meetings of parents that had been established to provide information, education, and support to the parents of children in the programme. The study highlighted the importance of the extended family, especially grandparents, in promoting the development of the children with the hearing impairment (Morton, 2000).

The above-mentioned studies have shown that resources and social support directly and indirectly impact on family functioning, the family members' well-being, parent-child interaction and child development. Research has repeatedly shown that social support enhances parent and family well-being, decreases the time demands placed upon a family by a child with a disability, and enhances the parents' positive perception of their child with a disability (Dunst, Trivette & Jodry, 1997).

#### 3.11.5 Family appraisal processes (C – CCCCC)

A family's perception of a child with a disability is affected by the family's socio-cultural background (Jansen, 1994). Negative societal beliefs about impairment and disability impact on the family's beliefs about a disability and influence how they engage with their child with a hearing impairment (Woolfson, 2004). The family's perception of a disability is influenced by the attitudes and perceptions of their family, friends, community and those in society as a whole. Society typically views a disability as a tragedy, both for the individual as well as for the family. Attitudes of fear, pity and disgust by people with no disabilities are commonly reported (Woolfson, 2004). It therefore is proposed that parents (that do not have disabilities) of children that have disabilities are likely to hold the same views.

Different cultures interpret symptoms of a disability differently; they use different vocabulary to express the symptoms and vary in their willingness to act on the symptoms of the disability (Jansen, 1994). In Western society, a disability is often viewed as a personal tragedy and

medical problem (Woolfson, 2004). In a number of African societies, witchcraft is strongly linked to ill health and disabilities (Satariano, Belle & Swanson, 1986). In Indian societies, where the belief in reincarnation is strong, a disability may be seen as the result of transgressions in a previous life, either on the part of the parents or the child (Groce & Zola, 1993). When a disability is seen as a divine punishment, the family may be ashamed of the child with a disability and may thus fail to adequately care for the child. The family may also be reluctant to make use of professional services, because a disability is regarded as unacceptable in their culture (Jansen, 1994). This implies that societal beliefs will impact on the parental beliefs and have a direct influence on the parents' behaviour towards the child with a disability.

Adjustment centres on a search for the meaning of the disability. Orr *et al.* (1991) applied Hill's ABCX-model to the families of children with disabilities and identified that the perception (appraisal) of the event is the first step in coping with the birth of the child with a disability. A disability requires that the family makes shifts in their thinking. Cognitions about the disability must change to help the family make sense of the disability, e.g. 'why were we chosen to live with this?' Tunali and Power's (1993) review of the literature on stress and coping in families with a child with a disability highlighted the cognitive changes that occur when the fulfilment of the family's needs is threatened by having a child with a disability, and suggested that the family copes with this stress by redefining what constitutes fulfilment of that specific need.

Trute and Hiebert-Murphy (2002) conducted a longitudinal study in which 87 families were assessed while their children with developmental disabilities were in the preschool years. After seven years, 64 of the families were again interviewed. The parents' views on the child and family's functioning were explored. Trute and Hiebert-Murphy suggest that the appraisal

by parents of the impact of the disability on the family, is formed early in the life of the child with the disability, and tends to remain unchanged through to preadolescent years. In addition, the researchers found no difference between the appraisals of the mother and father with regard to the impact the disability had on the family. Their findings did, however, confirm that the appraisal of the fathers in these families was an important element of their parenting stress in the long run.

In addition, a member's disability can result in a shift in identity and focus (Hornby & Seligman, 1991). Instead of, for example, viewing a disability as negative, the family may become advocates fighting for the rights of members with a disability. Those with adequate coping resources are less likely to appraise a potential stressor as stressful and, should they appraise a situation as stressful, they are more likely to make reasoned and informed decisions about the course of action, thereby curtailing the length of the stressful episode (Knussen & Sloper, 1992).

Beresford (1996) examined what resources and strategies help families cope with the stresses associated with caring for a child with a disability and identified appraisal as a fundamental component of the coping process. Gillard (2002) conducted a study with children with mental disabilities and found that the redefinition of crisis situations and a passive appraisal of the situation assisted in the adaptation process. The researcher stated that families fare better when evaluating the stressful situation as a challenge and positively redefining the situation. How parents perceive and interpret the stresses they experience with their child with a disability is important for the family's well-being (Knussen & Sloper, 1992). On the one hand, parents need to be realistic about their child and accept the child as he/she is. On the other hand, they must never give up hope that their child will make progress.

Lazarus and Folkman (1984) listed several factors that may influence how parents appraise their situation positively when faced with a crisis such as a child's disability. One is novelty. Although they may have no background in raising a child with a disability, it may be exciting and create opportunities for learning and developing new skills. Another factor is predictability. Professionals should encourage parents to make their life more predictable by gaining information about the disability. A third factor is event uncertainty. A child with a hearing impairment may or may not learn to talk and parents should be encouraged to carefully mark the events amounting to small steps of progress that take place. Imminence is another factor. Parents may like to prepare for events, although this may increase the stress. Professionals can encourage parents to focus on the present and what they can do now. A fifth factor is temporal uncertainty. This occurs when an event is going to happen but one does not know when. Here parents can be encouraged to progress towards an event by focusing on markers. Ambiguity is a sixth factor. Professionals or parents may not have the absolutely right answer, but they can make the best decision based on what is known. The final factor is timing in the life cycle. This may become an issue if the parent finds that the event occurs 'off time'.

When combining all the studies on family resilience it appears that the main perceptions and beliefs of parents that mediate stress and help families to cope include: maintaining hope, optimism, faith, courage and an altruistic view of the situation (McCubbin & Patterson, 1983a).

#### 3.11.6 Problem solving and coping (PSC)

Coping with a child with a disability is a highly individual process (Taanila *et al.*, 2002). The ultimate aim of the family's coping procedure is to maintain or restore the balance between the demands placed on them and the resources they have available. To achieve this, the

family with a child with a disability must reduce the number or intensity of the demands by, for example, letting the mother leave her job in order to better care for the child, or increasing their social ties, that provide emotional support. One coping strategy may be useful in a certain situation, but dysfunctional in another. The important issue thus is not which strategies are used, but how many strategies the family has in their coping repertoire and how flexibly these strategies are used.

Parents have been found to cope better if they used predominantly practical or problem-solving strategies to deal with disability-related problems (Frey *et al.*, 1989). Poorer outcomes have been noted if parents use predominantly emotion-focused strategies of wishful thinking, self-blame, avoidance and passive acceptance (Knussen & Sloper, 1992). Of note is that those experiencing greater distress tend to use proportionately fewer practical or problem-solving ways of coping and more 'wishful thinking'. Judge (1998) found that 58% of the coping strategies used by parents with a child with a disability were problem focused, i.e. efforts were made to alter the cause of the stress. The three most frequently used coping strategies were: (a) efforts to seek social support; (b) actively trying to solve the problem; and (c) maintaining a positive outlook on life (Judge, 1998).

Taanila *et al.* (2002) found that the most frequently used coping strategies in high-coping families were good family co-operation, social support, as well as information about the disability and acceptance of it. The low-coping families seemed to have problems that were not only caused by the disabled child, but also, for example, by problems between the spouses or between the parents and other children (Taanila *et al.*, 2002). The researchers found that the high-coping parents had an optimistic and realistic attitude towards their child's and family's future. It was also found that family cohesion and feelings of togetherness and co-operation were very important. Discussions with other parents who had a

child with a similar disability were also rewarding. Informal support from friends and relatives was regarded as essential for managing in everyday life. It was also very important that the parents had time for themselves and their hobbies. After the initial shock of the diagnosis, the parents accepted the disability quickly, obtained information and believed their child would cope in his/her life. Family values changed and the family had very extensive and supportive social support networks, both formal and informal. In addition, the parents had a good marital relationship, which implied that the spouses helped each other. The family had a shared understanding of their situation and expressed a strong feeling of togetherness. They spoke openly about their feelings and experiences and accommodated their roles and tasks in order to cope with the increased care demands. The parents stated that family cohesion was the most helpful factor for coping. Margalit and Ankonina (1991) also found that adaptive functioning was closely related to marital bonding and family harmony. In addition, they found that greater use of avoidance as a coping style led to a higher level of distressed affect.

Turnbull (1988) emphasised that raising a child with a disability is a long-term activity. She suggested eight skills that families need to develop in order to cope with the demands. These include the ability to meet basic needs, to know one's self and one's family's needs, to love one's child unconditionally, to establish relationships, to experience and benefit from emotions, to take charge and make things happen for one's child, to anticipate the future and learn transition planning, and to establish balance in one's life.

According to Taanila *et al.* (2002), the first moments and days after the diagnosis of the child's disability are crucial in determining whether the parent's adaptation is positive or negative. The essential issues are the way in which the initial information is given and how things are dealt with immediately afterwards. The family's coping and functioning patterns

remain relatively consistent if they receive no interventions, and therefore it is so important to support families immediately after the disclosure. The programme developed in this study aims to help parents begin to use effective coping strategies from the start so that a positive adaptation process can take place.

### 3.11.7 Family adaptation (XX)

Family adaptation refers to the outcome of a family's efforts to grow and heal following a crisis such as the diagnosis of a hearing impairment. Available research has shown that families are able to adapt to the disability and, after a time of adjustment, are again able to function effectively (Behr, Murphy & Summers, 1992; Hartshorne, 2002; Moores *et al.*, 2001). It is the aim of the current study to assist families with this adaptation process by enhancing a specific resilience factor.

## 3.12 Conclusion

A hearing impairment can be a serious and disruptive experience for the child and his/her family. It is assumed that most families will struggle to adjust to the diagnosis of a hearing impairment and that the demands of such a disability will exceed the family's ability to cope. The family will enter a time of crisis and the Resiliency Model assists in defining what is required in order to re-establish equilibrium in the family. Families will initially be exposed to a pile-up of demands, increasing the pressure on the family. Resources such as social support, a positive perception of the child with the disability, and good problem-solving skills can act as resilience factors that promote the adaptation of the family.

This chapter has highlighted the wide range of coping strategies and adaptation processes shown by these families. Although the families are confronted with diverse demands that may initially outweigh their capabilities, research has shown that they are able to adapt to the

disability and are again able to function effectively. The following chapter will highlight the research design and methodology used to identify specific resilience qualities associated with better adaptation in families with a child with a hearing impairment.

## CHAPTER 4

### DESCRIPTIVE PHASE

#### RESEARCH DESIGN AND METHODOLOGY

##### 4.1 Chapter preview

Chapter 4 focuses on the descriptive phase of the study. First the problem will be formulated, followed by a statement of the objectives of this phase, the design and measures used to achieve these objectives, and a description of the participants. This will be followed by a discussion of the procedure and ethical considerations that were taken into account.

##### 4.2 Problem formulation

Parenting a child can be exciting, rewarding and, at times, quite challenging and demanding. Having a child with a hearing impairment tends to increase the daily challenges and demands that a family faces, and often even changes family dynamics and the home environment (Meadow-Orlans, Mertens & Sass-Lehrer, 2003). Parents of children with disabilities experience the same difficult life events as do parents of children with no disabilities, but in addition to this they also face stressors that are related specifically to the child's hearing impairment (Woolfson, 2004). These may include increased financial costs, many hours spent at medical and therapeutic interventions, and the parental grieving process for the loss of the healthy child they expected. With the considerable strain placed on such families, it is evident that there is a great need to assist these families in the adaptation process.

For decades, the dominant perspective was that families have a difficult time adjusting to the presence of a child with a hearing impairment (Luckner & Velaski, 2004). Much attention was given to pathology, with the image of these families being one of sorrow, depression and emotional turmoil. More recently, researchers have reported that many families with a child

with a disability are able to adjust, especially when they are provided with adequate information and support (Hartshorne, 2002; Moores *et al.*, 2001). Family resilience is becoming an increasingly visible concept in the family field (Hawley, 2000) and can be used to enhance the understanding of which factors and conditions influence how parents react to the presence of a child with a disability and how parents cope after the diagnosis of their child's hearing impairment (Kurtzer-White & Luterman, 2003; Mapp & Hudson, 1997). The theoretical framework of this study, namely, the Resiliency Model of Stress, Adjustment and Adaptation (McCubbin & McCubbin, 1993), suggests that a number of factors interact to predict families' levels of adaptation to stressors, including their level of vulnerability, family type, resources, appraisal of the stressor and problem-solving and coping skills. The question thus arises as to what are the key family processes that reduce stress and vulnerability in this high-risk situation, which foster healing and growth out of a crisis, and which empower the families to overcome the adversity of having a child with a hearing impairment.

#### **4.3 Specific aims-/primary objectives of the descriptive phase**

Following the problem formulation, two specific research questions guided the present study, namely (1) what are the specific resilience characteristics that are associated with better adaptation in families who have a child with a hearing impairment, and (2) can the identified resilience characteristics be enhanced in these families?

From the above research questions, the following specific aim was developed for the descriptive phase of this study:

- To identify and explore those resilience factors that are associated with adaptation in families who have a child with a hearing impairment.

#### 4.4 Research design

The present study is essentially exploratory-descriptive in design. Such research attempts to observe, record and describe a specific construct in order to develop scientific knowledge and to develop theory (Cozby, 1993). This approach is suitable for family resilience research, as it is still a relatively new area of interest. The advantage of an exploratory-descriptive approach is that it is specific and objective (McGuigan, 1990). Although it is difficult to control for extraneous variables, this study does so in a multiple regression context. This, however, does not yet establish cause-and-effect conclusions (McGuigan, 1990).

Since resilience is a complex construct to define, data was collected quantitatively and qualitatively. Triangulation allows the data to be explored and evaluated from various angles, thereby providing diversified information on the phenomenon under study (Taanila *et al.*, 2002). Using both questionnaires and interviews allowed for the comparison and validation of results, thereby complementing the descriptive nature of the study. In addition, Beresford (1994) stated how important it is to use both qualitative and quantitative methods when studying families with a child with a disability, as there are so many unanswered questions regarding how these families use coping resources, including social support. Inferences were excluded, as the researcher merely wanted to describe the strengths and resilience factors in families with a child with a hearing impairment.

The researcher attempted to understand family resilience by collecting a cross-section of information relevant to the topic. The advantages of a survey include considerable savings in terms of time and expenses (Kerlinger, 1986). Participants could also be assured of greater anonymity and privacy because most of the data collection involved self-report paper-and-pencil questionnaires. Disadvantages of this design include a lack of control over the environment, an increase in the likelihood of misunderstood items, and incomplete responses

(Dane, 1990; Salkind, 1997). To overcome these problems, the researcher held meetings for the questionnaires to be completed, verbally explained the procedure and answered any questions that the participants may have.

The study can also be described as correlative in nature, because the relationship among variables was investigated (Cozby, 1993). Attempts were made to measure the degree or strength of the relationship between the dependent and independent variables in the study. This ensured that the first aim of the study could be achieved, namely to identify the resilience factors that are associated with adaptation in families with a child with a hearing impairment.

## **4.5 Participants**

### 4.5.1 Sampling procedure

Non-probability sampling, specifically purposive sampling, was employed to select the sample for the present study. In non-probability sampling, the probability of any particular member of the population being selected is not known (Graziano & Raulin, 2000). In purposive sampling, the researcher uses his or her own judgement to select only those who best meet the purpose of the study (Cohen, Manion & Morrison, 2000). The advantages of using a non-probability, purposive sampling method include the ease with which it can be carried out, its cost effectiveness, and its practicality (Cozby, 1993; Graziano & Raulin, 2000). The disadvantage, however, is that the results may be biased because the sample is not necessarily representative of the population (Graziano & Raulin, 2000). As a result, external validity may be limited and generalisability is reduced (Dane, 1990). Sampling was based on voluntary participation and emphasis was placed on including enough participants to allow for meaningful statistical analysis.

#### 4.5.2 Description of the sample

The sample in the descriptive phase of this study comprised of 54 families. Families who met the following criteria were invited to participate in the study: (1) the child had been diagnosed as having a hearing impairment by an ear, nose and throat specialist; (2) the diagnosis had been made one to four years previously; (3) the child's hearing impairment was moderate to profound; (4) the child was under 10 years old; and (5) the child was enrolled in a formal programme and lived at home with his/her parent or caregiver. Both single and two-parent families, as well as those parents/caregivers living with extended families, were included in the sample. Both hearing and deaf parents/caregivers as well as all cultural and socio-economic groups residing in the Western Cape, South Africa were included in the descriptive phase of the study.

The families were identified through the institutions that cater for children with a hearing impairment in the Western Cape, South Africa. The prospective families were informed about the nature and goals of the study and what would be required of them in terms of time and availability. The families were requested to be represented by the parent most involved in the day-to-day care of the child with the hearing impairment, thereby providing an insider's perspective on the family's functioning.

The participants in the descriptive phase of this study were drawn from the black, coloured and white cultural subgroups residing in the Western Cape, South Africa. English was the home language of 33.3% of the sample, while 29.7% were Afrikaans speaking and 37% spoke Xhosa. The participants were representative of the lower, middle and upper socio-economic groups living in the urban areas in the Western Cape. Table 5 provides a summary of the sample in terms of the mean age range, gender, cultural group, marital status, socio-

economic status (SES), employment and education. A more in-depth description of the sample follows below.

Table 5

*Descriptive Phase Sample Breakdown in Terms of Age, Gender, Cultural Group, Marital Status, SES, Employment and Education Level (N=54)*

Variable		Number
Mean age		34.3 years
Gender:	Female	50 (93%)
	Male	4 (7%)
Cultural group *:	Coloured	26 (48.1%)
	Black	21 (38.9%)
	White	7 (13%)
Marital status:	Married	34(63%)
	Separated	3 (6%)
	Divorced	2 (4%)
	Cohabiting	2 (4%)
	Single	13 (24%)
SES (per annum):	<R20 000	20 (36%)
	R21 000-R40 000	14 (26%)
	R41 000-R60 000	6 (11%)
	R61 000-R80 000	3 (6%)
	R81 000-R100 000	2 (4%)
	>R100 000	6 (11%)
	Unknown	3 (6%)
Employment:	Permanent	18 (33%)
	Temporary	9 (17%)
	Non-working	27 (50%)
Educational level:	Primary school	11 (20%)
	Secondary school	26 (48%)
	Tertiary diploma	14 (26%)
	Tertiary degree	3 (6%)

Note: \* Using SA statistics categories

- Age distribution of participants

The mean age of the participants was 34.4 (S.D. = 9.2 years), with a minimum and maximum age of 20 years and 64 years respectively, with 52 of the 54 participants indicating their age. The majority of the participants (n = 24, 44%) were between 26 and 35 years old; 24% (n = 13) of the participants were between 36 and 45 years old, 17 % (n = 9) were between 15 and 25 years old, 9% (n = 5) were between 46 and 55 years old and 2% (n = 1) were between 56 and 65 years old. Figure 3 represents the breakdown of the sample into the various age groups according to percentages.

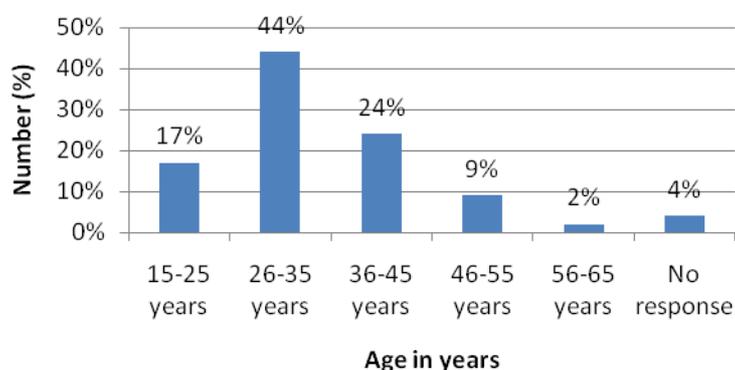


Figure 3. Sample breakdown in terms of age.

- Gender distribution of participants

All participants (N = 54) indicated their gender. Due to cultural norms as well as voluntary participation, no equal distribution of gender could be achieved. The majority of the participants were female (n = 50, 93%), while four (7%) were male. Figure 4 provides a graphic representation of the gender distribution.

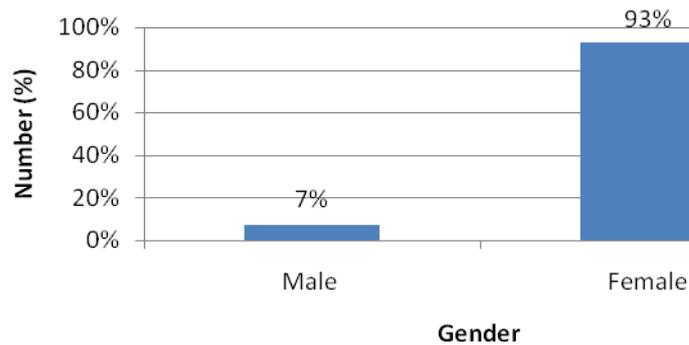


Figure 4. Sample breakdown in terms of gender distribution.

- Cultural group distribution of participants

Achieving an equal distribution for the cultural groups was difficult, as participation was voluntary and the incidence and perception of hearing impairment varies so drastically among the cultural subgroups (see Chapter 3). As a result, the sample consisted of 26 coloured people (48%), 21 black people (39%) and seven white people (13%). The unequal distribution will have to be taken into account when interpreting the results. Figure 7 provides a graphic illustration of the sample in terms of cultural groupings.

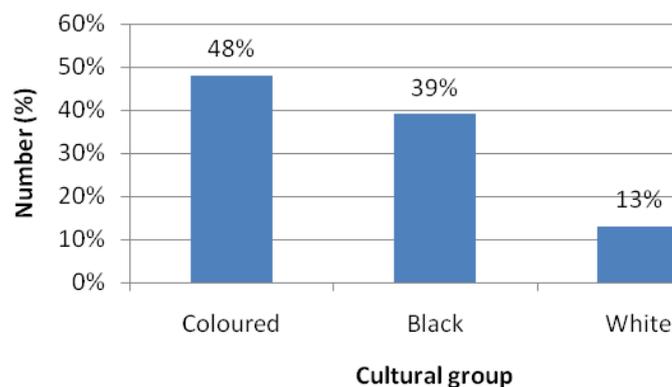


Figure 5. Sample breakdown in terms of cultural group.

- Marital status of participants

All 54 participants indicated their marital status. Thirty-four (63%) of the participants were married, while 13 (24%) were not married, three (6%) were separated, two (4%) were

divorced and two (4%) were cohabiting. Figure 6 provides a graphic illustration of the participants' marital status.

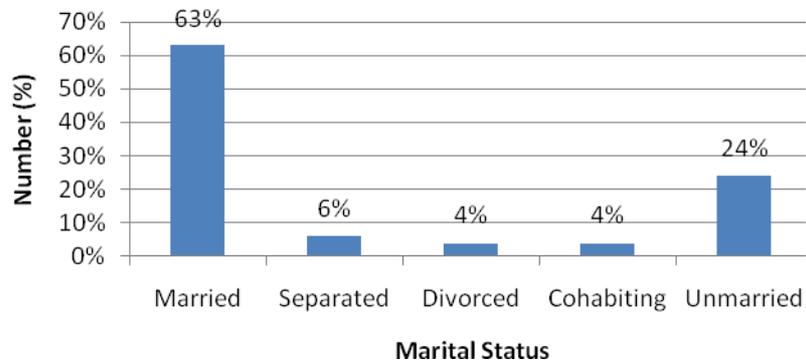


Figure 6. Sample breakdown in terms of marital status.

- Income status of participating families

Fifty-one of the 54 participants indicated their family's income status. Eighty percent ( $n = 43$ ) of the families reported that their annual income was below R80 000.00; 37% ( $n = 20$ ) of the families had an income of less than R20 000.00 per annum, while 15% ( $n = 8$ ) had an income higher than R80 000.00 per annum. It is evident that most of the participants had a low socio-economic status. Figure 7 provides a graphic illustration of this distribution.

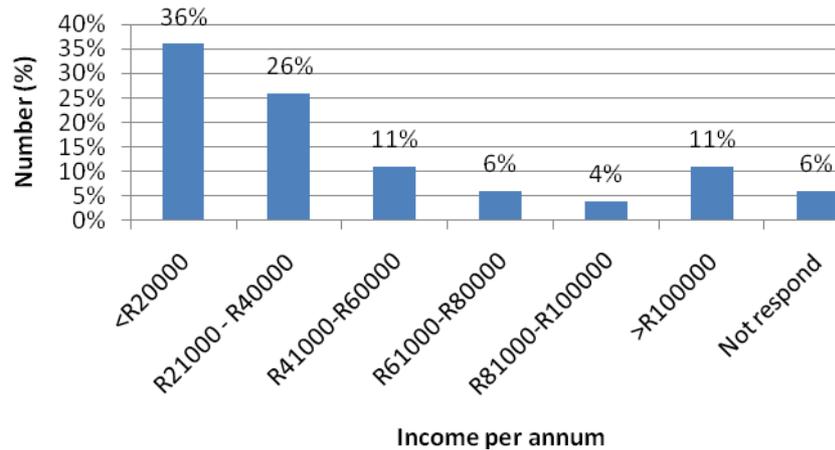


Figure 7. Sample breakdown in terms of income status.

- Employment distribution of the participants

Twenty-seven (50%) of the participants indicated that they had some form of permanent or temporary employment, while 50% were non-working at the time of data gathering. Figure 8 provides a graphic representation of the employment distribution.

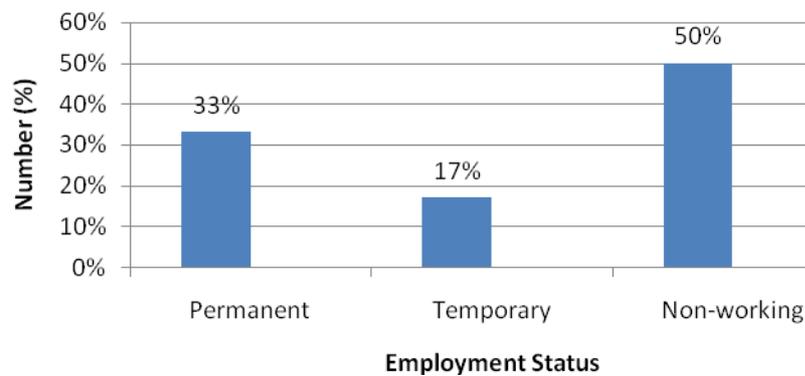


Figure 8. Sample breakdown in terms of employment status.

- Educational level of participants

All 54 participants indicated their educational level. Eleven (20%) of the participants had a primary school education, while 26 (48%) had completed secondary school and 17 (32%) had a tertiary education. Figure 9 provides a summary of the sample in terms of educational level.

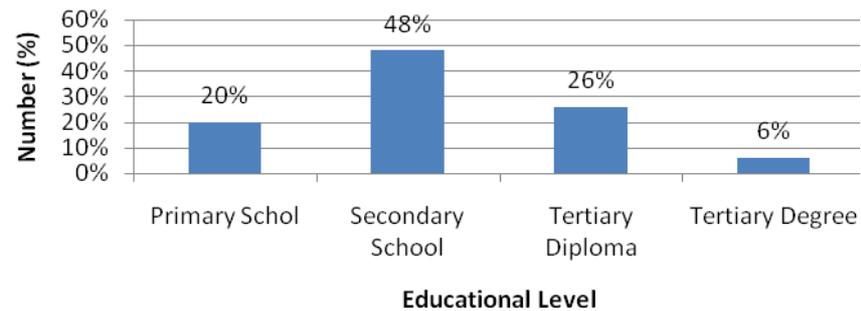


Figure 9. Sample breakdown in terms of educational level.

One of the main inclusion criteria for the study was that a child with a hearing impairment is present in the family. Thirty-eight (70.4%) of the children had a moderate to severe hearing impairment, while 14 (25.9%) had a profound hearing impairment. Forty-four (81.4%) of the children made use of a hearing aid for amplification, while five (9.3%) had a cochlear implant and five (9.3%) had no amplification. Most children (57.4%) used signing as their method of communication, while 38.9% use the oral approach to communicate. Nine (16.7%) parents reported that their child had another medical condition in addition to the hearing impairment. Table 6 provides a summary of the degree of hearing impairment, amplification, method of communication and comorbidity of the children with hearing impairments.

Table 6

*Summary of the Degree of Hearing Impairment, Amplification, Method of Communication and Comorbidity of the Children with Hearing Impairments (N = 54)*

Variable		Number
Degree of hearing impairment:	Moderate	12 (22.2%)
	Severe	26 (48.2%)
	Profound	14 (25.9%)
	No response	2 (3.7%)
Amplification:	Hearing aid	44 (81.4%)
	Cochlear implant	5 (9.3%)
	None	5 (9.3%)
Method of communication:	Oral	21 (38.9%)
	Signing	31 (57.4%)
	No response	2 (3.7%)
Comorbidity:	Yes	9 (16.7%)
	No	45 (83.3%)

#### 4.6 Measures

A biographical questionnaire was developed for this study. The questionnaire consisted of questions regarding marital status and duration of the relationship, family composition, age and gender of family members, characteristics of the child with a hearing impairment, employment, level of education, income and home language.

Family resilience factors were identified and described by using semi-structured interviews, as well as existing quantitative instruments designed by McCubbin *et al.* (1996).

The participants were requested to respond to three open-ended questions, which focused on gathering information on what challenges the families faced with their child with a hearing impairment and what factors they believed contributed to their coping and adjustment. The

interviews were tape-recorded and the transcriptions were written down word for word as far as possible. The interviews of the Xhosa- and Afrikaans- speaking participants were transcribed and translated into English by independent raters in the medical and educational professions respectively.

Using the Resilience Model of Stress, Adjustment and Adaptation (McCubbin *et al.*, 1996), the resilience process was mapped in terms of stressors, risk and protective factors, and adaptation. The measures were selected based on McCubbin *et al.*'s 1996 model and aimed to identify the factors that alleviate the effects of stressors and facilitate the adjustment and adaptation process. The Family Attachment Changeability Index 8 (FACI8) (McCubbin *et al.*, 1996) was used to measure the dependent variable, namely adaptation of the family following the crisis. The other measures were used to measure the independent variables that contribute to the resilience process. All measuring instruments were available in English, Afrikaans and Xhosa. A translation-back-translation procedure was followed to develop the Afrikaans and Xhosa questionnaires.

#### 4.6.1 Quantitative measures

The eight questionnaires that were employed were the following:

*The Social Support Index (SSI)*, developed by McCubbin, Patterson and Glynn (1982), was incorporated to assess the extent to which the families have integrated into the community; the degree to which the families find support in their community; and the degree to which they make use of community resources for emotional support, esteem support (affection) and network support (relationships with relatives) (McCubbin *et al.*, 1996). The SSI consists of 17 statements that are scored on a five-point Likert scale, ranging from strong disagreement to strong agreement. The internal reliability of the SSI measure is .82 (Cronbach's alpha), the

validity coefficient (correlation with the family well-being criterion) is .40 and the test-retest reliability is .83 (McCubbin *et al.*, 1996). The internal reliability (Cronbach's alpha) of the SSI in the present study was .72 and the Guttman split-half alpha reliability coefficient was .53.

*The Family Hardiness Index (FHI)*, developed by McCubbin *et al.* (1996), was utilised to measure the most important strengths that families use when confronted with a transition or crisis, as well as to measure the durability of the family unit. The FHI measures the ability to have a sense of control over the outcomes of life events and to take an active approach when dealing with the challenges (McCubbin *et al.*, 1996). The scale consists of 20 items that are rated on a five-point Likert scale, ranging from false to not applicable. The participants were asked to choose the statements that best describe their current family situation. Items are divided into three subscales, namely commitment, challenge and control. The Commitment subscale measures the family's ability to work together, their dependability and sense of internal strengths. The Challenge subscale measures the family's efforts to learn, to positively reframe crises, to be innovative, and to actively seek out new experiences. The Control subscale measures the family's sense of being in control of life rather than being the victims of fate (McCubbin *et al.*, 1996). The internal reliability of the total scale is 0.82 (Cronbach's alpha), with an internal reliability of .81 for the Commitment subscale, .80 for the Challenge subscale and .65 for the Control subscale (McCubbin *et al.*, 1996). The test-retest reliability is .86 and the validity coefficient ranges from .20 to .23, with criterion indices of family flexibility, satisfaction, time and routine (McCubbin *et al.*, 1996). The internal reliability of the total scale in the present study was .46 (Cronbach's alpha), and for the Challenge subscale it was .56, the Control subscale .64 and the Commitment subscale .61.

*The Relative and Friend Support Index (RFS)*, developed by McCubbin, Larsen and Olson (1982) was employed to assess the degree to which families make use of friend and relative support to help them cope (McCubbin *et al.*, 1996). The scale consists of eight questions scored on a five-point Likert scale ranging from strong disagreement to strong agreement. The RFS has an internal reliability of .82 (Cronbach's alpha) and a validity coefficient (correlation with the original Family Crisis Oriented Personal Evaluation Scales) of .99 (McCubbin *et al.*, 1996). The internal reliability in the present study was .75.

*The Family Crisis Oriented Personal Evaluation Scales (F-COPES)*, developed by McCubbin, Larsen and Olson (1981), was administered to identify the problem-solving and behavioural strategies families use in difficult situations. The scale evaluates the internal family coping strategies (i.e. where crises are managed by using resources within the nuclear family system) and external coping strategies (i.e. where crises are managed by eliciting support from the community) (McCubbin *et al.*, 1996). The scale consists of 30 five-point Likert-scale items, ranging from strong disagreement to strong agreement, and is divided into five subscales. The two subscales reflecting internal coping strategies are: (a) reframing – redefining the crisis situation to make it more meaningful (Cronbach's alpha = .69); and (b) passive appraisal – the family's tendency to accept situations as they are since they lack confidence in their own ability to change the outcome (Cronbach's alpha = .57). The external coping strategies include: (a) actively seeking out social support from relatives, neighbours and friends (Cronbach's alpha = .84); (b) seeking spiritual support (Cronbach's alpha = .87); and (c) mobilising family to acquire and accept help from community resources (Cronbach's alpha = .58) (McCubbin *et al.*, 1996). The internal reliability coefficient is .77 for the whole scale and the test-retest reliability is .71. The internal reliability of the total scale in the present study was .61 (Cronbach's alpha), and for the Reframing subscale it was .71, for the

Passive appraisal subscale it was .60, for the Acquiring social support subscale .81, the Seeking spiritual support subscale .79 and for the Mobilizing family subscale it was .61.

*The Family Problem Solving and Communication Scale (FPSC)*, developed by McCubbin *et al.* (1988), was administered to measure the positive and negative communication patterns families use during stressful situations. The scale consists of 10 items on a four-point Likert scale (0-False, 1-Mostly false, 2-Mostly true, and 3-True). The positive communication subscale, referred to as 'Affirming Communication', refers to the type of communication that conveys support and care (McCubbin *et al.*, 1996). The negative communication subscale, known as 'Incendiary Communication', refers to communication that tends to exacerbate a stressful situation. The total scale has an internal reliability (Cronbach's alpha) of 0.89, the Affirming communication subscale has an internal validity of .86 and the Incendiary communication subscale's internal validity is .78. The FPSC total scale had an internal validity of .64 in this study (Affirming communication .81 and Incendiary communication .59).

*The Family Time and Routine Index (FTRI)*, developed by McCubbin, McCubbin and Thompson (1986), was utilised to assess the type of activities and routines families engage in, and how important these practices are to them. The scale consists of 30 items and eight subscales. Participants respond to each item on two scales, namely (a) the degree to which each statement applies to their family (false to true), and (b) how important each routine is (not important to very important or not applicable). The eight subscales are as follows:

- the Child routines subscale, which measures the family's emphasis on establishing predictable routines to promote a child's sense of autonomy and order (Cronbach's alpha = .4; in this study it was .28);

- the Couple togetherness subscale, which measures the family's emphasis on establishing predictable routines to promote couple communication (Cronbach's alpha = .69; in this study it was .74);
- the Meals together subscale, which measures the family's efforts to incorporate family mealtimes into a predictable routine to promote togetherness (Cronbach's alpha = .55; in this study it was .50);
- the Parent-child togetherness subscale, which measures the family's emphasis on developing predictable communication patterns between parents and their children (Cronbach's alpha = .27; in this study it was .53);
- the Family time together subscale, which measures the emphasis that families place on togetherness by including activities such as family time, quiet time and special events in their routine (Cronbach's alpha = .49; in this study it was = .60);
- the Relatives' connection routine subscale, which measures the family's efforts in establishing routines that promote meaningful relationships with relatives (Cronbach's alpha = .27; in this study it was .50);
- the Family chores routine subscale, which measures the family's efforts in establishing routines that encourage child and adolescent responsibilities within the home environment (Cronbach's alpha = .56; in this study it was .78);
- the Family management routines subscale, which measures the family's efforts in establishing routines that promote a sense of family organisation and maintain family order (Cronbach's alpha = .65; in this study it was .27).

The FTTRI has an internal reliability of .88 (Cronbach's alpha) and the validity coefficients range from .19 to .34 with criterion indices of family functioning (McCubbin *et al.*, 1996). The FTTRI had an internal reliability of .87 (Cronbach's alpha) in the present study.

The *Short-Form of the Questionnaire on Resources and Stress (QRS-F)*, developed by Friedrich, Greenberg and Crnic (1983), measures the impact that a child with a disability or chronic illness may have on other family members. The QRS-F is considered to be a general measure of adaptation and coping (Friedrich *et al.*, 1983). The questionnaire consists of 52 true-false questions, has a readability level of Grade 6 and is considered to be a culture-fair measuring instrument (Friedrich *et al.*, 1983; Jansen, 1994). The scale has a KR-20 reliability coefficient of .95 and is divided into four subscales. Factor I, labelled Parent and family problems, assesses the respondent's perception of the problems the family may be facing. Factor II, labelled Pessimism, measures the respondent's immediate and future pessimism regarding the child's prospects of achieving independence. Factor III, labelled Child characteristics, measures the respondent's perception of the specific behavioural or attitudinal difficulties shown by the disabled child, while Factor IV (Physical incapacitation) involves the respondent's perceptions of limitation in the child's physical abilities and self-help skills (Friedrich *et al.*, 1983).

*The Family Attachment and Changeability Index 8 (FACI8)*, an adaptation by McCubbin, Thompson and Elver (1995a) of the Family Adaptability and Cohesion Evaluation Scales (Olson, Portner & Bell, 1989) was used in the present study to measure the dependent variable, namely family adaptation. The questionnaire evaluates family functioning by measuring the family's level of attachment (cohesion) and changeability (flexibility). The scale consists of 16 items with a 5-point Likert scale on which respondents are asked how applicable statements are to their family at present and how often the respondent would like

the item to occur in the family. The measure is divided into two subscales, namely Attachment and Changeability. The Attachment subscale measures the strength of attachment that family members have to one another and the Changeability subscale measures the level of flexibility in the relationship that family members have with one another (McCubbin *et al.*, 1996). The Attachment subscale has an internal reliability of .73 (Cronbach's alpha), while the Changeability subscale's internal reliability is .80 (Cronbach's alpha) (McCubbin *et al.*, 1996). The validity was determined by exploring the FACI8's relationship with the successful outcome of a treatment programme (McCubbin *et al.*, 1996). The internal reliability for the Adaptation subscale in this study was .66 and for the Changeability subscale it was .70.

The above-mentioned instruments measure aspects such as a family's internal strengths and durability, community integration and support, utilisation of social support, problem-solving techniques, routines and communication patterns, which all contribute to the resilience process according to the Resilience Model of Stress, Adjustment and Adaptation (McCubbin *et al.*, 1996).

#### **4.7 Procedure**

After conducting a literature review and writing a proposal, permission was granted by the Ethics Committee of the University of Stellenbosch, Tygerberg Hospital and Western Cape Education Department to conduct the study. The Principals of the various schools were then informed of the study and permission was gained to contact the parents of their learners. Families were either identified by staff members or by the researcher, who worked through the files of the learners. The identified families were approached by the researcher and informed about the study, its aims and what commitment it would entail. Participation was

based on voluntary participation and informed consent. Privacy and confidentiality were valued and all data was coded to ensure anonymity.

A total of 124 families that adhered to the inclusion criteria for the study were identified across the Western Cape, South Africa. However, contact could not be made with 17 families due to incorrect telephone numbers, telephone lines that were disconnected or families that had relocated. Letters informing these specific parents of the study were then sent via the school. Of the 124 with whom contact was made, 54 families accepted the invitation and came for the interviews, while eight accepted but repeatedly missed appointments, and 45 declined. The participants were invited to attend the focus groups at the school of their child with a hearing impairment. The researcher conducted focus groups with the English- and Afrikaans- speaking participants, while two Xhosa-speaking social workers were trained to conduct the assessment and interviews with the Xhosa-speaking participants. Both interviewers received the same instructions regarding the data-gathering process and were supervised by the researcher. Due to the high levels of illiteracy of the Xhosa-speaking participants, they had to be guided through the questionnaires question by question.

The data-gathering process started once participants had again been informed about the study and had given their written, informed consent to participate. The process may be summarised as follows:

- all participants completed a biographical questionnaire (see Addendum B);
- the quantitative phase was introduced whereby participants were required to individually complete questionnaires in the presence of the researcher (see Addendum C);

- this was followed by the qualitative phase, in which the participants were asked the three open-ended questions (see Addendum C). The answers were tape-recorded and transcribed.

The participants each received refreshments and R20.00 remuneration for transport costs. Many made use of school transport, while others were collected at the various taxi ranks and taken to the school. All the interviews were conducted in March and April 2006. The groups were conducted during the morning in the week and on weekends, as was convenient for the participants. The sessions generally lasted two hours.

#### **4.8 Ethical considerations**

Ethical principles and values were implemented to protect the welfare and rights of all the participants and to reflect respect (Ethics in Health Research in South Africa, 2000). A brief discussion will follow that highlights the ethical principles that were upheld throughout the study.

- Respect and dignity

The main principle to be upheld in research is to treat participants with respect (Ethics in Health Research in South Africa, 2000). Factors such as language, culture, customs and perceptions need to be considered. Respect was shown by conducting the groups in English/Afrikaans/Xhosa and in a familiar environment. The participants were also not exposed to any physical or psychological harm.

- Informed consent

Informed consent is the key to ethical research and reinforces respect for freedom of choice (Coady, 2001). All the participants were informed about the nature of the study, as well as of

the benefits and risks involved. They were free to withdraw from the study at any stage. Informed consent was obtained in writing from all the participants before the research commenced (see Addendum A).

- Privacy and confidentiality

Confidentiality was stressed throughout the study in order to respect the privacy of the participants. The participants were free to choose which private information would be shared or withheld. The researcher made contact with the prospective participants to ensure confidentiality. All data was coded to ensure confidentiality. The training of the Xhosa-speaking fieldworkers included maintaining confidentiality and anonymity during data collection.

- Relevance

As a South African researcher one has an ethical and moral responsibility to ensure that the research is relevant to the country's health and development needs, as well as to those suffering from the disability being studied (Ethics in Health Research in South Africa, 2000). The results of the current study will ultimately strengthen the conceptual base needed to frame both preventative and treatment interventions for families with a child with a hearing impairment.

## **4.9 Data analysis**

### 4.9.1 Quantitative data

The quantitative data was analysed using the STATISTICA V8 package (StatSoft, Inc. 2008). All empirical analyses were planned and executed in partnership with a senior statistician at the Statistical Consultation Service of the University of Stellenbosch. The data was analysed predominantly according to correlation and regression analysis techniques.

Spearman's and Pearson's correlations were calculated to determine which independent family variables (measured with the questionnaires) were related to the dependent variable (family adaptation). Spearman's correlations allow one to correlate the relationships between the ranks of variables when no actual values exist. This becomes useful when you have categorical variables that denote rank (D. von Fintel, personal communication, June 3, 2009). The value of the Pearson's product-moment correlation is that it gives information about the strength and direction of the relationship between two variables (Harris, 1998). A positive relationship means that, as scores increase on the one variable, they also increase on the other variable, while a negative relationship means that, as scores increase on the one variable, they decrease on the other (Howell, 1995). To evaluate the significance of the determined correlation coefficients, the 0.05 probability level was used. This implies that, when the probability was 0.05 or less, the null hypothesis ( $H_0: r = 0$ ) was rejected and a correlation was found to exist between the independent and dependent variable.

Multiple regression analysis was also performed to measure whether there is a causal relationship between the dependent and independent variables and what the strength of this relationship is. Best-subsets regression was then used to select the 'best' subset of independent variables for predicting family adaptation.

#### 4.9.2 Qualitative data

The qualitative data was categorised according to themes and frequencies, using grounded theory analysis as described by Strauss and Corbin (in Babbie & Mouton, 2003). This narrative technique promotes sensitivity and is recommended for explorative research (Charmaz, 1995). The following process was followed:

- transcripts were read and initial codes were assigned to the data according to identified themes (open coding);

- focus was then placed on the initial coded themes to determine whether categories should be added or collapsed (axial coding);
- focus was placed on working through the previous codes to identify themes and contrasts in specific cases (selective coding);
- frequencies were identified, i.e. counting how often a theme occurred.

In accordance with Bryman and Cramer's (2004) recommendation, each item applied only to one category. Using the categories, the qualitative data could be quantified in terms of how often a certain theme was mentioned. Trustworthiness of the data was assured through triangulation. Results from the quantitative data were used to verify the information obtained from the analysis of the qualitative data. In addition, it was assured that the results were congruent with the findings of previous research.

#### **4.10 Conclusion**

An exploratory-descriptive research design proved to be best suited to achieve the aims of the descriptive phase of this study. Sampling was based on voluntary participation, and ethical principles were upheld throughout the assessment. Semi-structured interviews, as well as existing quantitative instruments, were used for data collection. The following chapter will highlight the results of the descriptive phase.

## CHAPTER 5

### RESULTS AND DISCUSSION OF THE DESCRIPTIVE PHASE

#### 5.1 Chapter preview

This chapter reports the results of the first phase of the study. The aim of this phase was to identify specific resilience characteristics that are associated with better adaptation in families who have a child with a hearing impairment. Data gathering took place in three stages. Firstly the demographics of the participants were collected via the biographical questionnaire, followed by the quantitative data-gathering questionnaires and the interviews for the qualitative data collection.

The chapter will begin by discussing the quantitative findings. The relationships found between the dependent and independent variables will be illustrated and discussed. This will be followed by the results of the correlation analyses between the coloured and black cultural subgroups, and the results of the multiple regression analysis, which attempted to identify the combination of independent variables that will best predict the dependent variable (namely family adaptation). The qualitative data will then be presented and the chapter will conclude with a discussion of the findings.

#### 5.2 Results of measures

##### 5.2.1 Quantitative findings

###### 5.2.1.1 Correlations between family adaptation and other measured family variables

To statistically determine the relationship of the independent variable with the dependent variable (namely family adaptation), it was assumed that the independent variable in question is not correlated with the dependent variable ( $H_0: r = 0$ ). A statistical analysis was run on the

total sample included in the study, before also exploring the subgroups within the sample based on cultural subgroupings (i.e. black, coloured, white). The families from the white cultural subgroup were excluded from any further analyses, however, due to the small number of participants, and high socio-economic status and educational levels. Further correlation analyses were therefore only conducted on the black and coloured cultural subgroups.

As was discussed in Chapter 4, correlation analyses were calculated to determine the possible relationship between the dependent and independent variables. Table 7 provides a summary of the correlations and significance values found for the total sample. Although Pearson's and Spearman's correlations were calculated, only the Spearman's correlation coefficients were used for interpretation because categorical variables that denote rank were used to describe the measured variables.

Table 7

*Correlations Between Family Adaptation and the Various Independent Variables Measured for the Total Population*

Variable	TOTAL GROUP	
	Spearman's r	p
Family's routines and activities (FTRI Family Total)	0.32	0.02*
Importance assigned to having family time and routines (FTRI Importance Subscale Scores)	0.52	0.00**

Table 7 (continued)

Variable	TOTAL GROUP	
	Spearman's r	p
Family's emphasis on creating predictable routines to promote children's sense of independence and order (FTRI Child Routines)	-0.03	0.82
Family's attempts to create predictable routines to encourage togetherness through mealtimes (FTRI Meals Together)	0.17	0.24
Family's emphasis on creating predictable routines to encourage communication between spouses (FTRI Couple Togetherness)	0.22	0.12
Family's emphasis on creating predictable communications between parents and children (FTRI Parent-Child Togetherness)	0.25	0.08
Family's emphasis on family togetherness including special events, quiet time and family time (FTRI Family Togetherness)	0.30	0.03**
Family's emphasis on establishing predictable routines to encourage children's responsibilities in the home (FTRI Family Chores)	0.47	0.00**
Family's attempts to create predictable routines to encourage a meaningful connection with relatives (FTRI Relative's Connection)	0.15	0.30
Family's attempts to create predictable routines to promote an atmosphere of family organisation and accountability necessary to uphold family order in the home (FTRI Family Management)	0.30	0.03*

Table 7 (continued)

Variable	TOTAL GROUP	
	Spearman's r	p
Family Hardiness (FHI Total)	0.48	0.00**
Family's sense of internal strength, dependability and ability to work together (FHI Commitment)	0.32	0.02*
Family's efforts to be innovative, active and to experience new things and to learn (FHI Challenge)	0.36	0.01**
Family's sense of being in control of family life (FHI Control)	0.30	0.03*
Availability and use of community resources (SSI Total)	0.34	0.01**
Family's ability to actively engage in acquiring family, friend and neighbours support (FC SOC)	0.19	0.18
Family's capability to redefine events to make them more manageable (FC RE)	0.14	0.31
Family's ability to acquire spiritual support (FC SPIR)	0.17	0.23
Family's ability to accept problematic issues minimising reactivity (FC PA)	0.05	0.71
Family's ability to seek out community resources and accept help (FC MO)	0.09	0.50
Relative and friend support (RFS Total)	0.08	0.57
Family's patterns of communication (FPSC Total)	0.55	0.00**
Family's incendiary communication patterns (FPSC Incendiary)	-0.54	0.00**
Family's affirming communication patterns (FPSC Affirming)	0.40	0.00**

Table 7 (continued)

Variable	TOTAL GROUP	
	Spearman's r	p
Family's perception of the behavioural or personality problems as well as cognitive deficits presented by the disabled child (QRS-F Child Characteristic)	-0.24	0.08
Family's pessimism about the child's prospects of achieving self-sufficiency (QRS-F Pessimism)	-0.16	0.25
Family's perception of limitations in the child's physical abilities and self-help skills (QRS-F Physical Incapacitation)	-0.05	0.70
Family's perception of problems they, other family members and the family as a whole face (QRS-F Parent and Family Problems)	-0.57	0.00**

Note: \*  $p < 0.05$       \*\*  $p < 0.01$

As can be seen from Table 7, 14 of the 28 correlations were significant for the total sample. Most of the correlations were positive, with negative correlations being found only between family adaptation and (a) incendiary communication on the Family Problem Solving and Communication Scale (FPSC), and (b) parent and family problems on the short form of the Questionnaire on Resources and Stress (QRS-F).

A graphical example of the significant correlations found between family adaptation and the other measured family variables is provided in the figure below.

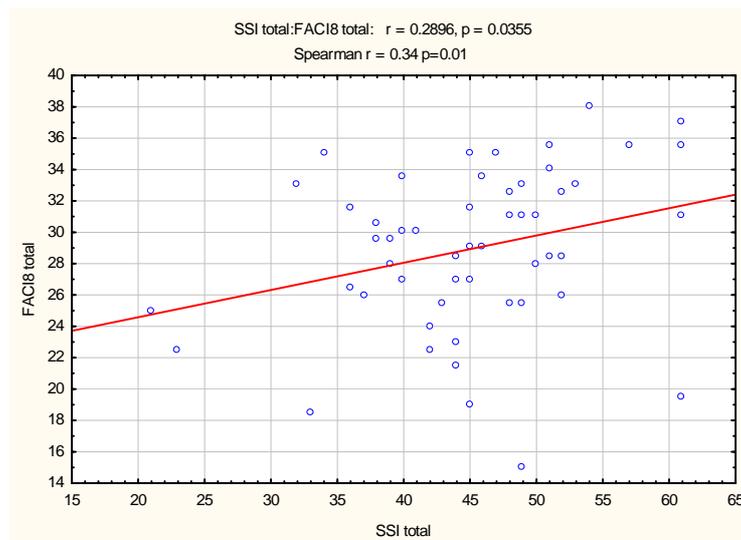


Figure 10. Correlation between family adaptation (FACI8 scores) and finding and using community resources for support (SSI scores).

The scatterplot in Figure 10 indicates a strong positive correlation ( $r=0.34, p < 0.05$ ) between family adaptation (FACI8 scores) and the degree to which the family finds and uses community resources for emotional support, esteem support and network support (SSI scores). This specific correlation is used as a graphical example of the correlations found in the study because it is the resilience quality that will be enhanced in the intervention phase of the study.

Only two biographical variables showed positive correlations with family adaptation, and they will be discussed briefly below.

#### 5.2.1.2 Correlations between family adaptation and biographical variables

Figure 11 below indicates that a positive correlation exists between family adaptation and the number of years the parents have been married. This implies that the longer the marriage of parents, the better the family's adaptation to the disability.

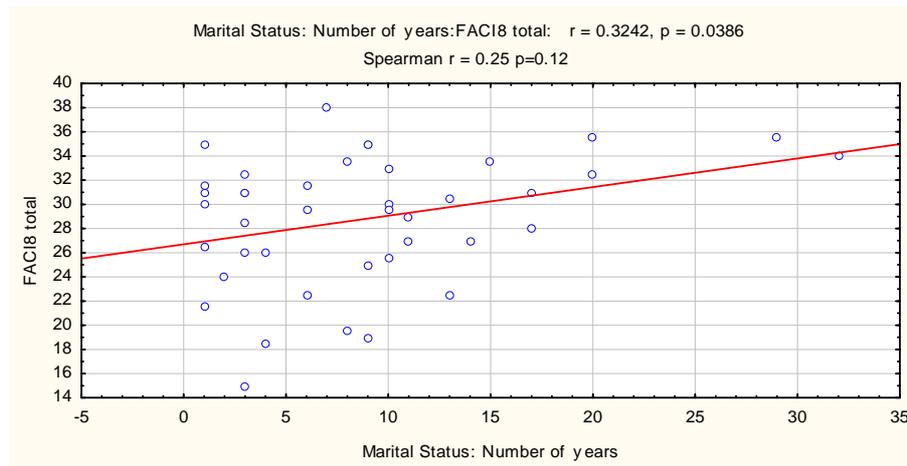


Figure 11. Correlation between family adaptation (FACI8) and number of years married

In addition, when examining family adaptation and employment (see Figure 12), the means of both the employed and unemployed groups fell outside the confidence interval of the other group, indicating a significant difference.

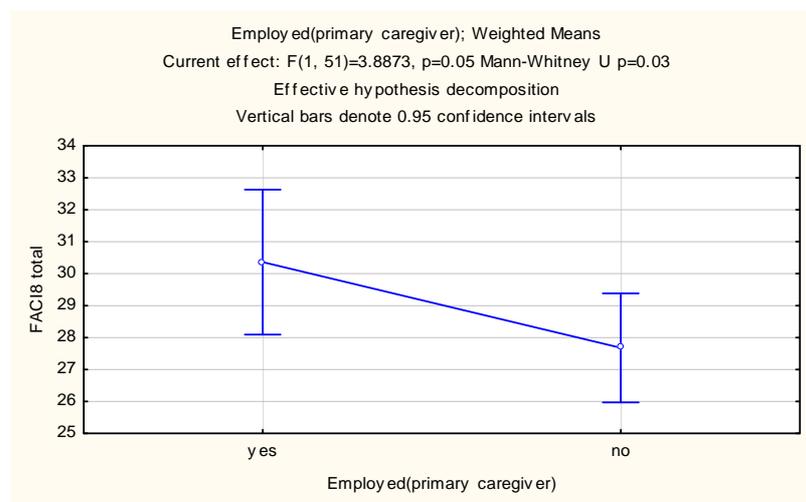


Figure 12. A comparison of family adaptation (FACI8 scores) of families where the primary caregiver is employed or unemployed.

It can be seen from Figure 12 that families in which the primary caregiver is employed appear to adapt more successfully to having a child with a hearing impairment.

The focus will now shift to the correlations found between the dependent and independent variables for the black and coloured cultural subgroups respectively.

#### 5.2.1.3 Correlation analysis for the black and coloured cultural subgroups

The second phase of the statistical analysis entailed calculating the relationship between family adaptation and the measured variables for the black and coloured cultural subgroups respectively (see Table 8). The differences between the correlations for the two cultural groups were then analysed in order to determine whether the relationship between family adaptation and the independent variables differs significantly between the two subgroups (see Table 8). This analysis was achieved by using the Fisher z-test.

Table 8

*Correlations Between Family Adaptation and the Various Independent Variables Measured for the Black and Coloured Cultural Subgroup as well as the Differences Found Between the Correlations*

Variable	Black cultural subgroup		Coloured cultural subgroup		Difference between groups
	Pearson's r	p	Pearson's r	p	p
Family's routines and activities (FTRI Total Score)	0.377	0.092	0.432	0.031*	0.837
Family's emphasis on creating predictable routines to promote children's sense of independence and order (FTRI Child Routines)	0.027	0.909	0.090	0.675	0.846
Family's attempts to create predictable routines to encourage togetherness through mealtimes (FTRI Meals Together)	0.559	0.010**	0.071	0.737	0.083
Family's emphasis on creating predictable routines to encourage communication between spouses (FTRI Couple Togetherness)	0.457	0.037*	0.240	0.258	0.439
Family's emphasis on creating predictable communication between parents and children (FTRI Parent-Child Togetherness)	0.284	0.213	0.096	0.678	0.559

Table 8 (continued)

Variable	Black cultural subgroup		Coloured cultural subgroup		Difference between groups
	Pearson's r	p	Pearson's r	p	p
Family's emphasis on family togetherness including special events, quiet time and family time (FTRI Family Togetherness)	0.283	0.214	0.383	0.059	0.723
Family's emphasis on establishing predictable routines to encourage children's responsibilities in the home (FTRI Family Chores)	0.431	0.058	0.330	0.156	0.730
Family's attempts to create predictable routines to encourage a meaningful connection with relatives (FRTI Relative's Connection)	-0.009	0.971	0.392	0.058	0.188
Family's attempts to create predictable routines to promote an atmosphere of family organisation and accountability necessary to uphold family order in the home (FTRI Family Management)	0.145	0.529	0.571	0.004**	0.121
Family Hardiness (FHI Total)	0.250	0.273	0.724	0.000**	0.040*

Table 8 (continued)

Variable	Black cultural subgroup		Coloured cultural subgroup		Difference between groups
	Pearson's r	p	Pearson's r	p	p
Family's sense of internal strength, dependability and ability to work together (FHI Commitment)	0.085	0.713	0.473	0.020*	0.182
Family's efforts to be innovative, active and to experience new things and to learn (FHI Challenge)	-0.033	0.886	0.637	0.001**	0.013*
Family's sense of being in control of family life (FHI Control)	0.277	0.223	0.507	0.010**	0.389
Availability and use of community resources (SSI Total)	0.397	0.074	0.414	0.040*	0.950
Family's ability to actively engage in acquiring family, friends and neighbours support (FC SOC)	0.396	0.076	-0.091	0.665	0.109
Family's capability to redefine events to make them more manageable (FC RE)	0.245	0.284	0.224	0.281	0.945
Family's ability to acquire spiritual support (FC SPIR)	0.450	0.041*	0.139	0.508	0.278

Table 8 (continued)

Variable	Black cultural subgroup		Coloured cultural subgroup		Difference between groups
	Pearson's r	p	Pearson's r	p	p
Family's ability to accept problematic issues minimising reactivity (FC PA)	0.041	0.859	0.164	0.434	0.696
Family's ability to seek out community resources and accept help (FC MO)	-0.204	0.376	0.188	0.368	0.212
Relative and friend support (RFS Total)	-0.004	0.986	0.043	0.843	0.884
Family's patterns of communication (FPSC Total)	0.636	0.002**	0.555	0.004**	0.690
Family's incendiary communication patterns (FPSC Incendiary)	-0.492	0.023*	-0.496	0.012*	0.987
Family's affirming communication patterns (FPSC Affirming)	0.415	0.061	0.548	0.005**	0.586
Family's perception of the behavioural or personality problems as well as cognitive deficits presented by the disabled child (QRS-F Child Characteristics)	-0.321	0.156	-0.489	0.013*	0.55

Table 8 (continued)

Variable	Black cultural subgroup		Coloured cultural subgroup		Difference between groups
	Pearson's r	p	Pearson's r	p	p
Family's pessimism about the child's prospects of achieving self-sufficiency (QRS-F Pessimism)	-0.357	0.112	-0.107	0.610	0.41
Family's perception of limitations in the child's physical abilities and self-help skills (QRS-F Physical Incapacitation)	-0.096	0.680	-0.332	0.105	0.18
Family's perception of problems they, other family members and the family as a whole face (QRS-F Parent and Family Problems)	-0.736	0.000**	-0.588	0.002**	0.41

Note:  $p < 0.05^*$  and  $p < 0.01^{**}$

As can be seen in Table 8, six variables were associated with family adaptation for the black cultural subgroup, while 12 variables were associated with family adaptation for the coloured cultural subgroup. Three of these variables, namely the family's pattern of communication, incendiary communication patterns and perception of problems, were common to both groups. The other variables found to be associated with family adaptation in the families from the black cultural subgroup are: (a) predictable mealtime routines, which encourage togetherness; (b) predictable routines that encourage communication between spouses; and (c) the ability to acquire spiritual support. For the families from the coloured cultural subgroup, the following variables were found to be associated with family adaptation in addition to the three already mentioned above: (a) family time and routines; (b) predictable routines, which promote an atmosphere of family organisation to uphold order in the home; (c) family hardiness; (d) a sense of internal strength, dependability and ability to work together; (e) efforts to be innovative, active, and to learn and experience new things; (f) a sense of being in control of family life; (g) availability and use of community resources; (h) affirming communication patterns; and (i) the perception of behavioural/personality/cognitive deficits presented by the disabled child.

When examining the differences between the correlations for the black and coloured cultural subgroups (see Table 8), a significant difference was found for only two variables, namely family hardiness (FHI Total score) and the family's efforts to be innovative, active and to experience and learn new things (FHI Challenge). Both these variables were significantly correlated with family adaptation for the coloured cultural subgroup and not for the black cultural subgroup. It appears that the family as a unit and the family's ability to take control is important for, and associated with, better adaptation in the coloured cultural subgroup, while not for the black cultural subgroup. This finding should be explored in future studies.

#### 5.2.1.4 Regression analysis

The third phase of the statistical analyses entailed identifying which combination of independent variables would best predict the dependent variable (family adaptation), as determined by multiple regression analysis. A best-subsets analysis was carried out in order to identify the best predictor variables of family adaptation, as measured with the FACI8. The following tables summarise the results of this analysis performed on the basis of the data obtained for the total sample, as well as for the black and coloured cultural subgroups.

Table 9

*Summary of the Multiple Regression Analysis to Determine which Combination of Independent Variables best Predicts Family Adaptation for the Total Sample (N=54)*

Variable	Beta	B	t(47)	p-level
Family hardiness (FHI Total score)	0.537	0.341	4.988	0.000
Availability and use of community resources (SSI Total score)	0.278	0.164	2.505	0.016
Redefining events to make them more manageable (F-COPES Reformulating)	0.269	0.277	2.355	0.023

According to the above findings (Table 9), the combination of independent variables that were identified by the total population as being the best predictors of family adaptation were family hardiness, the use of community resources, and the ability to redefine stressful life events in a way that makes them more manageable.

By looking at the R-value ( $R = 0.680$ ) obtained in the multiple regression analysis, it is evident that there is a strong positive correlation between the true FACI8 scores and the estimated FACI8 scores, using the measures of the three independent variables highlighted in Table 9. When looking at the R squared value ( $R^2=0.462$ ), one can conclude that the three independent variables listed above account for approximately 46% of the variation in the

FACI8 scores. The significant p-values in Table 9 indicate the importance of including the above-mentioned independent variables in the multiple regression model. Looking at the beta values, one can see that family hardiness is the most important independent variable in magnitude.

Table 10 below represents the regression analysis that was conducted to identify the best predictor variables for the black cultural subgroup.

Table 10

*Summary of the Multiple Regression Analysis to Determine which Combination of Independent Variables best Predicts Family Adaptation in the Black Cultural Subgroup (N=21)*

Variable	Beta	B	t(16)	p-level
Relative and friend support (RFS total score)	0.379	0.284	2.416	0.028
Ability to acquire spiritual support (F-COPES Spiritual)	0.543	0.813	2.875	0.011
Ability to seek out community resources and accept help (F-COPES Mobilising)	-0.511	-0.565	-3.136	0.006
Patterns of communication (FPSC Total score)	0.527	0.519	3.229	0.005

According to the above findings (Table 10), the results for the black cultural subgroup revealed that the family's relative and friend support, their mobilisation of spiritual and community support and their problem-solving and communication skills are statistically significant contributors to the prediction of their family adaptation (dependent variable).

The R-value ( $R = 0.826$ ) obtained in the multiple regression analysis indicates the strong positive correlation between the true FACI8 scores and the estimated FACI8 scores using the measures of the four independent variables highlighted in Table 10. The R squared value ( $R^2 = 0.683$ ) indicates that the four independent variables listed above account for approximately

68% of the variation in the FACI8 scores. Looking at the beta values, one can see that the ability to acquire spiritual support is the most important independent variable in magnitude.

The regression results displayed in Table 10 indicate that families from the black cultural subgroup appear to rely more on community support (i.e. external resources) to enhance their adaptation to having a child with a hearing impairment in the family. This may be reflective of the African concept that all members of the community, family, relatives, tribe and ancestors are involved in caring for one another (Masango, 2005). ‘Ubuntu’, a traditional concept linked to the collective African value system, shapes the relationship between an individual and his/her community by encouraging mutual support and caring for the well-being of others (Nyaumwe & Mkabela, 2007; Smith, 2006). This may explain why external resources appear to be an important coping mechanism for the black cultural subgroup, and why they are willing to make use of them.

Table 11 below illustrates the results of the regression analysis for the coloured subgroup.

Table 11

*Summary of the Multiple Regression Analysis to Determine which Combination of Independent Variables best Predicts Family Adaptation in the Coloured Cultural Subgroup (N=26)*

Variable	Beta	B	t(18)	p-level
Family hardiness (FHI Total score)	0.638	0.384	3.975	0.001
Availability and use of community resources (SSI Total)	0.436	0.276	2.416	0.027

The results in Table 11 indicate that family hardiness as well as finding and using community resources are statistically significant contributors to the prediction of the coloured cultural subgroup’s family adaptation (dependent variable).

The R-value ( $R = 0.803$ ) obtained in the multiple regression analysis indicates the strong positive correlation between the true FACI8 scores and the estimated FACI8 scores using the two independent variables highlighted in Table 11. The R squared value ( $R^2 = 0.645$ ) indicates that the two independent variables listed above account for approximately 65% of the variation in the FACI8 scores. The beta variables indicate that family hardiness is the most important independent variable in magnitude.

From the results in Tables 8 and 11 it appears that families from the coloured cultural subgroup perceive internal resources, such as the family's internal strength, sense of control and organisation, to be more important coping resources than external resources, such as friend or community support. This is reflective of western culture, in which individuality is emphasised. The western world typically rotates around privacy, respect for personal space and self-centeredness (Masango, 2005), not encouraging dependency on others. This may explain why families from the coloured cultural subgroup rely more on internal resources.

### 5.2.2 Qualitative findings

In order to obtain qualitative data for the study, the participants were asked to answer the following three open-ended questions:

1. In your own words, what are the most important factors or strengths, which have helped your family to cope with a child with a hearing impairment?
2. What were the challenges that you had to overcome with regard to having a child with a hearing impairment in your family?
3. What advice would you offer to other families who have a child with a hearing impairment?

Forty-eight of the 54 families responded to the questions posed. Their answers were analysed in order to identify common themes and to identify the prevalence of these themes. A process

of familiarisation, coding and categorising was followed based on principles of Grounded Theory. A summary of the identified themes and the prevalence thereof is provided in Table 12.

Table 12

*Participant's Perspectives on Factors Contributing to Family Resilience (N=48)*

Strengths/resilience factor	No. of responses for total sample (n=48)	%	No. of responses for black subgroup (n=20)	%	No. of responses for coloured subgroup (n=20)	%
School and professional support *	20	42	13	65	7	35
Faith in God	16	33	1	5	14	70
Support from immediate and extended family	15	31	2	10	11	55
Acceptance of child / diagnosis	10	21	4	20	5	25
Viewing the child as God's gift to the family	6	13	2	10	2	10
Patience	4	8	1	5	2	10
Gaining knowledge about the impairment	4	8	1	5	2	10
Support from other parents of children with a hearing impairment	4	8	2	10	1	5
Treating the child as normal	4	8	-	-	3	15

Table 12 (continued)

Strengths/resilience factor	No. of responses for total sample (n=48)	%	No. of responses for black subgroup (n=20)	%	No. of responses for coloured subgroup (n=20)	%
Financial support (disability grant)	2	4	2	10	-	-
Support of friends	2	4	1	5	1	5
Community support	1	2	-	-	1	5
Respect	1	2	-	-	-	-
Use of technology (e.g. hearing aids)	1	2	-	-	1	5
Parents themselves have a hearing impairment	1	2	-	-	-	-
Routine	1	2	-	-	1	5

Note: \* includes doctors, speech therapists, physiotherapists, social workers, teachers, psychologists, organisations for the deaf

As can be seen from Table 12, the factors reported most often by parents as facilitating the adaptation process following the diagnosis of a child's hearing impairment are school and professional support (42%), faith in God (33%), support from immediate and extended family (31%), acceptance of the child/diagnosis (21%) and viewing the child as a gift from God (13%).

A comparison was also made between the responses of the parents in the black and coloured cultural subgroups. The most important factors facilitating the adaptation process in the black cultural subgroup were reported to be school and professional support (65%) and acceptance of the child/diagnosis (20%). In contrast, for the coloured cultural subgroup faith in God

(70%) and support from immediate and extended family (55%) were regarded as the most important factors promoting adaptation to the disability. Although not as significant as for the black cultural subgroup, the coloured cultural subgroup also rated school and professional support (35%) and acceptance of the child/diagnosis (25%) as important. It again appears that the black cultural subgroup perceives external resources as being more important than the coloured cultural subgroup does.

Table 13 reflects the challenges that parents had to face following the diagnosis of their child's disability.

Table 13

*Participants' Perspectives on Challenges that may Impede the Resilience Process (N=48)*

Challenges	No. of responses for total sample (n=48)	%	No. of responses for black subgroup (n=18)	%	No. of responses for coloured subgroup (n=20)	%
Inability to communicate with the child	16	33	6	33	9	45
Child's behavioural problems	11	23	7	39	3	15
To accept and adjust to the diagnosis	10	21	1	6	7	35
Community and peer rejection	8	17	4	22	3	15
Financial constraints	6	13	5	28	1	5
Lack of knowledge regarding the handicap (in the family and community)	5	10	-	-	4	20

Table 13 (continued)

Challenges	No. of responses for total sample (n=48)	%	No. of responses for black subgroup (n=18)	%	No. of responses for coloured sub- group (n=20)	%
Child is cognitively impaired or has other comorbidity	5	10	2	11	-	-
Increased care and attention the child requires	4	8	1	6	2	10
Absent dad / dad who cannot accept the handicap	4	8	3	17	1	5
Child's refusal to wear the hearing aids	4	8	-	-	3	15
Feeling embarrassed / guilty	4	8	-	-	4	20
Unknown future for the child	4	8	2	11	1	5
Parent had to sacrifice his/her job to care for the child	3	6	1	6	2	10
Extended family and strangers' reactions to the child	3	6	-	-	-	-
Handicap is a punishment	3	6	-	-	2	10
Safety of the child	2	4	2	11	-	-

Table 13 (continued)

Challenges	No. of responses for total sample (n=48)	%	No. of responses for black subgroup (n=18)	%	No. of responses for coloured sub- group (n=20)	%
Access to treatment/education	2	4	1	6	-	-
Long travelling distances to treatment programmes	2	4	1	6	-	-
To remain strong in ones faith	1	2	-	-	1	5
To be positive about the child's progress	1	2	-	-	-	-
Having to continue working in order to be able to care for the child	1	2	-	-	-	-

Table 13 indicates that parents believe that the following factors impeded their family's adaptation process: an inability to communicate with the child (33%), behavioural problems presented by the child (23%), difficulties with accepting and adjusting to the diagnosis (21%), experiencing community and peer rejection (17%), financial difficulties (13%), having a lack of knowledge regarding the disability (10%) and having a child that suffers from comorbid conditions (10%).

For the parents in the black cultural subgroup, the following factors seem to have been the greatest challenges that they needed to face: behavioural problems presented by the child (39%), an inability to communicate with the child (33%), financial difficulties (28%), community and peer rejection (22%) and an absent dad/dad who does not accept the diagnosis

(17%). The challenges for the coloured cultural subgroup generally seem to be different from those for the black cultural subgroup. They reported the following difficulties: an inability to communicate with the child (45%), difficulties in accepting and adjusting to the diagnosis (35%), a lack of knowledge regarding the impairment (20%) and feeling embarrassed or guilty about the disability (20%). These factors are all important for ensuring that a family feels in control (internal coping resource) of their life.

The parents were also asked what advice they would offer other parents with a child with a hearing impairment in order to promote their family adaptation process. The results are presented in Table 14.

Table 14

*Participants' Advice to Other Families with a Child with a Hearing Impairment (N=47)*

Advice	No. of responses for total sample (n=47)	%	No. of responses for black subgroup (n=19)	%	No. of responses for coloured sub- group (n=18)	%
Give much attention and love to the child	17	36	2	11	11	61
Seek professional help	14	30	8	42	6	33
Accept the child / diagnosis	12	26	6	32	6	33
Be patient with the child	11	23	4	21	6	33
Treat the child as normal	7	15	1	5	4	22
Actively participate in child's treatment programme	6	13	2	11	4	22

Table 14 (continued)

Advice	No. of responses for total sample (n=47)	%	No. of responses for black subgroup (n=19)	%	No. of responses for coloured sub- group (n=18)	%
Do not be embarrassed	5	11	1	5	4	22
Gain knowledge	4	9	1	5	1	6
Faith in God	4	9	1	5	3	17
Hope	4	9	1	5	1	6
Communicate with the child	3	6	-	-	1	6
Meet other parents with a child with a hearing impairment	3	6	1	5	1	6
Discipline the child	2	4	-	-	1	6
Be positive	2	4	-	-	1	6
Do not overprotect the child	2	4	-	-	1	6
Seek family support	2	4	-	-	1	6
Have ears tested	2	4	-	-	2	11
Ensure hearing aids are permanently worn	2	4	1	5	1	6

Table 14 highlights that the most important advice was to give much attention and love to the child with the hearing impairment (36%). Parents should also seek professional help (30%), accept the child and diagnosis (26%), be patient with the child (23%), treat the child as normal (15%), actively participate in the child's treatment programme (13%), not be embarrassed about the disability (11%), gain knowledge (9%), have faith in God (9%) and have hope (9%).

The parents in the black cultural subgroup would advise others to seek professional help (42%), to accept the child and diagnosis (32%) and to be patient with the child (21%). The coloured cultural subgroup would advise parents to give the child much attention and love (61%) and, like the black cultural subgroup, to seek professional help (33%), to accept the child and diagnosis (33%) and to be patient with the child (33%). In addition, they felt it was important to treat the child as normal (22%), not to be embarrassed about the disability (22%) and to actively participate in the child's treatment programme (22%).

Overall it seems that the biggest challenge faced by a family with a child with a hearing impairment is to accept and adjust to the disability and to communicate with the child. Furthermore it appears that support from professionals and family and faith in God are important factors that promote the adaptation process. The results show that the coloured cultural subgroup believes the family can positively influence the child themselves (61% vs. 11%), while the black cultural subgroup (42% vs. 33%) relies more on external help, as they may feel they have less control over their situation.

A discussion of the results in relation to the theories relating to resilience and hearing impairment will follow below.

## 5.3 Discussion of findings

### 5.3.1 Family demographic variables

The findings of the current study reveal that the longer the parents of a child with a hearing impairment are married, the better the family's adaptation (see Figure 10). Similar findings have been reported by Featherstone (1980) and Suarez and Baker (1997). It was also found that the employment of the primary caregiver is positively related to family adaptation (see Figure 11). Knussen and Sloper (1992) found in their literature review that material resources such as good finances and employment are important resources that can provide resistance against stress in families with a child with a disability. These resources were found to be especially important for mothers, who were also the main respondents in this phase of the study. The employment of the primary caregiver gives the family more financial freedom and ensures easier access to the professional help available within the community. The black cultural subgroup, who reported the highest rate of unemployment, stated that financial problems were one significant factor that impeded their adjustment to the child's hearing impairment (see Table 13).

Studies of family characteristics, such as socioeconomic standing, and family composition, as well as of child variables such as the severity of the impairment and the age of the child, have often been inconclusive, as in the present study (Jansen, 1994; Mapp & Hudson, 1997; Scorgie, Wilgosh & McDonald, 1999).

### 5.3.2 Family time and routines

Children require routine and consistency in order to make the world a safe and secure place. This may be even more important for children with a hearing impairment, for whom the world can be unpredictable due to their limited access to communication. Research has emphasised the important role that routines and family time play in the process of adaptation by creating

stability and continuity within the family system (Greeff & Van der Walt, in press; McCubbin *et al.*, 1996; McCubbin & McCubbin, 1988). A strong positive correlation was also found in this study between the routines and activities used by families and their level of adaptation (see Table 7).

Findings in the current study highlighted that families that emphasise family togetherness showed higher levels of family adaptation (see Table 7). The Resiliency Model has acknowledged family celebrations and time together as an important resource that facilitates adaptation (McCubbin *et al.*, 1996). Taanila *et al.* (2002) found that family togetherness and co-operation, as well as time spent together, are especially important for families with a child with a disability. These findings were also obtained in Greeff and Van der Walt's (in press) study of families with an autistic child.

Family chores routines were also correlated positively with family adaptation in this study (see Table 7). This implies that it is important for families with a child with a hearing impairment to establish routines that promote the children's responsibilities in the home. This may again be related to the increased burden of care the parents face with having a child with a disability. It may also be related to the fact that often both parents need to work in order to carry the increased financial burden and, as a result, the responsibilities of the housework need to be shared. This is also closely related to the finding in this study that a family's efforts to establish routines, which promote a sense of family organisation and order in the home, promote family adaptation (see Table 7). Routines, traditions, celebrations and organisation have been found to be an important resistance resource in the resilience process (Greeff & Van der Walt, in press; Mc Cubbin *et al.*, 1996; Walsh, 2003).

### 5.3.3 Family characteristics

Families who possess family hardiness showed higher levels of adaptation than those with little hardiness (see Table 7). This implies that a family's ability to adjust and adapt is related to their sense of internal strength, dependability, durability and ability to work together. Family hardiness has been identified as an important resistance and family resource in the Resiliency Model and plays a fundamental role in achieving successful adaptation (McCubbin *et al.*, 1996).

According to Table 8, families who depend on one another and are able to work together during times of hardship show higher levels of adaptation. Walsh (2003) described mutual support, collaboration and commitment as factors that promote family cohesion and resilience. Greeff and Van der Walt (in press) also found in their study of families with a child with autism that adaptation is better when the disability is approached as a shared challenge.

Families who are willing to experience new things, to learn, and to be innovative and active show higher levels of family adaptation (see Table 7). According to Walsh (2003), such flexibility is essential for family resilience. It allows families to adapt easier to a stressor because they have the skills and ideas to reorganise their patterns of functioning to meet the demands. McCubbin *et al.* (1996), Smith (2006) and Greeff and Van der Walt (in press) also reported that changes in patterns of family functioning are crucial for successful adjustment and adaptation to a crisis such as a child's disability.

Families with an internal locus of control showed higher levels of family functioning than those who perceived their lives as being shaped by outside influences and out of their control (see Table 7). In this study, it became evident that the coloured and black cultural subgroups' attitudes differ with regard to internal and external control, with the coloured cultural

subgroup perceiving internal control to be more important for adaptation than the black cultural subgroup.

#### 5.3.4 Social support

According to previous research, social support is an important resource that helps alleviate the demands and challenges associated with having a chronic stressor, such as a child with a hearing impairment, and promotes successful adaptation (e.g. Frost Olsen *et al.*, 1999; Judge, 1998; McCubbin *et al.*, 1996; Taanila *et al.*, 2002; Walsh, 2003). The current study also found that a family's level of adaptation is associated with the extent to which they receive support from the community in which they live (see Table 7). The more support they receive, the better the family adaptation.

However, it is interesting to note that the results obtained with other quantitative measures of social support, namely The Family Crisis Oriented Personal Evaluation Scales (F-COPES) and the Relative and Friend Support Index (RFS), did not indicate a similar positive correlation. These findings are similar to those of Smith (2006) and Thiel (2005). The contradiction may be an indication of slight differences in what aspect of social support is measured. The F-COPES measures social support as an external strategy to family problem solving, namely that the family unit makes use of external resources in times of need (Smith, 2006). The Social Support Index (SSI), in contrast, assesses community integration, i.e. whether the family is part of the community and is able to make use of the resources in the community. It could therefore be concluded from the findings of this study that social support, viewed from a cultural prerequisite of integration and connection, is a contributing factor to family adaptation (see Table 7).

The results of the qualitative data support the findings of results obtained with the Social Support Index. Parents reported that access to and support from school and treatment

programmes, the involvement of immediate and extended family members, support from other parents with a child with a hearing impairment, as well as friend and community support all assisted them in the adaptation process (see Table 12). These aspects were found to be significant across the various cultural groups.

### 5.3.5 Communication

A clear positive correlation was found between communication and family adaptation (see Table 7). Based on these findings it can be concluded that family communication and problem solving are highly important mechanisms in fostering family resilience. This corresponds to the empirical findings of, for example, Der Kinderen and Greeff (2003), Smith (2006), Greeff and Van der Walt (in press), Greeff and Van der Merwe (2004), Hawley and DeHaan (1996), McCubbin *et al.* (1996), Patterson (1991) and Walsh (2003).

Family adaptation is enhanced by affirming communication (see Table 7), while it declines when incendiary patterns of communication are used (see Table 7). The quality of the communication within the family provides a good indication of the degree to which families manage tension and strain and obtain a satisfactory level of adjustment, adaptation and family functioning (McCubbin *et al.*, 1996). Therefore a high quality of communication is associated with better family adaptation (see Table 7).

Hearing impairment in the context of the hearing family attacks the backbone of the family structure, namely communication. Verbal and non-verbal channels of communication in the family are altered. The literature suggests that everyday parenting activities, which are critical for conveying social norms, values and acceptable behaviour, may become very challenging when all families members do not have full access to a shared language (Evans, 1995; Freeman *et al.*, 2002). In addition, communication is integral to the emotional bond between parents and children (Yoshinaga-Itano & deUzcategui, 2001). The frustrations and challenges

of not being able to communicate with their child was one of the most significant factors noted by parents in the qualitative data as impeding the adjustment process (see Table 13). Anecdotal evidence from the workshop indicated that most of the families from the coloured cultural subgroup did not attend sign language classes, while families from the black cultural subgroup did so more readily. This again highlights the different perceptions, with the coloured cultural subgroup believing that internal resources are more important than external resources, while the black cultural subgroup readily seeks support from others in the community.

#### 5.3.6 Problem-solving and coping strategies

Parents with a child with a disability have been found to cope better if they use predominantly practical or problem-solving strategies to deal with the child-related problems (Frey *et al.*, 1989). Taanila *et al.* (2002) found that gaining information about the disability was one of the coping strategies used in high-functioning families. A lack of knowledge was one of the most significant factors that the coloured cultural subgroup in this study reported as impeding their adaptation process (see Table 13). Similarly, in two studies conducted by Hartshorne (1993, 2000), parents also rated information as their most important need. McCubbin *et al.* (1996) reported knowledge to be an important personal resource that contributes to successful family adaptation. Anecdotal evidence from the workshop discussions revealed a proudness in the coloured cultural families that seems to impede the process of information gathering, as it may be interpreted as a sign of weakness.

#### 5.3.7 Family appraisal processes

Faith in God was rated by families in this study as an important factor contributing to family adaptation (see Table 12). Faith gives meaning and purpose to the sacrifices the family makes in caring for their child with a hearing impairment. According to McCubbin *et al.* (1996), shared spiritual beliefs are an essential resistance resource in family adaptation. Belief

systems contribute to family resilience by helping families to make meaning out of the adversity and to maintain a positive outlook. Most families find comfort, guidance and strength through spiritual resources, which constitute an important variable in promoting the resilience of the family (Walsh, 2003). Bennett and DeLuca (1996), Greeff and Van der Walt (in press) and Gillard (2002) found that religious beliefs can be particularly supportive and an important resilience factor for families with a child with a disability. Religion helped the parents to initially accept the child's disability and continued to guide them in their efforts to provide their child with the best possible future. Faith was reported by the total sample in this study as one of the most important resilience factors that promote family adaptation (see Table 7). For the coloured cultural subgroup, faith in God was the most important factor helping them to cope (see Table 12).

Adjustment centres around a search for the meaning of the disability. Beresford (1996) identified appraisal as a fundamental component of the coping process. Knussen and Sloper (1992) stated that the parents need to accept the child as she/he is. Gillard (2002) found in a study of children with disabilities that the redefinition of crisis situations assisted in the adaptation process. Accepting the child and diagnosis was reported by parents in this study to be one of the important resilience factors that assisted them with adjusting and adapting to the disability (see Table 12). Many, however, also reported that this was one of the greatest challenges they had to face (see Table 13).

#### **5.4 Conclusion**

The qualitative and quantitative findings of this study yielded results that are supported by previous research. This implies that the Resiliency Model can be used successfully to outline variables that promote better adaptation in families that have a child with a hearing impairment. Family time and routines, family hardiness, social support, affirming communication, problem-solving skills, faith in God and ascribing meaning to the disability

were some of the qualities identified as enhancing family functioning and adaptation to the diagnosis of a hearing impairment.

The following chapter will highlight the intervention phase of this study, which entailed developing, implementing and evaluating a psycho-educational programme designed specifically to promote adaptation in families with a child with a hearing impairment.

## CHAPTER 6

### INTERVENTION PHASE

#### PROGRAMME DEVELOPMENT, IMPLEMENTATION AND EVALUATION

##### 6.1 Chapter preview

This chapter focuses on the intervention phase of the study and is divided into two main areas. Firstly, an overview will be provided of the theoretical framework guiding the development of the resilience-based, family-focused programme. Focus will then be placed on the development, implementation and evaluation of the social support programme.

##### 6.2 Theoretical frameworks guiding the programme development

In reviewing recent literature on programme development, various theoretical models were identified that could serve as a general conceptual basis for intervention in the current study (e.g. psychodynamic, cognitive-behavioural, systems, community, narrative and psychosocial models). The researcher, however, decided that the most effective therapeutic model for the design and development of the social support programme would be psycho-education and adult education, grounded in a family resilience orientation. The reasons for this decision will be highlighted in the discussion below.

###### 6.2.1 Family resilience

A family resilience framework has been found to provide valuable conceptual guidelines for interventions aimed at supporting and strengthening vulnerable families (Walsh, 2002). The framework can be used with a variety of intervention models and has been applied to crises such as serious illnesses, disability and loss (Walsh, 2003). The framework is suitable for this specific study as it provides a map to describe and target the central family processes (as discussed in Chapter 2) that have been found to lower the risk for dysfunction and promote healing and growth following the diagnosis of a child's hearing impairment (Walsh, 2002).

The advantages of using the family resilience framework in the present study are numerous. Firstly, the framework focuses on strengths rather than on deficits and thereby provides a positive and empowering form of intervention. Secondly, it provides guidelines for developing an intervention for a specific target group, as it acknowledges that all families are unique and no single model will be appropriate for all families. Thirdly, it acknowledges that family functioning varies over time and across the family's life cycle (Walsh, 2002).

### 6.2.2 Psycho-education

Psycho-education is an evidence-based practice that combines multiple strategies of intervention drawn from well-established theories and practices (Brendtro & Long, 2005). Psycho-education as a framework was influenced by various psychological theories, the most prominent being the existential-humanistic models, behavioural and cognitive models, and general systems theory (Fouche, 1995). Having drawn knowledge from various theories has ensured that psycho-education is integrated, holistic, systemic, comprehensive and functional and can be implemented across cultures (Wood, Brendtro, Fecser & Nichols, 1999).

In practice, the facilitator focuses on prevention rather than cure, and on the development of the client's potential rather than the elimination of pathology (Fouche, 1995), thereby reinforcing the strength-orientated paradigm in the current study. Clients are viewed as advocates in their own learning and recovery, rather than as passive beings, reinforcing the concept of empowerment. The learning experiences are designed in such a way as to bring about behavioural, emotional and interpersonal change over time (Marshall, 1990).

The premise for using psycho-education in the current study was based on Walsh's (1996) finding that multifamily psycho-educational groups are suitable for enhancing family resilience. Psycho-educational family interventions have already been implemented successfully with children suffering from asthma, diabetes and cystic fibrosis (Goldbeck &

Babka, 2001). In addition, psycho-educational programmes can provide families with skills that have found to be especially important for families who have a child with a hearing impairment, namely practical information, problem-solving skills and social support (Walsh, 1998; 2003). Research has also shown that psycho-education can be used successfully in enhancing the acceptance of an illness or disability, promoting co-operation with treatment, and enhancing the parents' sense of dignity and self esteem (Hayes & Gantt, 1992; Swanson, Pantaloni & Cohen, 1999).

Roos, Kunzman, Prinsloo and Alant (2000) proposed a number of steps that need to be followed in order for any psycho-educational intervention to be successful, namely:

1. Problem-identification
2. Situation analysis
3. Development of the intervention
4. Evaluation
5. Implementation
6. Re-evaluation and adaptation

Since the intervention was aimed at the parents of children who have a hearing impairment, cognisance had to be taken of how adults learn. As a result, the principles of adult education were explored and it was found that the model developed by Roos *et al.* (2000) correlates closely with the models proposed by adult education theorists. In addition, the adult education paradigm is embedded in the philosophy of psycho-education (Greeff, 2003). As a result, the principles of psycho-education and adult education were merged in the current study in order to plan, design and implement the social support programme. A discussion of adult education follows below.

### 6.2.3 Adult education

Most research on programme development has been conducted in the field of adult education, with researchers such as Tyler (1949), Houle (1996), Knowles (1990), Sork (2000) and Caffarella (2002) playing key roles in developing models that guide programme planning. Sork and Caffarella's (1989) model for systematically planning educational programmes links well with the steps proposed by Roos *et al.* (2000). The six steps of Sork and Caffarella's (1989) model are: (1) analyse planning context and client system; (2) assess needs; (3) develop programme objectives; (4) formulate instructional plan; (5) formulate administrative plan; and (6) design programme evaluation.

Caffarella (2002) expanded on the above six steps to develop a comprehensive, interactive model, based on the evaluation of previous programme planning models. Caffarella's (2002) interactive model of programme planning was applied in the present study, as it allows for the merging of theories, provides a clear mission and has been researched. The model is embedded within seven major assumptions, namely:

1. The focus is on learning and how this learning results in change.
2. Recognition of the non-sequential nature of programme planning.
3. Discernment of the magnitude of context and negotiation.
4. Attendance to preplanning and last-minute changes.
5. Heeding and honouring of diversity and cultural differences.
6. Acceptance of different ways of working when programmes are planned. No single method of planning ensures success.
7. Understanding that programme planners are learners too; reflection and evaluation will strengthen individual abilities (Caffarella, 2002; Marshall, 1990).

Caffarella (2002) illustrates her model with a concentric spherical graph that includes 12 spokes that highlight the building blocks required for effective programme planning (refer to Figure 13). The steps are cyclic in nature and interdependent, and can at any time influence each other or cause a change of direction in the process. Due to the cyclic nature of the model, steps can be skipped temporarily, or work can be done on several tasks simultaneously.

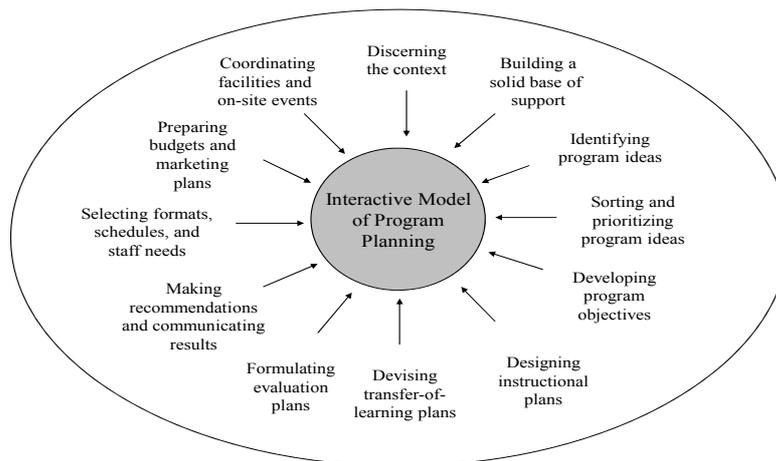


Figure 13. Interactive model of programme planning (Caffarella, 2002).

Figure 13 above highlights the twelve tasks involved in effective programme planning, namely: (1) discerning the context; (2) building a solid base of support; (3) identifying programme ideas; (4) sorting and prioritising programme ideas; (5) developing programme objectives; (6) designing instructional plans; (7) designing transfer of learning plans; (8) formulating evaluation plans; (9) making recommendations and communicating results; (10) selecting formats, schedules and staff needs; (11) preparing budgets and marketing plans; and (12) coordinating facilities and on-site events.

The above tasks guided the development and implementation of the social support programme, which will be discussed in greater detail below and is attached in Addendum E and F.

## **6.3 Development, implementation and evaluation of the Social Support Programme**

### 6.3.1 Discerning the context

The first step of Caffarella's model involves learning about the target group and its context (Caffarella, 2002). The researcher familiarised herself with the target group and their possible needs, by drawing from her previous experience and research, reviewing recent literature and conducting interviews with relevant stakeholders.

### 6.3.2 Building a base of support

This step involved gaining support from the key groups and stakeholders (Caffarella, 2002; Marshall, 1990). The researcher met with the relevant authorities and introduced the proposed study to them. A research proposal was written and submitted to the authorities for their approval. Permission was gained from the Western Cape Education Department, the University of Stellenbosch, the Ethics Committee of the University of Stellenbosch and the principals of the various schools involved.

### 6.3.3 Identifying programme ideas

This step involved identifying the methods to be used for identifying possible programme topics. Techniques include observation, questionnaires, interviews and community forums (Caffarella, 2002; Marshall, 1990; Sork, 2000). Questionnaires and open-ended questions were used during the initial phase of the study to identify which key family processes enhance resilience in families with a child with a hearing impairment. Based on the findings of the initial phase of the study, the literature review and the specific needs raised by the various schools involved in the study, an intervention plan could be formulated in the form of a family resilience, psycho-education programme that, focuses on enhancing the utilisation of social support.

#### 6.3.4 Sorting and prioritising programme ideas

Through this step, decision making regarding the type of intervention was made easier. Various forms of interventions have been proposed to help families with a child with a disability. Traditionally, intervention programmes have focused on promoting the child's development, but with the evolution of the stress and adaptation models it has become a priority to include parents and other family members in programmes (Pelchat, Bisson, Ricard, Perreault & Bouchard, 1999). A discussion will follow below to highlight some of the programmes developed for families with a child with a disability, followed by a discussion of studies that focus specifically on people with a hearing impairment.

Pelchat and Lefebvre (2004) developed a programme for families who have a child with Down's syndrome or cleft lip/palate. The primary purpose of the programme was to help family members adapt to the situation. The development of the programme was based on the psychodynamic theory of crisis resolution, the theory of stress and adaptation, the family stress management model and the systemic approach. The intervention consisted of six to eight meetings between the parents and a nurse. The results indicated that the parents were better adapted to their situations, experienced less stress and emotional problems, were more autonomous and were better equipped to cope with their parental responsibilities (Pelchat & Lefebvre, 2004).

Pelchat *et al.* (1999) assessed the longitudinal effects of an early intervention programme developed for parents of children with a disability. Better adaptation was shown among the participants in terms of lower levels of parental stress, more positive perceptions of the child's disability, more confidence in their own resources and the help available from others, lower levels of anxiety and depression and a perception of more emotional support from the spouse (Pelchat *et al.*, 1999). The gains were maintained and were similar for mothers and fathers.

Goldbeck and Babka (2001) developed, implemented and evaluated a psychoeducational programme for families who have a child with cystic fibrosis (CF). The aim was to enhance the families' coping with CF-related problems. The groups met three times for four hours. Due to the small sample size, the results were preliminary and no changes were seen in the parental coping patterns or health beliefs (Goldbeck & Babka, 2001).

Levitz (1991) developed a guidance programme that could be used by counsellors when guiding parents in the care and education of their children with a hearing impairment. The programme aims to help the parents accept their child with a hearing impairment, to have faith that their child is educable, and to provide the parents with the necessary knowledge, skills and attitudes to inspire commitment to their child's education (Levitz, 1991). The programme focuses on the following four main themes: (1) emotional effects of having a child with a hearing impairment and the attitudes parents may display towards their child; (2) gaining knowledge about deafness, e.g. the anatomy of the ear and causes of hearing impairment; (3) providing knowledge about the impact of deafness on the child's language, cognitive, emotional and social development; and (4) increasing positive attitudes in the parents towards the possibility of educating their child and then participating in the child's education (Levitz, 1991).

Kargin (2004) investigated the effectiveness of a family-focused, early intervention programme, developed for families who have a 0- to 4- year old child with a severe or profound hearing impairment. The intervention phase lasted seven weeks and the findings indicated that the programme improved the communication skills of the children and provided information to the parents according to their specific needs.

A few of the schools that cater for children with hearing impairments in South Africa adapt a number of overseas programmes. The schools promoting oral methods of communication

mainly use and adapt those programmes that focus specifically on promoting the development of speech in children with hearing impairment. The programmes are not offered on an ongoing basis, however, and are typically adjusted for each child's and/or family's individual needs (R. de Villiers, personal communication, June 22, 2007). A brief discussion will follow on what programmes are typically utilised at the schools:

(a) John Tracy Clinic: Distance Learning for Parents – this programme consists of 10 lessons that focus on communication skills. Each lesson addresses the overall growth of the child and activities are suggested to encourage auditory learning and language skills through enjoyable tasks and games (John Tracy Clinic, 2008);

(b) Listen, Learn and Talk – this consists of three videos that demonstrate habilitation strategies that can be used in the home environment. The focus is placed on the importance of parent participation and it describes the types of listening strategies and the stages of normal development of communication skills (Cochlear, 2008);

(c) Speech Perception Instructional Curriculum and Evaluation – this curriculum is designed for developing listening skills in children with cochlear implants and hearing aids. It should be used to provide guidance in selecting objectives for the specific child, in practising targeted skills and in evaluating progress in reaching these objectives. Goals for the curriculum are listed in four categories: Detection, Suprasegmental perception, Vowels and consonants, and Corrected speech (Biedenstein, Davidson & Moog, 1995);

(d) Developmental Approach to Successful Listening II – this is a step-by-step listening programme to help children and adults with hearing impairment develop and use their residual hearing (Goldberg Stout & Van Ert Windle, 2009); and

(e) the Teacher's Assessment of Grammatical Structures – this programme was developed to evaluate a child's understanding and use of the grammatical structures of English and to suggest a sequence for teaching these structures (Moog & Kozak, no date).

Programmes are then also offered to parents for learning basic parenting skills. These include (a) Systematic Training for Effective Parenting – this is a programme that teaches positive approaches to understanding and raising children. Parents are taught to appreciate that children's behaviour is motivated by a variety of goals, and that they should be encouraged to become the best that they can (Center for the Improvement of Child Care, no date); and (b) the Love and Logic Programme, which provides simple and practical techniques to help teachers and parents raise responsible children (Love and Logic, 2009). Unfortunately, those schools that cater for children with hearing impairment that are situated in the townships do not have access to any specific programmes (R. Dalvi, personal communication, June 22, 2007).

Reviewing the literature, it appears that family interventions are a promising strategy in the treatment of children with disabilities (Goldbeck & Babka, 2001; Levitz, 1991). Psycho-educational family interventions have been implemented successfully for children suffering from asthma, diabetes and cystic fibrosis, for example (Goldbeck & Babka, 2001). No suitable, existing workable programme could be identified for the current study and, as a result, a new programme had to be developed. However, note was taken of those existing programmes that utilised a similar format, structure and mode of presentation. Examples of such programmes are: (1) A Parent Guidance Programme for the Education of Deaf Children (Levitz, 1991); (2) The Strengthening Families Programme (Kumpfer, 1994); (3) A Psycho-Educational Programme for Families with a Child Affected by Cystic Fibrosis (Goldbeck & Babka, 2001). Ultimately an eclectic approach including systems theory (Minuchin, 1974), cognitive behavioural therapy (Hawton, Salkovskis, Kirk & Clark, 1989), person-centred

therapy (Rogers, 1957), and aspects of Walsh's (2003) resilience model were used to develop a social support programme for this study.

### 6.3.5 Developing programme objectives

This step included providing a description of what the participants would learn, as well as what changes should occur as a result of the intervention (Caffarella, 2002). The objectives should focus on the learning process that takes place within the group and can then serve as a benchmark against which any progress can be measured. Objectives should be established at the beginning of the programme planning to ensure that the content and presentation methods are geared towards achieving the desired goals (Simerly, 1990).

Following the needs assessment, and in keeping with the principles of family resilience, psycho-education and adult learning, the main aims of the programme were to:

- challenge and change the existing *attitudes* that the participants have about social support;
- provide *knowledge* about social support; and
- provide the *skills* required to mobilise family, friend and community support networks.

The following aims and objectives were established for each session in order to achieve the desired goals:

#### Session 1: Introduction

Aims:           1) To establish group cohesion.  
                   2) To familiarise the participants with the groupwork process and the content of the workshop.

Objectives:   1) Gain consent from participants.  
                   2) Complete the pre-test measure.

- 3) Formulate group norms.
- 4) Provide an overview of the programme.

#### Session 2: My social support network

- Aims:
- 1) Gain an understanding of the concept social support.
  - 2) Develop awareness that social support enhances resilience.
  - 3) Convey confidence that social support networks can be strengthened.
- Objectives:
- 1) Define social support.
  - 2) Identify present support systems and the possible need for additional support.
  - 3) Identify how the present support system is helpful.
  - 4) Identify the different types of support.

#### Session 3: The benefits of social support

- Aims:
- 1) Maximise the participants' utilisation of their personal social network as a source of support and resource for meeting their needs.
  - 2) Empower participants so that they become more competent in being able to mobilise resources, get their needs met and achieve desired goals.
- Objectives:
- 1) Identify the importance and benefits of social support.
  - 2) Identify that basic needs can be met through a social support network.
  - 3) Establish a plan to effectively utilise their existing social support network to meet their unmet needs.

#### Session 4: My beliefs about social support

- Aims:
- 1) Cognitive restructuring and behaviour modification required to develop a social support network.
- Objectives:
- 1) Identify irrational beliefs that keep from seeking social support.

- 2) Dispute and redefine irrational beliefs.
- 3) Maintain existing supportive relationships.

#### Session 5: Increasing my social support network

Aims: 1) Develop skills to nurture and maintain existing relationships with significant others.

2) Build vital community networks.

Objectives: 1) Apply newly learnt knowledge and skills to increase their current social support network.

2) Identify available resources within the community.

#### Session 6: Conclusion

Aims: 1) Reflect on the knowledge and skills obtained.

Objectives: 1) Review the day's work.

2) Complete the post-test measure.

3) Evaluate the workshop.

The researcher attempted to establish aims and objectives that were inspirational, contained a sense of urgency, reflected professional knowledge and appeared practical (Simerly, 1990).

#### 6.3.6 Designing instructional plans

This consisted of three processes, namely preparing objectives for each session (discussed above), selecting learning material for the sessions, and selecting aids that enhance the techniques incorporated to present the learning material (Caffarella, 2002).

When planning the content of the programme, the aim was to promote the acquisition of knowledge, to build skills and to change the attitudes of the participants towards the

utilisation of social support. In addition to the content, the format and structure of the sessions had to be planned carefully in order to enhance the effectiveness of the programme.

#### 6.3.6.1 Format of the programme

Generally, three kinds of formats are used in programmes: (1) formats for individual learning; (2) formats for small-group learning; and (3) formats for large-group learning (Caffarella, 2002). In the present study, the programme was presented to small groups and, for this, the most suitable training formats generally are: (a) course/class, (b) seminar, (c) workshop, (d) clinic, or (e) trip/tour (Caffarella, 2002; Houle, 1996). It was decided to present the programme in the form of a workshop for the following reasons: (1) a workshop emphasises skills development in a defined content area (Caffarella, 2002; ); (2) it focuses on active participation and experiential learning, the means by which adult learning are stimulated (Henderson, 2006); (3) it can encompass a single information/skill session lasting only an hour, or may include a series of modules and activities over a period of time, depending on the needs, objectives, costs involved and feasibility (Henderson, 2006); and (4) cost-effectiveness. The workshop was presented in one day to overcome the transport and financial constraints that most participants are faced with. In addition, it was hypothesised that attendance would deteriorate over the weeks due to the practical difficulties most parents face. According to Munson (1989), a narrowly focused programme can be implemented effectively in one day if a proven, adult learning process is followed.

#### 6.3.6.2 Structure of sessions

Each session followed the same basic design to ensure continuity and to make the presentation easier. The group sessions were guided by the aims and objectives and included ice breakers, lecturing, group discussions and experiential learning (see manual, Addendum E). The programme consisted of six sessions. Each session was limited to an hour, with two 15-minute breaks in the morning and afternoon respectively, and an hour-long lunch break.

Refreshments and meals were served throughout the day. To ensure participant interest and involvement, periods of straight lecturing were limited to 10 minutes (Munson, 1989). Adequate time was built into the programme for participants to share their experiences, problems and successes. Through these social activities the participants could experience firsthand the benefits of social support.

#### 6.3.6.3 Content of sessions

The choice of topics covered in the programme was based on the factors identified in the literature review and needs assessment as being associated with enhancing resilience in families with a child with a hearing impairment. In addition, the choice of topics was also guided by themes from the pre- and post-test measure (Social Support Index) and Walsh's (2003) theory of key family processes. Notice also had to be taken of the background and experience of the participants, the time available, and the space, equipment and materials required for the presentation of the contents.

#### 6.3.6.4 Techniques

When designing a programme with the aim of presenting information and enhancing the learning process, it is advisable to use a combination of techniques (Henderson, 2006). Techniques should promote the achievement of the desired goals and should be selected on the basis of: (1) the level of active group participation they allow; (2) how well they match the programme objectives; and (3) whether they correspond to the participants' backgrounds and educational levels (Caffarella, 2002; Knowles, 1970).

Cognisance must be taken of the various adult learning styles when deciding which techniques to incorporate. The preferred adult learning styles are: (1) passive learning, which includes lectures and formal presentation; (2) active, concrete learning, which includes exercises, group discussion and role playing; (3) scientific experimentation learning, which

includes presenting papers, emphasising cognitive knowledge; and (4) balance learning, which incorporates all of the above (Knowles, Holton & Swanson, 1998).

It was hypothesised that the participants in the programme would be heterogeneous in terms of their learning styles and therefore a combination of approaches was used to present the content. All sessions included activities appropriate to the session themes and objectives. Factual information was presented in the form of a lecture and Power Point presentation, followed by exercises to promote active participation by group members. The exercises included worksheets, role-playing, experiential learning activities, a video clip and interactive group discussions. The exercises and discussions allowed the intervention to be attuned as much as possible to each family's unique needs, challenges, resources and strengths. The manual provides the facilitator with the lecture material and instructions for and purpose of the activities, guidelines for discussion topics, and worksheets or aids that can be copied and handed out to participants (see Addendum E). The researcher aimed to develop a logical, easy-to-follow programme to facilitate the learning process.

#### 6.3.6.5 Group composition

The 31 participants were randomly assigned to either an experimental or a control group, with 20 participants in the experimental group and 11 in the control group. The participants in the experimental group attended the social support programme and completed a pre- and post-test evaluation. The control group completed the pre-test evaluation and was exposed to an experiential learning activity that focused on effective communication. The purpose of the activity was to increase awareness of and to promote clear direct communication using verbal and non-verbal communication techniques. The activity was processed by discussing how the participants felt during the activity and what insight they had gained. The group was then provided with an opportunity to discuss the challenges they experienced in having a child with a hearing impairment and to raise their specific needs. The session lasted approximately

90 minutes. The participants in the control group were invited to return in three months for the post-test evaluation and treatment programme.

#### 6.3.6.6 Participants

Parents were chosen as participants in the programme as they are the core of the family system (Pelchat & Lefebvre, 2004). Although both parents were invited and encouraged to attend, few were able to attend as a couple.

#### 6.3.6.7 Facilitator

A formal, detailed manual was developed for the facilitator according to the guidelines suggested by Munson (1989). The manual included a: pre-workshop check-list, the objectives for the whole workshop and for each session, a summary overview of each session, a prescribed sequence of subject matter to be presented, suggested remarks for the facilitator to introduce the material and to bridge each section, visual material cues, and questions for leading group discussions (see Addendum E).

The effectiveness of a programme is highly dependent on the facilitator's efficacy and characteristics (Kumpfer & Alcarado, 1998). An attempt was made to include techniques such as listening, reflecting, clarifying, questioning, paraphrasing, summarising, humour and flexibility when presenting the programme. In addition, the facilitator continuously monitored the implementation of the programme by asking the following questions, suggested by Moynihan *et al.* (2004):

- Is the workshop sticking to its timetable?
- Are participants learning what the exercises intend?
- Is the behaviour of participants towards each other friendly and respectful?
- Is any participant dominating the discussion? Should it be addressed?
- Is any participant staying quiet? Should it be addressed?

- Are participants learning throughout the workshop? Are there enough breaks?

Using the above-mentioned techniques and by continuously monitoring the process, warmth, genuineness, empathy, respect, acceptance, and understanding were reflected.

#### 6.3.6.8 Ethical considerations

Two basic ethical principles governed the data collection, namely (1) the principle of informed consent, and (2) protecting the participant's right to privacy (Oppenheim, 1992). The participants were briefed thoroughly about the nature of the research, the benefits and risks of the research, and that they were free to withdraw from the programme at any stage. Informed consent (see Addendum C) was obtained in writing from the participants before the programme commenced. Participation was on an entirely voluntary basis.

In order to protect the participants' privacy, all questionnaires were completed anonymously. All data was treated with confidentiality by ensuring that the data was coded and that no identifying material was disclosed to anyone. The facilitator and independent rater were expected to hold themselves to high ethical standards and to respect confidentiality.

#### 6.3.7 Devising transfer-of-learning plans

This step involved selecting strategies that will assist the participants in applying what they have learnt (Caffarella, 2002). The participants were provided with workbooks that consisted of worksheets and summaries of the lectures (see Addendum F). Workbooks have been described by Munson (1989) as being the most useful learning aid. Participants actively used the workbook during the programme and were encouraged to take it home. The participants were also provided with opportunities to practise and apply newly learnt skills within the group session to ensure a positive and motivational attitude towards applying the skills in their home environment.

### 6.3.8 Formulating evaluation plans

Programme evaluation determines whether a programme is achieving its aims and objectives and assesses the value or worth of the programme (Wickham, 1998). Programme evaluation is useful and important because it (1) assists goal-directed programme execution, (2) serves as a reference guide for decision making; (3) explicates programme strengths and weaknesses, (4) allows for programme accountability, (5) highlights the achievements of the programme, and (6) suggests avenues for future research (Houle, 1996).

Programme evaluation can be quantitative or qualitative, formative or summative (Warren, 2000). Formative evaluations, which are conducted while the programme is being developed and implemented, are used to determine how a programme can be improved, while summative evaluations focus on measuring whether the programme was implemented as planned and whether the aims were achieved (Warren, 2000). The seven most widely used techniques for collecting evaluation data are: observations, interviews, written questionnaires, tests, trainee products, records and documents (Caffarella, 2002). According to Wickham (1998), the following questions should be asked when evaluating the programme:

1. Has the programme achieved its objectives and/or goals?
2. Have the anticipated outcomes been reached without unreasonable costs or undesirable side effects?
3. What difficulties are being/were encountered and how are/were these dealt with?
4. What are/were the strengths of the programme?
5. What are/were the weaknesses or absences?
6. What could have been done better or differently?

Since evaluation should occur at the onset of the programme, during the programme and after some time has lapsed since the completion of the programme, a pretest-posttest research design was employed in the current study (Caffarella, 2002; Levitz, 1991; Wickham, 1998).

Both the experimental and control group were measured at the onset of the programme, at the end of the programme and three months after the completion of the intervention. Through the allocation of participants to the control and experimental groups, the intervention (i.e. programme for experimental group and activity for the control group), methodological considerations and data-analysis it was ensured that any possible differences in post-test results could be attributed to the impact of the intervention.

It is extremely difficult to evaluate every aspect of the programme and it is recommended that the researcher decides on priorities to be evaluated and then develops an evaluation plan around the most important aspects of the programme (Wickham, 1998). In this study, the focus of evaluation was thus on whether the stated goals/objectives were achieved.

Evaluation in this study was summative, quantitative and qualitative, with a focus on what knowledge, skills, attitudes and behaviours were acquired and/or changed in the participants. An independent rater was present to ensure that the facilitator strictly adhered to the manual and that the programme was implemented as planned. The Social Support Index (McCubbin *et al.*, 1996), which measures the family quality addressed in the programme and which was utilised in the descriptive phase of the study, was used to evaluate the effectiveness of the programme (see Addendum B). Participants also completed structured questionnaires reflecting on their experiences of the programme, whether knowledge was gained, and whether the workshop was presented in a learner-friendly manner (see Addendum G).

The impact of the programme was determined through pre- and post-test evaluation. The Social Support Index (McCubbin *et al.*, 1996) seemed to be the most appropriate/suitable measuring instrument available for the pre- and post-test evaluation of the construct social support in a target population of parents with a child with a hearing impairment.

The goals of the evaluation were to:

1. determine whether there was a significant difference between the experimental and control group following the treatment, i.e. whether there was any change in the participants utilisation of social support following the workshop;
2. determine whether the workshop content was appropriate for the target group of parents;
3. determine whether the presentation techniques were effective in promoting the aims of the workshop;
4. determine whether the workshop increased the *knowledge* of the parents, relevant to increasing the adaptation of the family; and
5. determine whether the workshop furthered the development, clarification and/or change of the *attitudes* that promote the healthy adaptation of the family.

During the evaluation, confidentiality was honoured by letting the participants complete the questionnaires anonymously. Care was taken to respect the dignity and self-worth of the participants, and to ensure the honesty and integrity of the entire evaluation process.

Methodological considerations regarding the evaluation will be discussed in Chapter 7.

### 6.3.9 Making recommendations and communicating results

See Chapters 8 and 9 for an in-depth discussion of the results and recommendations respectively. An article will be submitted to an academic journal and all stakeholders involved in the study will receive a copy of this article and the programme. The study will also be presented at a conference.

### 6.3.10 Selecting formats, schedules and staff needs

This step refers to and correlates with the development of the instructional plan discussed in Section 6.3.6.3.

### 6.3.11 Preparing budget and marketing plans

This step involves determining the costs involved in developing, implementing and evaluating the programme (Caffarella, 2002). Expense items included instructional materials, facilities, travel, food and general administrative overheads. A summary of the budget is provided in Table 15 below.

Table 15

*Budget for the Development, Implementation and Evaluation of the Programme*

Description	Amount
Personal compensation	
Translator	R1000.00
Cutting DVD	R 560.00
Consulting services	
Statistical services	R1300.00
Travel	
Travel to schools	R 500.00
Telephone, cell phone, fax & internet	R1500.00
Office supplies	R1000.00
Courier & postage	R 100.00
Printing & copying	R 500.00
Hiring of hall	R 600.00
Refreshments & meals	R1725.00
Incentives	R2080.00
<b>Total expenditure</b>	<b>R10 865.00</b>

Marketing had to be conducted (1) to ensure adequate participation in the programme; (2) to inform the relevant organisations what the programme is about; and (3) to communicate to the wider public that the topic of family resilience and hearing impairment is useful and meaningful (Birkenholz, 1999). Since participation in the programme was voluntary, it was vital to convince the participants about the value of the programme. Personal contact was

made with all the potential participants in the programme via telephone, and reminders were distributed via the schools of their children.

#### 6.3.12 Co-ordinating facilities and on-site events

Community and school halls were hired that were accessible to the participants. Attempts were made to create a comfortable atmosphere. The venues had the basic equipment, such as tables and chairs, and the researcher organised the necessary equipment required for effective presentation, e.g. projector, screen and white board. An assistant helped with the serving of refreshments and meals and a babysitter was required on one occasion.

### **6.4 Conclusion**

The aim of the intervention phase was to design a family resilience, psycho-education programme that would enhance adjustment and adaptation in families with a child with a hearing impairment. Attempts were made to ensure that the programme was well planned, provided the parents with all the necessary information, had sound learning objectives, and had suitable assessment strategies. The programme was aimed to be population specific and the researcher was sensitive to the parents' ages, education, socio-economic status, culture, race and home languages while developing the programme. A priority of the programme was to empower parents to actively use their social support networks to reduce the stress related to having a child with a hearing impairment, and to promote their adaptation and healthy functioning. The programme content should be revised and adjusted frequently to ensure continuity and be reflective of on-going research and new developments. This study only focused on the initial implementation and evaluation of the programme, and suggestions for improvement of the programme will be made for the further implementation thereof.

## CHAPTER 7

### INTERVENTION PHASE

#### RESEARCH DESIGN AND METHODOLOGY

##### 7.1 Chapter preview

Chapter 7 focuses on the research design and methodology used during the intervention phase of the study. First the aims and objectives for this phase are presented, followed by a description of the design, participants and measures used. It ends with a discussion of the procedure followed, the ethical considerations and the data analysis.

##### 7.2 Specific aims-/primary objectives of the intervention phase

The intervention phase of the study aimed to answer the following research question: Can one of the resiliency qualities identified in the descriptive phase of this study be enhanced in families with a child with a hearing impairment to ensure better family adaptation?

From this research question, the following specific aims were developed for the intervention phase of the study:

- To develop and implement a programme that enhances one specific resilience quality identified (i.e. the utilisation of social support) to foster better adaptation in families with a child with a hearing impairment.
- To evaluate the effectiveness of the intervention programme.

##### 7.3 Research design

In the context of an experimental design, a randomised pretest-posttest control group design was applied in the intervention phase of the study (Cohen *et al.*, 2000; Tuckman, 1999). In this design, all participants are pre-tested on the dependent variable (i.e. the utilisation of social support), then the experimental group receives the treatment and both groups are post-

tested on the dependent variable (Graziano & Raulin, 2000). The fundamental purpose of this experimental design is to gain control over conditions that have the potential of blurring the true effects of the independent variables on the dependent variable (Cohen *et al.*, 2000). The critical comparison is then between the experimental and control groups on the post-treatment measure (Graziano & Raulin, 2000).

In the present study, the experimental group received the treatment (i.e. workshop on enhancing the utilisation of social support), while the control group received a neutral treatment (see Chapter 6, p.141). Both the experimental and control groups were given a pre-test and a post-test. Random assignment was used to place the participants into the respective groups in order to ensure that the groups were probabilistically equivalent. The advantage of the randomised, pretest-posttest control group design is that the researcher can largely control the threats to internal validity. By ensuring that the experimental and control group are exposed to all the same experiences, except for the treatment itself, the design controls for history, maturation and regression effects (Tuckman, 1999). In addition, by randomly assigning participants to the experimental and control group, one controls for selection and maturity (Tuckman, 1999). A disadvantage of the design, however, is that the pretest-posttest allows for a testing effect, which may reduce internal validity (Tuckman, 1999). In addition, the possibility that the pre-test will sensitise the participants to the treatment cannot be controlled for, thereby resulting in test-treatment interaction and affecting the external validity of the study (Tuckman, 1999). This design was still deemed suitable for the study, however, as the researcher required pre-test data in order to assess the degree of change in the dependent variable following the intervention. In addition, without incorporating a control group into the design, one could not eliminate or limit other conditions that could also influence the outcome of the programme and, as a result, one would not be able to make any causal conclusions about the effectiveness of the intervention (Tuckman, 1999).

After analysing the data of the pretest-posttest control group design, an attempt was made to overcome the limitation of the small sample size by incorporating the participants who were originally part of the control group into the experimental group. A further analysis was then conducted to determine whether there was any movement over time between the two experimental groups.

As was mentioned above, there are a number of threats to the internal and external validity of the intervention phase. The discussion below will highlight what the greatest threats to the internal and external validity were and how they were addressed. Generally, the primary methods used to achieve internal and external validity were randomisation, the use of a pre-test and post-test control group design, and statistical analysis that was appropriate to the data collected and the aims of the study (Krauth, 2000; Tuckman, 1999).

### 7.3.1 Internal validity

Internal validity refers to the extent to which the findings of the study accurately represent the degree to which changes in the dependent variable (utilisation of social support) can be attributed to the manipulations of the independent variable (workshop) (Tuckman, 1999). The table below provides a summary of the possible threats to internal validity (Krauth, 2000; Mertens, 2005; Tuckman, 1999) in the current study and what measures were implemented to control for these threats.

Table 16

*Summary of the Threats to Internal Validity and How they were Controlled for in the Study*

<b>Threat</b>	<b>Definition</b>	<b>How controlled for in the study</b>
History	Events other than the programme that happen during the course of the study that may influence the second measurement.	Random allocation to a control and experimental group. Experiences were identical in every way possible for the two groups.
Maturation	Biological/physiological changes in the person that occur naturally with the passage of time during the study and may not be related to the experimental situation.	Random allocation to the experimental and control group. Experiences were identical in every way possible for the two groups. Families are in the same developmental stage.
Testing	Participants may become 'test-wise' or sensitised if the pre-test is similar to the post-test.	Qualitative measures were included during the post-test.
Instrumentation	Occurs if different instruments are used during the pre- and post-test.	The same quantitative instruments were used during the pre- and post-test. Data collectors remained constant across time and groups.
Differential selection	If people with different characteristics are in the experimental and control group, the differences in the results for the two groups are not necessarily due to the treatment, but due to the different groups.	Random allocation to the experimental and control group to ensure that participants do not differ in general characteristics.
Experimental treatment diffusion	If control group hears of treatment and begins to use it themselves.	Participants were not informed who the other participants were and they did not have direct contact with each other.

Experimental mortality could not be controlled for in the study because participation was voluntary and members were allowed to withdraw at any stage of the study. This was in adherence to ethical standards and principles. In summary, however, it appears that the internal validity of the current study was controlled best by using a pretest-posttest control group design and by implementing the same instruments during the pre- and post-test.

### 7.3.2 External validity

External validity refers to the degree to which the results of a study can be generalised to the broader population (Cohen *et al.*, 2000). The research design took the following factors into consideration (Tuckman, 1999; Campbell & Stanley, 1966; Krauth, 2000) to ensure greater external validity (see Table 17):

Table 17

*A Summary of the Threats to External Validity and How they were Controlled for in the Study*

<b>Threat</b>	<b>Definition</b>	<b>How controlled for in the study</b>
Interaction between selection and treatment	The sample may not be representative of the larger population, thereby making it difficult to generalise the findings.	Purposive sampling of participants from the broadest possible population.
Multiple treatment interference	Early treatments such as a pre-test may have a cumulative effect on the subject's performance, thereby reducing the representative-ness of the effects of any one of them.	Random allocation of participants to the experimental and control group
The Hawthorne effect	The idea of receiving extra attention may increase motivation.	Random allocation of participants to the experimental and control group

However, generalisations from the findings of the present study need to be implemented with caution, as the sample was representative of an available population within a specific region, namely suburbs in and around Cape Town. The findings are therefore not necessarily representative of the general population. However, a sample representative of the available population was used. In addition, the reactive effects of testing could not be controlled for (i.e. the pre-testing sensitised the subjects to the treatment, the effect of the treatment therefore partially being the result of the pre-test) and therefore could cloud the results.

## **7.4 Participants**

### 7.4.1 Sampling procedure

Purposive sampling was once again used during the intervention phase. Families who were identified in the initial phase of the study and who belonged to the coloured cultural group were invited to participate in the intervention programme. The families from the coloured cultural subgroup were chosen as the target group for this phase of the study for the following reasons: 1) they represented the largest sample size in the first phase; and 2) language difficulties and the need for interpreters and translators could be eliminated as the researcher was fluent in English and Afrikaans. Sampling was again based on voluntary participation and attempts were made to include as many participants as possible.

### 7.4.2 Description of sample

To maximise homogeneity, the population for the intervention phase consisted of families from the coloured cultural subgroup living in urban communities surrounding Cape Town, Western Cape, South Africa. The target group could be defined as a distinctive cultural group within the larger South African population, namely, ‘people sharing a common history.... speaking the same language, observing common rituals, values, rules .... [who have] ...

culturally normative practices such as child-rearing, kinship, social role and power arrangements' (Veroff & Goldberger, 1995, p. 10).

Thirty-seven families were identified to participate in the intervention phase. The families were informed about the nature and goals of the intervention programme and what would be required from them in terms of time and availability via telephone or letter. Both parents/caregivers were invited and encouraged to attend the intervention programme.

The experimental group initially consisted of 20 participants, namely five couples and ten individuals. One couple withdrew from the study during the three month follow-up period, reducing the sample size to 18 individuals. The control group initially comprised eleven participants, namely three couples and five individuals. One couple withdrew before the pre-test, while one individual withdrew during the three month follow-up period, reducing the control group to eight participants. No reasons were provided for the withdrawal from the study and the participants could not be reached. The couples were treated as individuals during the data collection and analysis, as they had completed the forms independently and provided their subjective opinion of their family's functioning.

As was mentioned previously, the experimental and control groups were merged after the initial pre- and post-test measures for the two groups had been completed. This was done in order to increase the size of the experimental group. Two experimental groups were thus designed, one consisting of the 18 participants in the original experimental group (referred to as experimental group 1) and one consisting of the eight participants who were originally part of the control group but then also received the intervention (referred to as experimental group 2).

The table below provides a summary of the participants in the experimental and control groups in terms of their mean age range, gender, marital status, socio-economic status (SES), employment and education.

Table 18

*Breakdown of Intervention Phase Sample in Terms of Age, Gender, Marital Status, SES, Employment and Education Level*

		Experimental group (n = 18)	Control group (n = 8)
Mean age range		38.4 years	36.3 years
Gender:	Male	5 (25%)	3 (27%)
	Female	15 (75%)	8 (73%)
Marital status:	Married	14 (93%)	7 (88%)
	Single	1 (7%)	1 (12%)
SES:	<R20000	3 (20%)	2 (25%)
	R21000 - R40000	6 (40%)	4 (50%)
	R40000 - R60000	1 (7%)	1 (12.5%)
	R61000 - R80000	1 (7%)	1 (12.5%)
	R81000-R100000	3 (20%)	0
	No answer	1 (7%)	0
Employed:	Self	6 (40%)	4 (50%)
	Spouse	11 (73%)	5 (62.5%)
Unemployed:	Self	9 (60%)	4 (50%)
	Spouse	4 (27%)	3 (37.5%)
Educational level:	High school	10 (67%)	7 (87.5%)
	Diploma	5 (33%)	1 (12.5%)

As can be seen from Table 18, mainly mothers attended the workshop, although both parents/caregivers were invited and encouraged to participate. According to previous research, women in the coloured cultural community are responsible for the practical, nurturing and moral tasks of the household, while the male, as head of the household, has a relatively distant or absent role in terms of the daily activities of the family (Field, 1991).

Typically the husband spends much time at work or with his friends, while the wife directs her affection to their children and family (Rabie, 1996). This may explain why so few fathers voluntarily attended the intervention programme and it was rather seen as the responsibility of the mother to represent the family as a whole.

## **7.5 Measures**

Data was collected using quantitative and qualitative measures. Triangulation allows for the findings to be substantiated, thereby allowing more in-depth analysis and reducing the impact of potential biases (Smith, 2006; Tuckman, 1999).

The Social Support Index (SSI) of McCubbin *et al.* (1996) (see Addendum B), utilised in the descriptive phase of the study, was again used in the intervention phase to determine whether the intervention had an impact on the functioning of the families. In addition, a questionnaire was developed by the researcher for the evaluation of the workshop (see Addendum G). The questionnaire presented at the post-test evaluation consisted of open-ended and structured questions and was administered at the end of the workshop. Two additional open-ended questions were developed for the three month follow-up evaluation (see Addendum H) in order to obtain a qualitative indication of whether the workshop had had an impact on the participant's family functioning. A description of the procedure followed will be provided in Section 7.6.

### **7.5.1 Quantitative measures**

As mentioned in Chapter 4, the Social Support Index (SSI) of McCubbin *et al.* (1982) measures the extent to which families have integrated into their community, the degree to which the families find support in their community, and the degree to which they make use of community resources. The internal reliability coefficient of the SSI is .82, the test-retest reliability is .83 and the validity coefficient is .40 (McCubbin *et al.*, 1996). The internal

reliability (Cronbach's alpha) of the SSI for the experimental group in the intervention phase was .81 at pre-test, .79 at post-test and .60 at the three month follow up. The internal reliability (Cronbach's alpha) of the SSI for the control group was .84 at pre-test, .71 at three month post-test, .86 at workshop post-test (now becoming experimental group 2) and .94 at the three month follow-up.

#### 7.5.2 Qualitative measures

Following the workshop, the participants were requested to respond to the open-ended and structured questions, which focused on evaluating the intervention programme. Two open-ended questions were again posed at the three month follow-up session in order to gather information on what impact the workshop had had on the participants' family functioning and whether their social support network had changed in any way. On both occasions the participants were requested to give written feedback. The answers provided in Afrikaans were translated into English by a qualified bilingual professional in the educational profession.

### 7.6 Procedure

The families who were identified in the descriptive phase of the study were approached by the researcher and were informed about the intervention phase of the study and what commitment it would entail. Participation was again voluntary and based on informed consent (see Addendum D). Thirty-seven suitable families were identified, of which 23 agreed to participate, seven accepted but missed the appointments, two declined and five could not be reached telephonically and did not respond to a letter sent via the school. The participants were invited to attend either the experimental or control group, depending into which group they had been randomly assigned. The workshop took place either during the week or on the weekend at a community or school hall.

As mentioned previously, the experimental group was exposed to the intervention programme, while the control group received a neutral intervention (refer to page 141). None of the participants knew whether they were in the experimental or control group, i.e. they were operating in the blind. The workshop took place from 8:00 am until 17:00 pm, while the control group activity took place from 10:00 am until 12:00 noon.

All participants in the control group were also invited to attend the intervention programme at the end of the three month follow-up period. The participants in the control group then followed the same procedure as the experimental group (becoming experimental group 2), which allowed the researcher to merge the two groups in order to increase the number of participants who were exposed to the intervention.

The data-gathering process started once participants had been informed about the treatment and had given their written, informed consent to participate. The following procedure was followed for the experimental group (see Figure 14):

- participants individually completed the SSI in the presence of the researcher and independent rater (pre-test);
- the workshop was presented;
- participants completed the SSI and evaluation form (post-test);
- participants completed the SSI and two open-ended questions at the three month follow-up (three month post-test).

The following procedure was followed for the control group:

- participants individually completed the SSI in the presence of the researcher (pre-test);
- a neutral intervention was offered to the participants;
- participants completed the SSI at the three month follow-up before the workshop was presented (post-test/pre-test);

- the workshop was presented;
- participants completed the SSI and evaluation form (post-test);
- participants completed the SSI and open-ended questions at the three month follow-up (three month post-test).

A graphical representation of the procedure followed for the two groups is presented below.

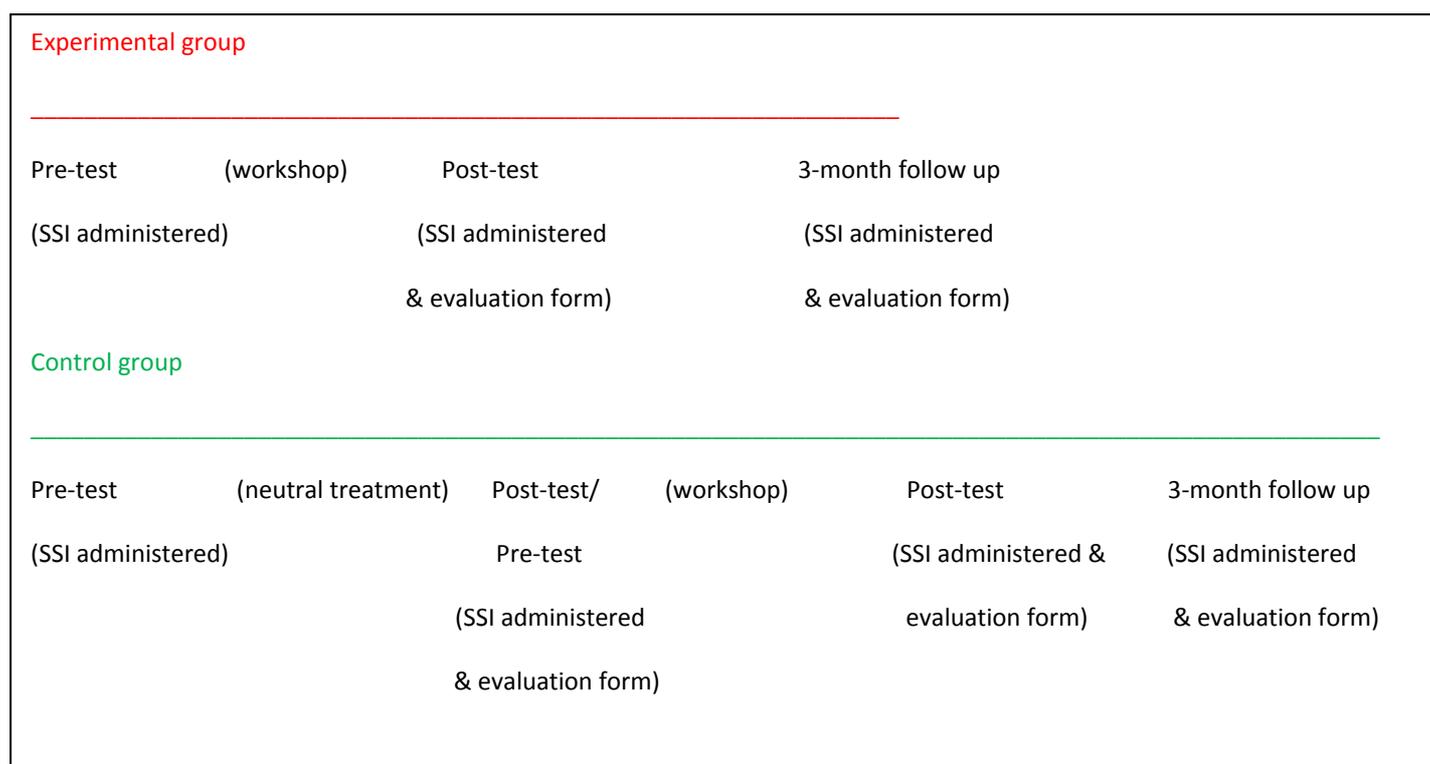


Figure 14: A representation of the procedure followed for the experimental and control group during the intervention phase

The following procedure was followed for the merging of the groups:

- The procedure for the experimental group (referred to as experimental group 1 in Figure 15 below) remained the same;
- The participants in the control group that were exposed to the treatment after the three month follow-up period were used to create a new experimental group (referred to as experimental group 2 in Figure 15 below).

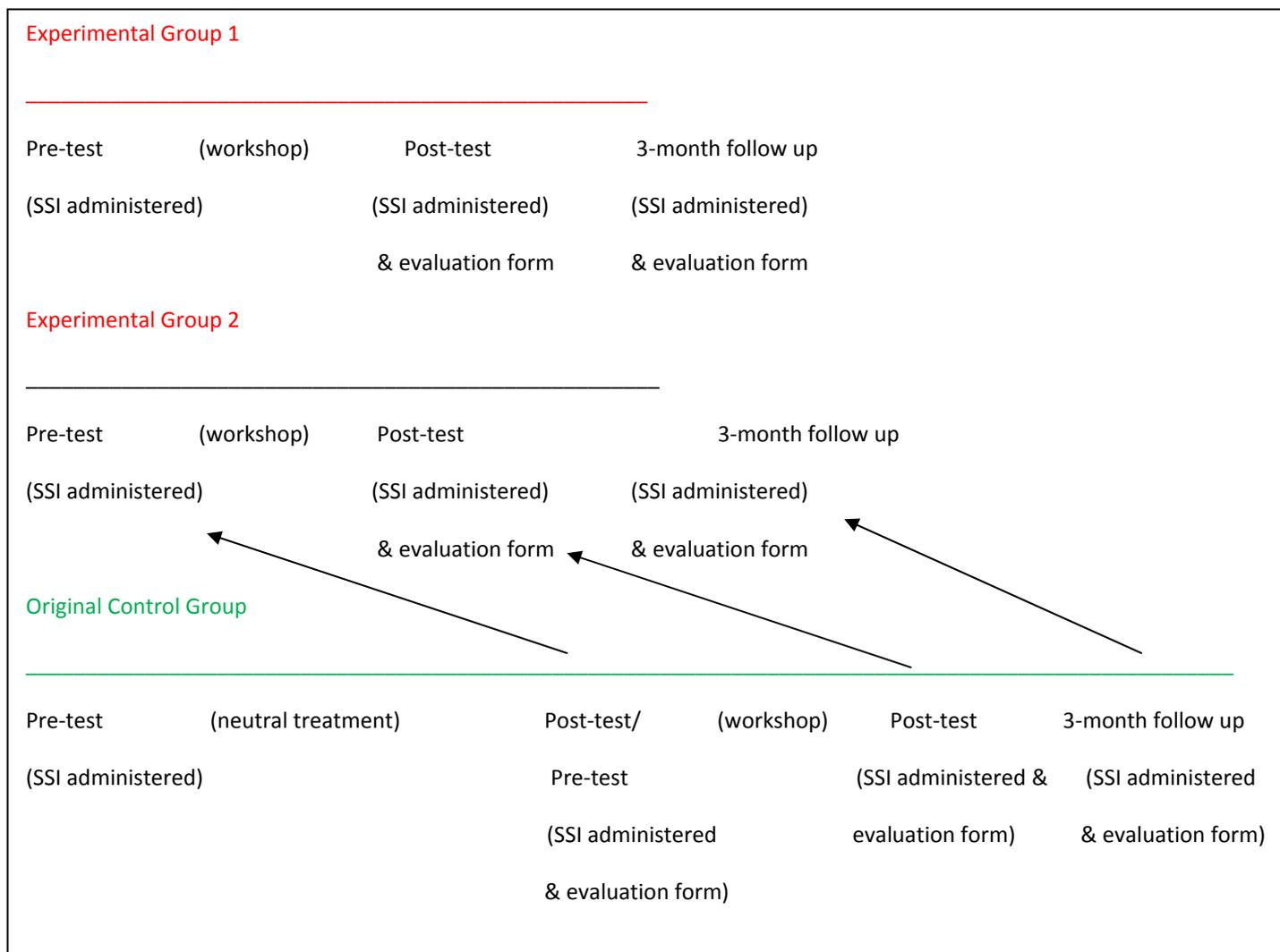


Figure 15: A representation of the procedure followed for the merging of the experimental and control groups

## 7.7 Ethical considerations

- Confidentiality

Confidentiality was again stressed throughout the intervention phase in order to respect the privacy of the participants. All data was coded to ensure confidentiality and the participants were free to share as much personal information as they felt comfortable to do.

- Informed consent

All the participants were informed about the intervention programme and its commitments. They were free to withdraw from the study at any time and participation was voluntary.

Informed consent was obtained in writing from all participants before the intervention commenced (see Addendum C).

- Assignment to control and programme groups

In a pretest-posttest control group design, the key internal validity issue is the degree to which the experimental and control groups are comparable before the study. According to Krauth (2000), randomisation is one of the most important control techniques used in experimental designs. In order to allocate the participants in the current study to a group, Excel random number generator was used to assign a random number to each participant. That random number was then used to determine in which group each participant fell, thereby ensuring that allocation to the experimental and control groups happened simultaneously (Prof M. Kidd, Consulting Statistician, University of Stellenbosch).

## **7.8 Data analysis**

### 7.8.1 Quantitative data

The quantitative data was analysed using STATISTICA V8 (StatSoft, Inc. 2008). The analyses were planned and executed in partnership with the same statistician used during the descriptive phase of the study. First, comparisons were made between the experimental and control groups using repeated measures analysis of variance. The groups were then merged to increase the sample size. This was possible as the control group received the intervention and followed the same procedure as the experimental group after their initial three month follow-up period. The original experimental group (Group 1) and newly compiled experimental group (Group 2) were then compared, without having a control group, using repeated measures analysis of variance.

The data was analysed using repeated measures analysis of variance, as repeated measurements were taken on the same individuals. The purpose of the analysis was to

determine whether there was any change in the variable (i.e. the utilisation of social support) after the intervention and whether there was a significant difference between the experimental and control groups following the intervention. This would allow the researcher to evaluate the effects or effectiveness of the intervention (i.e. social support workshop). The data analysis was conducted in three stages. Firstly, the interaction between group and time was identified. Once the difference over time was found to be the same for both groups, the two groups could be combined and only the effect of time could be examined. Similarly, the effect of group could also be examined once the difference following the intervention for the two groups was found to be the same.

#### 7.8.2 Qualitative data

The qualitative data was again categorised according to themes and frequencies using grounded theory analysis, as described in Chapter 4 (see Section 4.9.2).

### **7.9 Conclusion**

The basic experimental-control group design proved to be best suited to achieve the aims of the intervention phase of the study. The design allowed for the control of numerous threats to the internal and external validity of the study, and ensured that a comparison could be made between the experimental and control groups following the implementation of the workshop. Once again, qualitative and quantitative measures were used for the data collection. The following chapter will focus on the results of the intervention phase.

## CHAPTER 8

### RESULTS AND DISCUSSION OF THE INTERVENTION PHASE

#### 8.1 Chapter preview

This chapter reports the results of the intervention phase of the study. The first aim of this phase was to develop and implement an intervention (workshop) that enhanced the utilisation of social support in families with a child with a hearing impairment. Secondly, the effectiveness of the intervention had to be evaluated.

The chapter will begin by reporting the quantitative findings regarding the differences found between the experimental and control groups following the workshop (intervention). The qualitative data will then be presented, followed by a discussion of the findings.

#### 8.2 Results of the measures

##### 8.2.1 Quantitative findings

###### 8.2.1.1 Repeated measures analysis of variance

Repeated measures analysis of variance was conducted to determine the impact that the workshop had on the participants. The results would indicate whether there was any change in the participants' utilisation of social support following the workshop, and whether there was a significant difference between the experimental and control groups following the intervention.

Table 19 and Figure 16 below reflect the results when the interaction between group and time was explored.

Table 19

*Results of the Repeated Measures Analysis of Variance on the Experimental and Control Groups*

Effect	SS	Degrees of freedom	MS	F	P
Group	17.7	1	17.7	0.1308	0.7208
Time	78.8	1	78.8	2.7996	0.1073
Time*group	0.31	1	0.31	0.0109	0.9176

Note: SS = Sum of squares MS = Mean square

According to Table 19 and Figure 16 (below), the results show no statistically significant difference between the experimental and control groups at the pre-test and three month follow-up. This implies that no difference was found between the two groups, although the experimental group had been exposed to the intervention and the control group not. Since the scores of both groups increased after the pre-test, although not significantly, one can assume that the testing alone had an effect on the groups (i.e. reactive effects of testing).

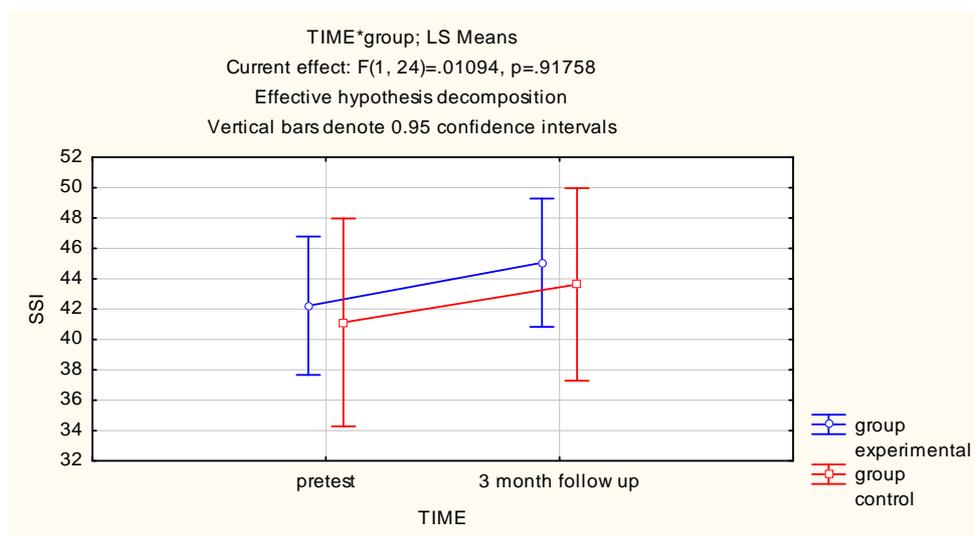


Figure 16. A reflection of the interaction between time and group

As discussed in Chapter 7 (p. 159), the experimental and control groups were merged to increase the sample size. The results of these analyses are reflected in Table 20 and Figure 17 below.

Table 20

*Results of the Repeated Measures Analysis of Variance on the Merged Groups (N = 26)*

Effect	SS	Degrees of freedom	MS	F	P
Group	65.8	1	65.8	0.3381	0.566357
Time	102.9	2	51.4	1.4551	0.243483
Time*group	109.5	2	54.8	1.5494	0.222802

Note: SS = Sum of squares MS = Mean square

Table 20 above and Figure 17 below indicate that no statistically significant difference was found between the merged groups following the treatment. This may be due to the small sample size, which resulted in the statistical test having a low power. With specific reference to Figure 17 below, the drop in the scores for both groups following the workshop may be attributed to an increased awareness and insight that the participants gained about their social support network after the workshop. The drop is not significant and the trend indicates that, at the three month follow-up, the participants were again at their pre-test level of functioning.

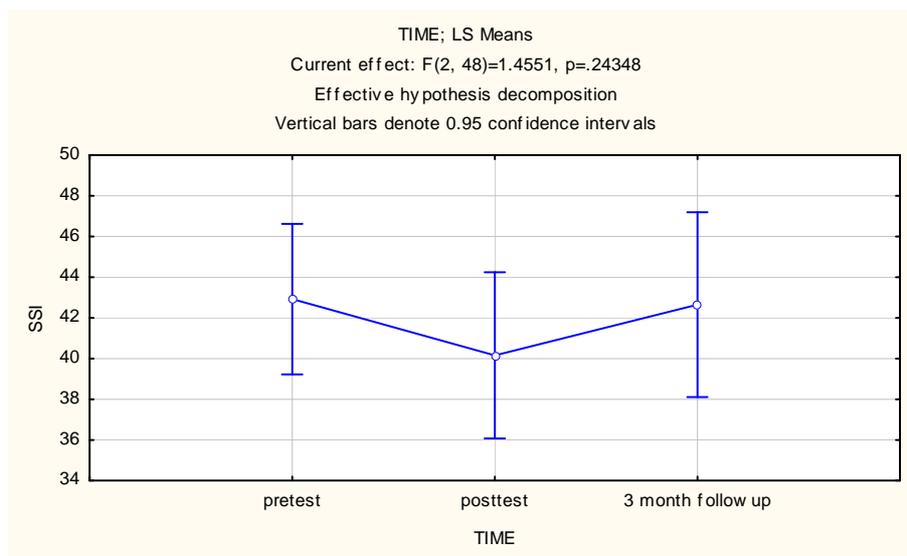


Figure 17. A reflection of the time effect

The qualitative findings will be presented below, after which a comprehensive discussion of the findings will be provided.

### 8.2.2 Qualitative findings

In order to obtain qualitative data for the evaluation of the workshop, the participants were requested to answer an evaluation form at the end of the workshop (see Addendum G). The form consisted of two open-ended questions and eight structured questions. The participants were again requested to complete two open-ended questions at the three month follow-up evaluation (see Addendum H).

All the participants responded to the questions posed. Their answers were again analysed according to themes using the principles of grounded theory. A summary of the identified themes and the prevalence thereof is provided in the tables below.

#### Post-test evaluation

Immediately after the workshop, the participants were asked to give a written response to the question: What have you enjoyed the most about the workshop? Twenty-seven of the 28

participants gave a response to the question. A summary of the responses is provided in Table 21.

Table 21

*Participants' Perspectives on the Positive Aspects of the Workshop (N = 27)*

Positive aspects about the workshop	No. of responses	%
Interaction with other parents	14	52%
Gaining skills and knowledge	12	44%
The informative and interactive nature of the presentation	5	19%
Feeling at ease and free to express opinions	5	19%
The term social support was clarified	3	11%

As can be seen from Table 21, the participants mostly appreciated the interaction with other parents with a child with a hearing impairment (51%). A total of 44% enjoyed gaining new knowledge and skills, and 19% commented on the presentation method and learning-conducive atmosphere in the group.

Table 22 below reflects the constructive criticism the parents provided with regard to the workshop. Their answers were in response to the question: What have you enjoyed the least about the workshop? Only four of the 28 participants gave a response to this question. Most respondents stated that the question was not applicable, while a few again wrote how the workshop had been beneficial to them.

Table 22

*Participants' Constructive Criticism of the Workshop (N = 4)*

<b>Criticism</b>	<b>No. of responses</b>	<b>%</b>
Long duration of the workshop	1	25%
Lack of participation from all participants	1	25%
Focusing on the negative beliefs of social support	1	25%
Realising that self focuses too much on the negative	1	25%

Table 22 indicates that one participant found it ineffective to complete the workshop in one day. Another participant felt frustrated that not all individuals participated during the workshop. However, this was due to religious reasons and therefore had to be respected. One participant felt uncomfortable about focusing on the negative belief systems that may impede making use of social support, while another participant felt that he/she had focused too much on hardships in the past and this was difficult to acknowledge.

The participants found it easier to respond to the structured questions and all 28 participants answered the questions posed. Table 23 provides a summary of these results.

Table 23

*Responses to the Structured Questions Regarding the Evaluation of the Workshop (N = 28)*

Aspects of the workshop	No. of responses	%
Knowledge was gained	28	100%
Able to express themselves freely	27	96%
Information presented was understandable	28	100%
Benefited from attending the workshop	27	96%
Change in attitude towards seeking support	26	93%
New skills acquired to build support network	27	96%
Presentation was done in a friendly, understandable manner	28	100%
Challenges can be faced with more confidence	27	96%

From Table 23 it can be concluded that, from the participants' personal points of view, the workshop brought about a change in attitude, knowledge and skills. The information and presentation of the workshop was also judged as being effective and constructive for the learning process.

#### Three month follow-up evaluation

Since one couple withdrew during the three month follow-up period, responses from 26 of the original 28 participants were received. The first semi-structured question on the three month follow-up evaluation form was: Did your family's social support network change in any way after having attended the social support workshop? If yes, state how and why it changed. If no, state why not.

Nineteen participants stated that their family's social support network had changed after the workshop, while seven reported no change. The responses are highlighted in Table 24 below.

Table 24

*Responses to Ways in which the Participants' Families' Social Support Network Changed Following the Implementation of the Workshop (N = 26)*

Changes in family's social support network following the workshop	No. of responses	%
Shared information with other family members, which improved family's functioning	7	26.9%
Increased community awareness, which improved family's integration into the community	5	19.2%
Increased support from husband	4	15.4%
Attended sign language classes, which improved communication within the family	4	15.4%
Children are more involved in daily tasks	1	3.8%

Those who stated that there was no change in their social support network, gave the following reasons:

- 'Every man is for himself'
- 'I have always received support from significant others and the community'
- 'My husband is not involved'

From Table 24 it appears that the majority of the participants (73%) subjectively felt that the workshop had changed their family's social support network. A further 26.9% felt that their

family's functioning improved after sharing the information from the workshop with significant others. A total of 19.2% felt that by sharing information with the community they were better integrated into the community and that they could request help and support from others.

The second question on the three month follow-up evaluation form was: Did the social support workshop have any impact on your family's functioning? If yes, state how. If no, state why not.

Twenty-one participants again reported that the workshop had an impact on their family's functioning, while five felt that it had had no impact. Table 25 highlights the themes identified in the participants' responses.

Table 25

*Responses to Whether the Workshop had an Impact on the Participants' Family's Functioning (N = 26)*

<b>Impact of workshop on family functioning</b>	<b>No. of responses</b>	<b>%</b>
Increased awareness in the family with regard to coping with the disability	6	23.1%
Shared knowledge with significant others and requested their support	5	19.2%
Improved communication and support among family members	4	15.4%
Realised own burden is not so heavy compared to other's burden	3	11.5%
Increased understanding among family members	3	11.5%
Improved problem-solving skills and communication within the family	3	11.5%
Increased family time spent together	3	11.5%
Increased awareness of the importance of family support	2	7.7%
Talk about disability in the family, no longer ignore it	1	3.8%

Those who stated there was no change in their family's functioning gave the following reasons:

- 'Life continues as usual'
- 'I always had support from my family and friends'
- 'I did not actively try to change'

From Table 25 it is again apparent that the participants subjectively felt that the workshop had an impact on their family's functioning. A total of 23.1% reported that the family's awareness with regard to coping with the disability had increased, while 19% stated that they shared the new information with other family members and requested their support, which in turn impacted on their family's functioning. Furthermore 15.4% stated that their family's communication and support for one another had improved after the workshop.

### **8.3 Discussion of findings**

The findings will be discussed according to the workshop evaluation goals that were highlighted in Chapter 6, p.146.

The first goal was to determine whether there was a significant difference between the experimental and control groups following the intervention, i.e. the workshop. The findings of the study did not reveal a statistically significant improvement in the participants' utilisation of social support following the implementation of the workshop. A number of factors may have contributed to this result, namely:

(1) the small sample size, which resulted in the statistical test having a low power (Krauth, 2000). When a study is insufficiently powered, the effect size estimates will be less accurate and, as a result, one could incorrectly conclude that the relationship between the treatment and outcome is not significant (Shadish, Cook & Campbell, 2002). This implies that, although the results were not statistically significant in the present study, one should not simply conclude that the workshop had no impact on the participants whatsoever.

(2) the measure (i.e. the Social Support Index) may not have been sensitive enough for the sample in order to detect any minor changes that occurred. Although the SSI was relevant to the construct being measured, the findings from the descriptive phase indicated that the participants focused more on internal resources for support (see p. 109). Since the SSI

measures community integration and the family's use of external resources, the measure may not have been sensitive enough to the actual changes that took place in the families.

(3) the evaluation of the workshop was based solely on a self-report measure, which is subjective in nature (Spoth, Redmond, Haggerty & Ward, 1995). With the use of such measures, there is the potential for bias associated with the tendency to give socially desirable responses (Spoth *et al.*, 1995). The participants may have distorted their answers to ensure the approval of others and to please the researcher, thereby reporting that they engage in higher levels of socially desirable behaviour than they actually do (Spoth *et al.*, 1995). The results at the pre-test may therefore have been elevated, thereby restricting the impact of the workshop.

(4) the workshop was only presented in one day and therefore the newly acquired knowledge, skills and attitudes could not be consolidated. In addition, the relatively short time between the pre- and post-test may have made it difficult for the participants to implement any behaviour change (Spoth & Redmond, 1996b), thereby reducing the impact of the workshop.

Although the results were not statistically significant, the qualitative data highlighted that the majority of participants (73%) felt that the workshop had changed their family's social support network. In addition, the participants reported a change in their attitude, knowledge, insight and family's functioning following the workshop. Many participants found the interaction with other parents with a child with a hearing impairment helpful. Such findings have also been highlighted in studies by Hintermair (2000) and Taanila *et al.* (2002). Increased support from the immediate and extended family was reported and was seen as being essential for managing in everyday life. The participants also reportedly felt free to ask for help or support after the workshop and, as a result, received better co-operation from family members. Family time and routines were increased, which is important for creating stability and continuity within the family system (Greeff & Van der Walt, in press; McCubbin

*et al.*, 1996). The participants also reported that the family's communication and problem-solving skills improved after the workshop. Problems were discussed rather than ignored, and the parents learnt to communicate effectively with their child with a hearing impairment after attending sign language classes. Communication and problem solving are very important mechanisms in fostering family resilience (Greeff & Van der Walt, in press; Smith, 2006; Walsh, 2003). It must, however, be noted that most of the reported changes following the workshop were related to the participant's immediate family rather than to community integration, and involved informal rather than formal support. This may again be reflective of the perceptions of the families from the coloured cultural subgroup, namely that internal resources are sufficient to cope with the demands placed on them when having a child with a hearing impairment in the family (as discussed in Chapter 5).

The second goal of the workshop evaluation was to determine whether the workshop content was appropriate for the target group. All the participants reported that the information presented was understandable, and 96% reported to have benefited from the workshop. One can thus assume that the content was appropriate. All the participants also reported that the presentation was done in a friendly, understandable manner (see Table 23), indicating that the presentation techniques were effective in promoting the aims of the workshop (goal 3, p. 146). The responses of the participants also indicated that they gained knowledge through the workshop and that the concept of social support was clarified, thereby impacting on their attitude towards social support (goals 4 and 5, p. 146; Table 23). A number of participants reportedly shared their newly acquired knowledge with family members and friends (see Table 24). Through this they were more integrated into the community and received more support, which is important for successful adaptation (McCubbin *et al.*, 1996; Walsh, 2003).

From the qualitative results of the evaluation one can conclude that the programme did have an impact on the participants. The small sample size clearly hampered the statistical outcome

of this study and therefore it is important to also highlight the factors that may have resulted in the small sample/poor attendance. The following factors were identified as the primary barriers to attending the workshop, based on the subjective reports of the participants and the researcher's own observations: lack of reliable transportation, unstable living environment, bad weather, illness (own/child), inconvenient date, unable to miss work for financial reasons or because they often have to take leave in order to take their child with a hearing impairment to the doctor or other health professionals, and the duration of the workshop (one whole day). Similar findings with regard to poor attendance have been reported by McCarthy, Reese, Schueneman and Reese (1992), Henggeler *et al.* (2007) and McCarthy, Sundby, Merladet & Luxenberg (1997). Holden (1986) found that workshop completers were more likely to be females, married or living with a partner, more highly educated, with a higher socio-economic status level, than the dropouts or non-attendees. These demographics are also reflective of the participants that partook in the present study. The few dropouts during the intervention phase may have been those families with very poor social support, as this has been related to early termination (Powell, 1984).

#### **8.4 Conclusion**

The results of the intervention phase do not indicate a statistically significant change in the utilisation of social support following the implementation of the workshop. The qualitative data, however, highlighted some improvements that were noted subjectively by the participants. The small sample size, the subjective nature of the measure, the lack of sensitivity of the measure, and the short duration of the workshop may all have impeded the ability to determine whether a statistical difference could be found following the treatment. However, the workshop was based on sound methodological and ethical principles, and the qualitative results indicated that it did help clinically. The results should be seen as preliminary. The following chapter will recap the primary findings of the study, highlight the practical implications of the study, and make recommendations for future research.

## CHAPTER 9

### REVIEW, RECOMMENDATIONS AND CONCLUSIONS

#### 9.1 Chapter preview

This chapter provides a review of the study. A summary of the primary findings will be provided, followed by a discourse on the implications thereof. The limitations of the study will be highlighted and suggestions will be made for future research.

#### 9.2 Review of this study

##### 9.2.1 Primary findings of the study

Using the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin *et al.*, 1996) as a theoretical basis, the study aimed at identifying factors that are associated with family resilience. Specifically, the focus was on identifying and exploring those qualities that contribute to the resilience of families with a child with a hearing impairment. The study further aimed to develop and implement a programme that enhances one specific resilience quality that was identified to foster better adaptation in these families. The value of such a pro-active health-orientated perspective is important in the South African context, where resources are limited (Der Kinderen & Greeff, 2003).

The results of the study indicated the significance of several resilience factors (see Table 7, p. 93; Table 8, p. 95), such as family time and routine, social support, communication, family hardiness, including commitment and an internal locus of control, faith, problem solving, searching for meaning, and accepting the adversity. These results compared favourably with those obtained in other studies (see Chapters 3 and 5). Based on the initial findings, a programme focusing on enhancing the utilisation of social support was developed and implemented (see Chapter 6). The programme implementation and evaluation proved to be the most difficult part of the study for methodological reasons, which will be discussed in

detail below. The results of the intervention phase did not indicate a statistically significant change following the implementation of the workshop. The qualitative data, however, revealed that the participants subjectively felt that the workshop had changed their family's utilisation of social support. Greater support from the immediate and extended family was reported, family time and routines were increased, communication and problem-solving skills improved, and the participants felt free to ask for help or support. In addition, the participants reported a change in their attitude, knowledge and insight following the workshop. This implies that, although the results were not statistically significant, one should not simply conclude that the workshop had no impact on the participants whatsoever.

### 9.2.2 Practical implications of this research

The results of this study indicate some specific issues that need to be considered when designing and implementing family resiliency interventions similar to the one used here. Before discussing these in depth, various limitations of the study first need to be acknowledged.

The sample in the study was relatively small due to poor attendance, and this made the statistical analyses difficult, especially in the intervention phase of the study. Although logistical barriers to workshop attendance were mitigated by offering incentives such as food and money, babysitters on site, transport and sessions being scheduled during the week and on weekends, this did not seem to motivate the prospective participants to attend.

Many fathers/male caregivers were unable to attend the interviews and workshops conducted for this study. When attempts were made to accommodate them at later stages, co-operation was still lacking. Other studies have also reportedly struggled to achieve satisfactory attendance of fathers (e.g. Bennett & De-Luca, 1996; Judge, 1998). This, however, is

regarded as a limitation of the study, as a systemic view was adopted and in the end mainly the mothers' personal assessments of coping strategies and family strengths were gathered.

For practical reasons (see Chapter 6, p.139) the workshop was presented in one day. As a result, the participants had limited time to apply and reinforce newly learnt behaviour, which may have restricted the outcome of the intervention phase of the study. The degree to which a more intensive intervention would have resulted in greater change in affective and behavioural dimensions of family functioning is unknown and could be explored further.

The shortage of standardised South African questionnaires remains a limitation. However, the questionnaires were implemented successfully in this study, as the combination of the quantitative and qualitative measures offered a means of preliminarily validating the results. In addition, the potential limitation of relying mainly on self-report measures, namely that the results may be biased because the participants provide socially desirable answers, was overcome by using triangulation.

The results can be generalised to the population targeted in the present study to a reasonable extent, but caution should be exercised when generalising to a more culturally diverse and/or rural population. Additional research might address the extent to which these findings would generalise to a sample more diverse with respect to race, culture, geographical areas and economical well-being.

There is a general consensus that South African families with children with hearing impairment are in need of support. The findings of the present study, however, show that families are hesitant to make use of the support offered. It seems that certain misperceptions exist with regard to the use of social support, based on the value system adopted by the various cultural groups in South Africa (e.g. 'ubuntu' vs. individualism). The question arises whether the hesitance to make use of the offered support is linked to the misperceptions, or

whether workshops are not the preferred method of support for families with a child with a hearing impairment, or whether families generally feel so disempowered and overwhelmed that they have adopted a sense of apathy. To ensure relevance in the provision of services, the findings and observations from the present study should be considered carefully, as they could assist in improving the service provision offered to families in crisis.

Firstly, services should focus on the child and family as a unit, as well as on the broader community. Clinics and schools should focus on educating parents about hearing impairment and the impact it can have on family functioning. Parents should be informed about the services available to them and the facilities that already exist in their vicinity to alleviate some of the pressure and to develop their social support networks. When establishing support groups, professionals need to ensure that there is a good fit between the characteristics of the family and other group members. Attention should be paid to time constraints facing groups members because of work and/or family obligations. Participation could possibly be enhanced if the workshop sessions do not exceed two hours per meeting. In addition, barriers to participation associated with child care and transportation should be minimised by offering babysitters on site and organising a transport shuttle or forming car pools among members. Efforts should also be made to develop a collaborative and mutually supportive alliance with schools and clinics to ensure families are attracted to the programme. Families participating in the support groups should also be encouraged to communicate and share information with other parents in order to encourage successful recruitment efforts.

Secondly, the broader community needs to be educated, possibly through mass media and rallies organised by schools and clinics. This could be vital to the acceptance of the family and child as members of the community, and to increasing the social support mechanisms of the family. Research has shown that families require environmental support in order to function effectively and to meet the various challenges they face (Kumpfer & Alvarado,

1998). As in the present study, interventions should aim to build linkages between individuals, families and communities.

On a national level, financial assistance in the form of disability grants is essential in order for many of the families to make use of these services and to help them provide their child with the special medical and educational requirements. It is difficult for families to attend workshops and support services if their basic needs of food, security and shelter are not even met.

### **9.3 Recommendations for future research**

The present study was a descriptive one, and exploratory in nature, which is an approach that suggests directions for future research. The following recommendations are made for further studies:

1. Sample sizes should be increased in order to verify the findings of the present study. A larger, more representative sample would also allow for greater generalisation.
2. The measuring instruments employed in the present study should be standardised for the South African population.
3. Strategies should be developed to enhance the attendance of fathers. Focus should also be placed on understanding the reasons people decide whether or not to join a support group by doing follow-up surveys of groups members who discontinued their participation in the group.
4. The programme should be translated into Afrikaans and Xhosa to make it accessible to a larger population.
5. The programme should be adapted where necessary and re-evaluated to determine its effectiveness. A larger sample and longitudinal studies are imperative in determining the programme's effectiveness.

## **9.4 Conclusion**

This study contributed to scientific knowledge and theory of its own accord and functioned as a valuable role-player within a larger international endeavour to explore, compare and conceptualise knowledge on family resilience within diverse cultural settings. The study offers valuable knowledge that can be incorporated into psychological and social training programmes, preventative community interventions and therapeutic settings. From a policy perspective, it would be much more cost effective to ensure that there are adequate support services and empowerment initiatives in the community that enable families to effectively meet the challenges they may face. The present study identified those resilience factors that promote family functioning. A programme was developed that can be replicated and adapted by other professionals who wish to initiate similar services. It is the author's conviction that support networks such as the Social Support Programme fulfil a vital need in facilitating the development of family resources that are necessary for successful coping and adaptation. The participants in the study were exposed to new coping strategies, they gained more information about resources in their community, and they began developing different attitudes. The positive and pragmatic approach adopted in this study ensured that families were empowered by bringing them hope, developing new competencies and building mutual support. The study has opened various new avenues for further research in relation to children with hearing impairment and their parents. It is hoped that the findings and recommendations will be of assistance to both professionals and researchers attending to these families.

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## **ADDENDUM A**

### **PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM**

**TITLE OF THE RESEARCH PROJECT:** A programme to enhance resilience in families in which a child has a hearing loss.

**PRINCIPAL INVESTIGATOR:** Mrs I. Ahlert

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Please feel free to ask any questions. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Committee for Human Research at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

#### **What is this research study all about?**

Parenting a young child can be exciting, rewarding and at times quite challenging and demanding. Yet having a child with a hearing impairment tends to change family dynamics and the home environment. In the past, much research has focused on pathology and how families of children with a hearing impairment were characterised by depression and sorrow. In the present study we would like to identify what helped you as parents to cope with your child with a hearing impairment.

Should you give your consent to participate in the study, you will be invited to attend a meeting at the school of your child. The meeting should not last longer than two hours and will entail that you anonymously complete a few questionnaires and give answers to three posed questions.

#### **Why have you been invited to participate?**

All families who met the following criteria were invited to participate in the study:

1. The child has a moderate to profound hearing impairment.
2. The diagnosis was made 1 to 4 years ago.
3. The child is under 10 years old.
4. The child is enrolled in a formal programme and lives at home.

#### **Will you benefit from taking part in this research?**

Based on the findings from the questionnaires completed by you, a programme will be developed that aims to strengthen the qualities/skills which help families to cope with a child

with a hearing impairment. This may be of benefit to yourself as well as other parents who still need to adjust to having a child with a hearing impairment in their family.

**Are there any risks involved in your taking part in this research?**

No risks are involved in taking part in this study.

**If you do not agree to take part, what alternatives do you have?**

If you decide not to participate in the study, you may receive the necessary support and information from professionals and other families with a child with a hearing impairment.

**Who will have access to your information?**

We are aware of the personal nature of the questions and assure you that the information obtained will be handled with the strictest confidentiality. All data will be coded and no information will be able to be related directly back to you or your child. The information obtained will form part of a doctoral study that will probably be published in an academic journal. Complete anonymity is assured.

**Will you be paid to take part in this study and are there any costs involved?**

You will receive R20.00 as a contribution to your transport costs. Refreshments and lunch will also be served.

**Is there anything else that you should know or do?**

- You can contact Mrs Ahlert at 021-948 9770 if you have any further queries or encounter any problems.
- You can contact the Committee for Human Research at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed.

**Declaration by participant**

By signing below, I .....(please print), agree to take part in a research study entitled 'A programme to enhance resilience in families in which a child has a hearing loss'.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been answered adequately.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2006.

.....

Signature of participant

-----

Signature of witness

**Declaration by investigator**

I (*name*) ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) ..... on (*date*) ..... 2006.

.....

Signature of investigator

.....

Signature of witness

**Declaration by interpreter**

I (*name*) ..... declare that:

- I assisted the investigator (*name*) ..... to explain the information in this document to (*name of participant*) ..... using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) ..... on (*date*) .....2006.

.....

Signature of interpreter

.....

Signature of witness

## DEELNAME INFORMASIE EN MAGTIGINGSVORM

**NAVORSINGS PROJEK TITEL:** ‘n Program om vooruitgang te bevorder in families met ‘n gehoorgestremde kind.

**HOOF ONDERSOEKBEAMPTE:** Mev. I Ahlert

U word versoek om deel te wees van ‘n navorsings-projek. Neem ‘n oomblik om die informasie aan u verskaf te lees wat die besonderhede van die projek sal verduidelik. Dit is baie belangrik dat u ten volle bewus is van die impak van die studie en hoe u deel daarvan kan wees. Enige vrae is welkom. U deelname aan hierdie studie is **ten volle vrywillig** en u kan enige tyd u deelname staak. Indien u nie antwoord nie sal dit u op geen wyse negatief beïnvloed nie. U kan ten enige tyd van die studie onttrek al het u ook ingestem om deel te neem.

Die studie is goedgekeur deur die **Komitee van Menslike Navorsing by die Universiteit van Stellenbosch** en sal bedryf word in ooreenstemming met die etiese riglyne en beginsels van die Internasionale Deklarasie van Helsinki, Suid-Afrikaanse Riglyne vir Goeie Kliniese Praktyk en die Mediese Navorsingsraad (MNR) se Etiese Riglyne vir Navorsing.

### **Wat is die doel van die navorsing?**

Om ‘n kind groot te maak is terselfdertyd opwindend, bevredigend en by tye uitdagend asook veeleisend. Die impak van ‘n gehoorgestremde kind op die familie en huislike omgewing is nog soveel meer veeleisend. In die verlede het navorsing gefokus op patologie en hoe meer vatbaar families met gehoorgestremde kinders was vir depressie en hartseer. In hierdie studie wil ons graag identifiseer wat u as ouer gehelp het om u gehoorgestremde kind beter te hanteer en te verstaan.

As u toestemming gee om deel te wees van hierdie studie sal u versoek word om ‘n vergadering by u kind se skool by te woon. Die vergadering behoort nie langer as teweens ure te duur nie. Naamlose vraelyste met ‘n paar vrae moet voltooi word asook u antwoord op drie gegewe vrae.

### **Waarom word u versoek om deel te neem?**

Alle families wat aan die volgende vereistes voldoen het, is gevra om deel te neem.

1. Die kind het ‘n matige- tot uitermatige- gehoorverlies.
2. Die diagnose is 1 tot 4 jaar gelede gemaak.
3. Die kind is onder 10 jaar oud.
4. Die kind is in ‘n formele program geregistreer en bly tuis.

### **Sal u voordeel trek uit deelname aan die studie?**

Gebaseer op bevindinge uit die vraelys deur u voltooi, sal 'n program ontwikkel word wat ten doel het om die vereistes/vaardighede te bevorder van 'n gesin met 'n gehoorgestremde kind. Dit kan tot u voordeel sowel as die van ander ouers wees wat nog moet aanpas met 'n gestremde kind in die huis.

### **Is daar 'n risiko verbonde aan die deelname aan die studie?**

Geen risiko is verbonde aan deelname aan die studie nie.

### **Indien u nie sou deelneem nie, wat is die alternatiewe beskikbaar?**

Indien u nie wil deelneem nie, kan u die nodige inligting en ondersteuning van professionele en ander ouers met gehoorgestremde kinders ontvang.

### **Wie sal toegang tot u informasie hê?**

Ons is bewus van die persoonlike aard van sommige vrae en verseker u dat die informasie ontvang in streng vertroulikheid hanteer sal word. Alle data sal gekodeer word en sal in geen mate met u of u kind terug verbind kan word nie. Die informasie ontvang is deel van 'n doktorsale tesis wat in alle waarskynlikheid in 'n akademiese joernaal gepubliseer sal word. Volle vertroulikheid word verseker.

### **Sal ek betaal word vir deelname, en is daar enige kostes betrokke?**

U sal 'n R20-vervoerkostebydrae ontvang. Versnaperings en middagete sal ook bedien word.

### **Is daar enige ander informasie wat ek benodig of moet doen?**

- Skakel Mev Ahlert by 021 948 9770 indien u enige navrae het of probleme ondervind.
- U kan die Komitee van Menslike Navorsing by 021 938 9207 kontak met enige navrae.

### Verklaring deur deelnemer

Ek, ..... die ondergetekende  
 onderneem om deel te wees van die Navorsingstudie 'Program om vooruitgang te bevorder in  
 families met 'n gehoorgestremde kind'.

Ek onderneem dat:

- Ek gelees of geles gehad het die informasie en magtigings vorm en dat dit in 'n taal is wat ek verstaan en gemaklik is mee.
- Dat ek 'n kans gehad het om vrae te vra en dat my vrae voldoende beantwoord is.
- Ek verstaan dat deelname aan die studie volkome vrywillig is en daar geensins enige druk op my uitgeoefen is vir deelname nie.
- Ek ten enige tyd die studie mag los en geensins gepenaliseer sal word nie.
- Dat ek gevra kan word om die studie te los voor dit klaar is, indien die navorsers voel dit is in my belang, of indien ek nie die studie nakom volgens die voorgeskrewe ooreenkoms nie.

Geteken te (plek) ..... op (datum) ..... 2006

.....

**Deelnemer**

.....

**Getuie**

## Verklaring deur Onderzoekbeampte

Ek (naam) ..... verklaar dat:

- Ek die inligting in hierdie dokument aan ..... verduidelik het.
- Ek hom/haar aangemoedig het om vrae te vra en voldoende tyd geneem het om vrae te beantwoord.
- Ek tevrede is dat hy/sy ten volle bewus is van alle aspekte rakende die studie soos uiteengesit hierbo.
- Ek het/het nie van 'n tolk gebruik gemaak (indien 'n tolk gebruik is moet hy/sy ook die verklaring onderteken).

Geteken te (plek) ..... op (datum)..... 2006

.....

**Onderzoekbeampte**

.....

**Getuie**

## Verklaring deur tolk

Ek (naam) ..... verklaar dat:

- Ek die ondersoek beampte (naam) ..... gehelp het om die informasie in hierdie dokument aan (naam van deelnemer) ..... te verduidelik deur gebruik te maak van Afrikaans/Xhosa.
- Ons hulle aangemoedig het om vrae te vra en voldoende tyd geneem het om vrae te beantwoord.
- Ek 'n feitelike korrekte weergawe oorgedra het soos dit aan my deurgee is.
- Dat ek tevrede is dat die deelnemer alle inligting verstaan en dat hy/sy vrae voldoende beantwoord is.

Geteken te (plek) ..... op (datum) ..... 2006

.....

**Tolk**

.....

**Getuie**

**PHEPHA ELINGOLWAZI NGOMTHATHI-NXAXHEBA NEFOMU  
YEMVUMELWANO**

**ISIHLOKO SEPROJEKTHI YOPHANDO:** Inkqubo yokonyusa ukomelela kweentsapho zabantwana abanengxaki yokungeva kakuhle’.

**UMPHATHI WOPHANDO:** Nkosk I. Ahlert

Uyamenywa ukuba uthabathe inxaxheba kuphando lwale projekthi. Nceda thatha ixesha lakho ukufunda inkcazelo elapha, nkcazelo leyo ezakuthi ichaze ngokupheleleyo ngale projekthi. Kubalulekile ukuba uqinisekise ukuba ucacelwe kakuhle kwaye ukwazi okuqulathiwe lolu phando, wazi kananjalo ukuba uza kuzibandakanya njani na wena kulo. Nceda ubuze xa ungaqondi. Kwakhona, **kuxhomekeke kuwe** ukuba uthathe inxaxheba kolu phando, kwaye ukuba uziva ufuna ukubuya umva, wamkelekile ukuba ukwenze oko. Ukungathathi kwakho nxaxheba/ ukungazibandakanyi kwakho kolu phando akunanto yakwenza nawe nangaluphi na uhlobo. Uvumelekile ukuba ubuye umva naninina, nokuba ubusele uvumile ukuba uzakuthatha inxaxheba.

Olu phando lavunywe **yiKomiti yoPhando yoLuntu; kwi Dyunivesiti yase-Stellenbosch** kwaye luza kuhlalelwa ngokwe migaqo efanelekileyo nevunyiweyo yomthetho kazwelonke ye ‘Declaration of Helsinki’ Imigaqo yoMzantsi Afrika enikezela (‘Good Clinical Practice’) ngenkonzo ezizizo zempilo nophando oluzakuthi (‘Medical Research Council’) lujonge iimeko zempilo kuluntu nemigaqo/imithetho ezakuthi ilandelwe ngethuba kusenziwa uphando.

**Lungantoni olu phando?**

Ukuba ngumzali kuyancomeka, kuyakhuthaza, ngamanye amaxesha kwenza ukuba ukwazi ukumelana nezinto ezithile ebomini kwaye kuthatha lonke ixesha lakho. Ukuba nomntwana ongeva kakuhle kwenza ukuba izinto zitshintshe kwimo ebezikuyo nendlela ekuphilwa ngayo ekhaya. Kudala uphando belujoliswe koonobangela neziphumo kwindlela usapho lwabantwa na abangeva kakuhle bebezibonakalisa ngazo iimpawu zoxinizelelo nosizeleko. Kodwa olu phando lujoliswe kwizinto ezinokuthi zincede wena njengamzali ukumelana nomntwana wakho ongeva kakuhle.

Ngokuzalisa kwakho le fomu yesivumelwano, unikezele nangezimvo zakho kolu phando, oko kuyakwenza ukuba umenywe/uye kwintlanganiso yesikolo somntwana wakho. Intlanganiso ayisokuze itsale de ifikelele kwisithuba seyure ezimbini, kwaye izakube ingokuzaliswa kwefomu ezinemibuzwana ngawe. Kufuneka unike inkcazelo kwimibuzo emithathu ezakube ijoliswe kuwe.

### **Kutheni le nto ucelwa ukuba uthathe inxaxheba?**

Zonke iintsapho ezichaphazelekayo koku kungezantsi, ziya menyiwe ukuba zithathe inxaxheba:

1. Umntwana ekwafumaniseka ukuba unako ukungeva okuthile okungengako-okungaphaya komlinganiselo.
2. Uxilongo lwenziwa kwisithuba seminyaka 1-4 edlulileyo.
3. Umntwana ungaphantsi kweminyaka eli-10 ubudala.
4. Umntwana ubhaliswe kwinkqubo esemthethweni kwaye uhlala ekhaya.

### **Ingaba kukhona oza kufumana ngokuthatha inxaxheba kolu phando?**

Leyo into izakuxhomekeka kwiziphumo zophando, ezizakuthi ziqhubele ekubunjweni kwenkqubo. Loo nkqubo iza kube ijoliswe ekwandiseni izakhono ezizakuthi zancede usapho lumelane nomntwana walo ongeva kakhuhle. Loo nto iza kuba luncedo kuwe nakwabanye abazali abasafuna ukuzixhobisa/ukuzilungiselela xa bethe banomntwana ongeva kakuhle kwiintsapho zabo.

### **Ingaba usemngciphekweni ngokuthatha inxaxheba kolu phando?**

Awukho semngciphekweni ngokuthatha inxaxheba kolu phando.

### **Ukuba akuvumi ukuthatha inxaxheba kolu phando, ziziphi ezinye izinto ocinga ukuba zingaluncebo?**

Ukuba ugqibe ekubeni ungathathi inxaxheba kolu phando, ungafumana inkxaso eyiyo nolwazi kwingcali nakwezinye iintsapho ezinabantwana abanengxaki yokungeva.

### **Ngubani onelungelo kokubhalwe nguwe/okuthethwe nguwe?**

Siyazi ukuba imibuzo ebuziweyo neempendulo ozinikileyo zezakho kwaye akukho mntu unelungelo lokuzazi, ngoko ke siyakuthembisa ukuba inkcazelo oyinikileyo izakugcinwa njengemfihlo emandla. Zonke iinkcazelo ezinikiweyo zizakubekwa ngendlela eyiyo kwaye akuzokubakho nkcazelo izakufaniswa njengephuma kuwe/emntwaneni wakho. Inkcazelo oyinikileyo izakuthatyathwa njengenkcabez enikwe ngugqirha ezakuthi ikhutshwe kwi ('Academic Journal'). Uyathenjiswa ukuba oko kuya kuhlala kuyimfihlo.

### **Ingaba uza kuhlulwa na ngokuthatha inxaxheba kolu phando? Ikho yona mali ekufuneka ikhutshi we?**

Uza kufumana i-R20 eyimali yeendleko zokukhwela. Uza kufumana iziselo namaqebengwana kwakunye nesidlo sasemini.

### **Ingaba ikhona into engenye ofuna ukuyazi/ukuyenza?**

- Qhagamishelana noNkosk Ahlert kule nombolo 021 948 9770 ukuba kukho izikhalazo nezinye iingxaki ozifumanayo.
- Ungaqhagamishelana kwakhona neKomiti yoPhando loLuntu kule nombolo 021 938 9207 ukuba kukho into ofuna ukuyiqonda/izikhalazo ezingakhange zondlalwe/kufikelelwe kuzo.

### **Ukuzibophelela komthathi-nxaxheba**

Ngokutyikitya oku kungezantsi Mna .....(nceda bhala igama ngoonobumba). yavuma ukathatha inxaxheba kuphando olunesihloko 'Inkqubo yokonyusa ukomelela kweentsapho zabantwana abanengxaki yokungeva kakuhle'.

Ndiyavuma ukuba:

- Ndilifundile/Ndiyifundelwe yonke inkcazelo ekule fomu kwaye ibhalwe ngolwimi endilwazi kakuhle, nendiziva ndikhululekile kulo.
- Ndilini kiwe ithuba lokubuza imibuzo, kwaye imibuzo yam iphendulekile.
- **Andinyanzelwanga** mntu ukuba ndithathe inxaxheba kolu phando, kuthande mna.
- Kuxhomekeke kum ukuba ndibuye umva kolu phando, kwaye akukho mntu unokundimangalela ngoko; kungekho mntu uzakundijongela loo nto.
- Ndingacelwa ukuba ndiluyeke uphando lungekagqitywa ukuba umphandi ubone ndikufanele oko/andilandeli migaqo njengesivumelwano.

Ityikitywe e-(indawo) ..... ngo-(umhla) ..... 2006.

.....

Umtyikityo womthathi-nxaxheba

.....

Umtyikityo wengqina

**Ukuzibophelela komphandi**

Mna (*igama*) ..... ndizibophelela-ukuba:

- Ndikucacisile okuqulathwe ngulo mqulu ku .....
- Ndimkhuthazile ukuba abuze imibuzo kwaye athathe ixesha elaneleyo ukuyiphendula.
- Ndanelisekile ukuba uqonde kakuhle wazivelela zonke iinkalo malunga noluphando njengoko beseluchaziwe ngasentla.
- Andikhange ndibenaye umntu othe waguqula/ozame ukucacisa okubhaliweyo ngolunye ulwimi. (Ukuba itoliki ikhona kufuneka ityikitye ukuzibophelela ngezantsi.)

Ityikitywe e- (indawo) ..... ngo- (umhla) ..... 2006.

.....

Umtyikityo womphandi

.....

Umtyikityo wengqina

***Ukuzibophelela kwetoliki***

Mna (*igama*) ..... ndizibophelela-ukuba:

- Ndimncedisile umphandi (*igama*) ..... Ekufundeni inkcazelo ekulo mqulu ku (*igama lothatha inxaxheba*) ..... ndisebenzisa ulwimi oluphakathi/olwaziwayo kakuhle ngothatha inxaxheba isiXhosa/isiAfricansi.
- Simikhuthazile yena ukuba abuze imibuzo kwaye athathe ixesha elaneleyo ekuphenduleni.
- Ubaxelele into eyiyo.
- Ndanelisekile ukuba othathe inxaxheba kolu phando uyaqonda kakuhle okuqulathwe ngulo mqulu kwaye nemibuzo ebenayo iphendulekile.

Ityikitywe e-(indawo) ..... ngo-(umhla) ..... 2006.

.....

Umtyikityo wetoliki

.....

Umtyikityo wengqina

## ADDENDUM B

### BIOGRAPHICAL INFORMATION

All information in this questionnaire is strictly confidential and your information will be processed anonymously. Please cross the box most appropriate to you, or complete the statement in the space provided.

Completed by: **mother / father (delete what is not applicable).**

1. **Living in** .....(neighbourhood) .....(town/city)

2. **Marital status** (please tick the box which best describes your current status and fill in the number of years)

- Married ..... years     
  Living together ..... years     
  Single ..... years  
 Separated ..... years     
  Divorced ..... years

How many times have you previously been married? .....      And your partner? .....

3. **Family composition**

	Self	Spouse	Child 1	Child 2	Child 3	Child 4
<b>Age</b>						
<b>Gender</b>						
<b>Hearing status</b> Normal / hearing impaired						
<b>Degree of hearing impairment</b>						

Is there anyone else who lives permanently with you in your home?     No       Yes

If yes, please give details.....

.....

4. **Characteristics of your child with a hearing impairment**

At what age was your child diagnosed with a hearing impairment? .....

Who identified the hearing impairment?       Parent       Professional

What degree of hearing impairment does your child suffer from?     Mild     Moderate     Severe     Profound

What was the cause of the hearing impairment? .....

How did you feel when you heard of the diagnosis? .....

.....

Does your child have a disability in addition to a hearing impairment?  Yes  No

If yes, please explain. ....

.....

What type of amplification does your child use?  Hearing aid  Cochlear implant  None

What type of communication method does your child use?  Oral  Signing

What type of intervention has your child received?  Speech therapy  Physiotherapy

Occupational therapy  Psychotherapy  Other .....

Is your child involved in an intervention programme?  Yes  No

If yes, where and at what age was he/she enrolled?.....

Child lives with:  Both parents  Mother  Father

Other – specify .....

Would you describe your child as: (please tick appropriate box)

	All the time	Most of the time	Seldom	Never
<b>Happy</b>				
<b>Unhappy</b>				
<b>Tearful</b>				
<b>Shy</b>				
<b>Fearful</b>				
<b>Attention-seeking</b>				
<b>Moody</b>				
<b>Impulsive</b>				
<b>Overactive</b>				
<b>Underactive</b>				

**5. Job, education, income and home language**

	<i>SELF</i>	<i>SPOUSE</i>
<b>Currently employed (Yes/No)</b>		
<b>Occupation</b>		
<b>Temporary/permanent job</b>		

What is the highest level of education received by:

Yourself:  Primary school  High school  Diploma  Degree  Other.....

Your Partner:  Primary school  High school  Diploma  Degree  Other .....

What is your family's estimated gross income per year?

- Less than R20 000                       R21 000 - R40 000                       R41 000 - R60 000  
 R61 000 - R80 000                       R81 000 - R100 000                       R101 000 – 120 000  
 R121 000 – R140 000                       R141 000 – R160 000                       R 160 000 or more

What is your home language?       English  Afrikaans  Xhosa  Other (specify).....

What language do you speak to your child with a hearing impairment?                       English                       Afrikaans  
 Xhosa                       Sign  Other (specify) .....

**Thank you for your co-operation!**

**ADDENDUM C**  
**FAMILY FUNCTIONING**  
**FACIS**

DIRECTIONS: Decide how well each statement describes what is happening in your family. In the column headed **Now**, circle the number which best describes how often each thing is happening right now.

	<b>Now</b>				
	<b>Never</b>	<b>Sometimes</b>	<b>Half the time</b>	<b>More than half</b>	<b>Always</b>
<i>In my family...</i>					
1. In our family it is easy for everyone to express his/her opinion.	1	2	3	4	5
2. It is easier to discuss problems with people outside the family than with other family members.	1	2	3	4	5
3. Each family member has input in major family decisions.	1	2	3	4	5
4. Family members discuss problems and feel good about the solutions.	1	2	3	4	5
5. In our family everyone goes his/her own way.	1	2	3	4	5
6. Family members consult other family members on their decisions.	1	2	3	4	5
7. We have difficulty thinking of things to do as a family.	1	2	3	4	5
8. Discipline is fair in our family.	1	2	3	4	5
9. Family members feel closer to people outside the family than to other family members.	1	2	3	4	5
10. Our family tries new ways of dealing with problems.	1	2	3	4	5
11. In our family, everyone shares responsibilities.	1	2	3	4	5
12. It is difficult to get a rule changed in our family.	1	2	3	4	5
13. Family members avoid each other at home.	1	2	3	4	5
14. When problems arise, we compromise.	1	2	3	4	5
15. Family members are afraid to say what is on their minds.	1	2	3	4	5
16. Family members pair up rather than do things as a total family.	1	2	3	4	5

*F-COPES*

**DIRECTIONS:** **First**, read the list of "Response Choices" one at a time. **Second**, decide how each statement will describe your attitudes and behaviour in response to problems or difficulties. If the statement describes your response very well, then select the number 5 indicating that you STRONGLY AGREE; if the statement does not describe your response at all, then select the number 1 indicating that you STRONGLY DISAGREE; if the statement describes your response to some degree, then select a number 2, 3 or 4 to indicate how much you agree or disagree with the statement about your response.

- 1 Strongly disagree      2 Moderately disagree      3 Neither agree nor disagree  
 4 Moderately agree      5 Strongly agree

**WHEN WE FACE PROBLEMS OR DIFFICULTIES IN OUR FAMILY, WE RESPOND BY:**

- 1. Sharing our difficulties with relatives
- 2. Seeking encouragement and support from friends
- 3. Knowing we have the power to solve major problems
- 4. Seeking information and advice from persons in other families who have faced the same or similar problems
- 5. Seeking advice from relatives (grandparents, etc.)
- 6. Seeking assistance from community agencies and programs designed to help families in our situation
- 7. Knowing that we have the strength within our own family to solve our problems
- 8. Receiving gifts and favours from neighbours (e.g. food, taking in mail, etc.)
- 9. Seeking information and advice from the family doctor
- 10. Asking neighbours for favours and assistance
- 11. Facing the problems "head-on" and trying to get a solution right away
- 12. Watching television
- 13. Showing that we are strong
- 14. Attending church services
- 15. Accepting stressful events as a fact of life
- 16. Sharing concerns with close friends
- 17. Knowing luck plays a big part in how well we are able to solve family problems
- 18. Exercising with friends to stay fit and reduce tension
- 19. Accepting that difficulties occur unexpectedly
- 20. Doing things with relatives (get-together, dinners, etc.)
- 21. Seeking professional counselling and help for family difficulties
- 22. Believing we can handle our own problems
- 23. Participating in church activities
- 24. Defining the family problem in a more positive way so that we do not become too discouraged
- 25. Asking relatives how they feel about problems we face
- 26. Feeling that no matter what we do to prepare, we will have difficulty handling problems
- 27. Seeking advice from a minister
- 28. Believing if we wait long enough, the problem will go away
- 29. Sharing problems with neighbours
- 30. Having faith in God

## FHI

**DIRECTIONS:** Please read each statement below and decide to what degree each describes your family. Is the statement **FALSE, MOSTLY FALSE, MOSTLY TRUE, TRUE**, or **NOT APPLICABLE** about your family? Please indicate your choice in the appropriate space.

IN OUR FAMILY .....	<i>False</i>	<i>Mostly False</i>	<i>Mostly True</i>	<i>True</i>	<i>Not Applicable</i>	<i>Official use</i>
1. Trouble results from mistakes we make						
2. It is not wise to plan ahead and hope because things do not turn out anyway						
3. Our work and efforts are not appreciated no matter how hard we try and work						
4. In the long run, the bad things that happen to us are balanced by the good things that happen						
5. We have a sense of being strong even when we face big problems						
6. Many times I feel I can trust that even in difficult times things will work out						
7. While we don't always agree, we can count on each other to stand by us in times of need						
8. We do not feel we can survive if another problem hits us						
9. We believe that things will work out for the better if we work together as a family						
10. Life seems dull and meaningless						
11. We strive together and help each other no matter what						
12. When our family plans activities we try new and exciting things						
13. We listen to each others' problems, hurts and fears						
14. We tend to do the same things over and over .... it's boring						
15. We seem to encourage each other to try new things and experiences						
16. It is better to stay at home than go out and do things with others						
17. Being active and learning new things are encouraged						
18. We work together to solve problems						
19. Most of the unhappy things that happen are due to bad luck						
20. We realise our lives are controlled by accidents and luck						

### FTRI

**DIRECTIONS:** **First**, read the following statements and decide to what extent each of the routines listed below are false or true about your family: **False (0), Mostly False (1), Mostly True (2), True (3)**. Please circle the number (0, 1, 2, 3) which best expresses your family experiences.

**Second**, determine the importance of each routine to keeping your family together and strong: **NI = Not Important, SI = Somewhat Important, VI = Very Important**. Please circle the letters (NI, SI, or VI) which best express how important the routines are to your family. If you do not have children, relatives, teenagers, etc., please circle NA = Not Applicable.

Routines	False	Mostly false	Mostly true	True	How important to keeping the family together and united			
					<i>Important to family</i>			
					Not	Somewhat	Very	Not applicable
1. Parent(s) have some time each day for just talking with the children	0	1	2	3	NI	SI	VI	NA
2. Working parent has a regular play time with the children after coming from work	0	1	2	3	NI	SI	VI	NA
3. Working parent takes care of the children some time almost every day	0	1	2	3	NI	SI	VI	NA
4. Non-working parent and children do something together outside the home almost every day (e.g., shopping, walking, etc.)	0	1	2	3	NI	SI	VI	NA
5. Family has a quiet time each evening when everyone talks or plays quietly	0	1	2	3	NI	SI	VI	NA
6. Family goes some place special together each week	0	1	2	3	NI	SI	VI	NA
7. Family has a certain family time each week when they do things together at home	0	1	2	3	NI	SI	VI	NA
8. Parent(s) read or tell stories to the children almost every day	0	1	2	3	NI	SI	VI	NA
9. Each child has some time each day for playing alone	0	1	2	3	NI	SI	VI	NA
10. Children/teens play with friends daily	0	1	2	3	NI	SI	VI	NA
11. Parents have a certain hobby or sport they do together regularly	0	1	2	3	NI	SI	VI	NA
12. Parents have time with each other quite often	0	1	2	3	NI	SI	VI	NA
13. Parents go out together one or more times a week	0	1	2	3	NI	SI	VI	NA
14. Parents often spend time with teenagers for private talks	0	1	2	3	NI	SI	VI	NA

Routines	False	Mostly false	Mostly true	True	How important to keeping the family together and united			
					<i>Important to family</i>			
					Not	Somewhat	Very	Not applicable
15. Children have special things they do or ask for each night at bedtime (e.g. story, good-night kiss, hug, etc.)	0	1	2	3	NI	SI	VI	NA
16. Children go to bed at the same time almost every night	0	1	2	3	NI	SI	VI	NA
17. Family eats at about the same time each night	0	1	2	3	NI	SI	VI	NA
18. Whole family eats one meal together daily	0	1	2	3	NI	SI	VI	NA
19. At least one parent talks to his or her parents regularly	0	1	2	3	NI	SI	VI	NA
20. Family have regular visits with the relatives	0	1	2	3	NI	SI	VI	NA
21. Children/teens spend time with grandparent(s) quite often	0	1	2	3	NI	SI	VI	NA
22. We talk with/ write to relatives usually once a week	0	1	2	3	NI	SI	VI	NA
23. Family checks in or out with each other when someone leaves or comes home	0	1	2	3	NI	SI	VI	NA
24. Working parent(s) comes home from work at the same time each day	0	1	2	3	NI	SI	VI	NA
25. Family has certain things they almost always do to greet each other at the end of the day	0	1	2	3	NI	SI	VI	NA
26. We express caring and affection for each other daily	0	1	2	3	NI	SI	VI	NA
27. Parent(s) have certain things they almost always do each time the children get out of line	0	1	2	3	NI	SI	VI	NA
28. Parents discuss new rules for children/teenagers with them quite often	0	1	2	3	NI	SI	VI	NA
29. Children do regular household chores	0	1	2	3	NI	SI	VI	NA
30. Mothers do regular household chores	0	1	2	3	NI	SI	VI	NA
31. Fathers do regular household chores	0	1	2	3	NI	SI	VI	NA
32. Teenagers do regular household chores	0	1	2	3	NI	SI	VI	NA

## RFS

**DIRECTIONS:** Decide for your family whether you: **STRONGLY DISAGREE; DISAGREE; are NEUTRAL; AGREE; or STRONGLY AGREE** with the statements listed below. Indicate your choice in the appropriate space.

<i>We cope with family problems by:</i>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>	<b>Official use</b>
1. Sharing our difficulties with relatives						
2. Seeking advice from relatives						
3. Doing things with relatives (get-togethers)						
4. Seeking encouragement and support from friends						
5. Seeking information and advice from people faced with the same or similar problems						
6. Sharing concerns with close friends						
7. Sharing problems with neighbours						
8. Asking relatives how they feel about the problems we face						

## FPSC

<i>When our family struggles with problems or conflicts which upset us, I would describe my family in the following way:</i>	<b>False</b>	<b>Mostly False</b>	<b>Mostly True</b>	<b>True</b>
1. We yell and scream at each other	0	1	2	3
2. We are respectful of each others' feelings	0	1	2	3
3. We talk things through till we reach a resolution	0	1	2	3
4. We work hard to be sure family members are not hurt, emotionally or physically	0	1	2	3
5. We walk away from conflicts without much satisfaction	0	1	2	3
6. We share with each other how much we care for one another	0	1	2	3
7. We make matters more difficult by fighting and bringing up old matters	0	1	2	3
8. We take time to hear what each other has to say or feel	0	1	2	3
9. We work to be calm and talk things through	0	1	2	3
10. We get upset, but we try to end our conflicts on a positive note	0	1	2	3

## SSI

<i>Please rate the following statements as they apply to your family:</i>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>	<i>Official use</i>
1. If I had an emergency, even people I do not know in this community would be willing to help						
2. I feel good about myself when I sacrifice and give time and energy to members of my family						
3. The things I do for members of my family and they do for me make me feel part of this very important group						
4. People here know they can get help from the community if they are in trouble						
5. I have friends who let me know they value who I am and what I can do						
6. People can depend on each other in this community						
7. Members of my family seldom listen to my problems or concerns; I usually feel criticised						
8. My friends in this community are a part of my everyday activities						
9. There are times when family members do things that make other members unhappy						
10. I need to be very careful how much I do for my friends because they take advantage of me						
11. Living in this community gives me a secure feeling						
12. The members of my family make an effort to show their love and affection for me						
13. There is a feeling in this community that people should not get too friendly with each other						
14. This is not a very good community to bring children up in						
15. I feel secure that I am as important to my friends as they are to me						
16. I have some very close friends outside the family who I know really care for me and love me						
17. Member(s) of my family do not seem to understand me; I feel taken for granted						

### QRS-F

**DIRECTIONS:** This questionnaire deals with your feelings about a member in your family. There are many blanks on the questionnaire. Imagine the name of your child with a hearing impairment filled in on each blank. Give your honest feelings and opinions. Please answer all of the questions, even if they do not seem to apply. If it is difficult to decide **True (T) or False (F)**, answer in terms of what you and your family feel or do **most** of the time.

1. .... doesn't communicate with others of his/her age group.	T	F
2. Other members of the family have to do without things because of ....	T	F
3. Our family agrees on important matters.	T	F
4. I worry about what will happen to .... when I can no longer take care of him/her.	T	F
5. The constant demands for care for .... limit growth and development of someone else in our family.	T	F
6. .... is limited in the kind of work he/she can do to make a living.	T	F
7. I have accepted the fact that .... might have to live out his/her life in some special setting.	T	F
8. .... can feed himself/herself.	T	F
9. I have given up things I have really wanted to do in order to care for ....	T	F
10. .... is able to fit into the family social group.	T	F
11. Sometimes I avoid taking .... out in public.	T	F
12. In the future, our family's social life will suffer because of increased responsibilities and financial pressure.	T	F
13. It bothers me that .... will always be this way.	T	F
14. I feel tense whenever I take .... out in public.	T	F
15. I can go visit with friends whenever I want.	T	F
16. Taking .... on a vacation spoils pleasure for the whole family.	T	F
17. .... knows his/her own address.	T	F
18. The family does as many things together now as we ever did.	T	F
19. .... is aware who he/she is (for example, male 14 years).	T	F
20. I get upset with the way my life is going.	T	F
21. Sometimes I feel very embarrassed because of ....	T	F
22. .... doesn't do as much as he/she should be able to do.	T	F
23. It is difficult to communicate with .... because he/she has difficulty understanding what is being said to him/her.	T	F
24. There are many places where we can enjoy ourselves as a family when .... comes along.	T	F

25. .... is over-protected.	T	F
26. .... is able to take part in games or sports.	T	F
27. .... has too much time on his/her hands.	T	F
28. I am disappointed that .... does not lead a normal life.	T	F
29. Time drags for ....., especially free time.	T	F
30. .... can't pay attention for very long.	T	F
31. It is easy for me to relax.	T	F
32. I worry about what will be done with .... when he/she gets older.	T	F
33. I get almost too tired to enjoy myself.	T	F
34. One of the things I appreciate about .... is his/her confidence.	T	F
35. There is a lot of anger and resentment in our family.	T	F
36. .... is able to go to the bathroom alone.	T	F
37. .... cannot remember what he/she says from one moment to the next.	T	F
38. .... can ride a bus.	T	F
39. It is easy to communicate with ....	T	F
40. The constant demands to care for .... limit my growth and development.	T	F
41. .... accepts himself/herself as a person.	T	F
42. I feel sad when I think of ....	T	F
43. I often worry about what will happen to .... when I no longer can take care of him/her.	T	F
44. People can't understand what .... tries to say.	T	F
45. Caring for .... puts a strain on me.	T	F
46. Members of our family get to do the same kinds of things other families do.	T	F
47. .... will always be a problem to us.	T	F
48. .... is able to express his/her feelings to others.	T	F
49. .... has to use a bedpan or nappy.	T	F
50. I rarely feel blue.	T	F
51. I am worried much of the time.	T	F
52. .... can walk without help.	T	F





## ADDENDUM D

### PROGRAMME PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

**TITLE OF THE RESEARCH PROJECT:** A programme to enhance resilience in families in which a child has a hearing loss.

**PRINCIPAL INVESTIGATOR:** Mrs I. Ahlert

#### **What is this research study all about?**

You were invited to take part in a research study which aimed to identify what helped you as parents to cope with having a child with a hearing impairment in your family. We identified a number of important factors/strengths in the questionnaires completed by you. Based on these findings, a programme has now been developed which aims to enhance the identified strengths/skills in order to help you and other families to cope better with the challenges and demands of having a child with a hearing impairment child in the family.

This study has been approved by the **Committee for Human Research at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

Your participation in the programme is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the programme at any point, even if you did agree to take part.

#### **Why have you been invited to participate and what will it entail?**

Families who participated in the initial stage of the study have been invited to take part in a programme. By agreeing to take part in the programme, you will be randomly allocated to either an experimental or control group. You will be invited to attend a workshop, with a follow-up in three months time. By the end of the follow-up all participants will have received the treatment intervention.

**Will you benefit from taking part in the programme?**

By taking part in the programme, you will learn important skills which are necessary to cope with having a child with a hearing impairment in the family. Learning these skills will improve your family's functioning and will also have a positive impact on the development of your child.

**Are there any risks involved in your taking part in the programme?**

No risks are involved in taking part in the programme.

**If you do not agree to take part, what alternatives do you have?**

If you decide not to participate in the programme, you may receive the necessary support and information from professionals and other families with a child with a hearing impairment.

**Who will have access to your information?**

1 independent psychologist will be present to evaluate the programme. All the information obtained will be handled with the strictest confidentiality. All data from the questionnaires will be coded and no information will be able to be related directly back to you or your child. Complete anonymity is assured.

**Will you be paid to take part in the programme?**

Individuals who attend the programme will be paid R100.00, while couples will be paid R200.00. Each participant will also receive R20.00 to contribute towards their travelling expenses.

**Is there anything else that you should know or do?**

- You can contact Mrs Ahlert at 021-945 4439 if you have any further queries or encounter any problems.
- You can contact the Committee for Human Research at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed.

**Declaration by participant**

By signing below, I .....(please print), agree to take part in the programme.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in the programme is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the programme at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the programme before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) .....2007.

.....

Signature of participant

.....

Signature of witness

### **Declaration by investigator**

I (*name*) ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did/did not use an interpreter.

Signed at (*place*) ..... on (*date*) .....2007.

.....

Signature of investigator

.....

Signature of witness

## PROGRAM DEELNAME INFORMASIE EN MAGTIGINGSVORM

**NAVORSINGSPROJEK TITEL:** ‘n Program om vooruitgang te bevorder in families met ‘n kind met ‘n gehoorgestremdheid.

**HOOF ONDERSOEKBEAMPTE:** Mev. I Ahlert

### **Wat is die doel van die navorsing?**

U was genooi om deel te neem in ‘n navorsingsprojek waar gemik is om te identifiseer wat u as ouers gehelp het om u kind met ‘n gehoorgestremdheid beter te hanteer en te verstaan. Ons het ‘n paar belangrike sterktes en aanpassings vaardighede geïdentifiseer in die vraelyste wat u voltooi het. Gebaseer op hierdie bevindings, is ‘n program nou ontwikkel wat mik om die geïdentifiseerde sterktes/vaardighede te bevorder om u en ander families te help om beter met die uitdagings en vereistes van ‘n kind met ‘n gehoorgestremdheid klaar te kom.

Die studie is goedgekeur deur die **Komitee van Menslike Navorsing by die Universiteit van Stellenbosch** en sal bedryf word in ooreenstemming met die etiese riglyne en beginsels van die Internasionale Deklarasie van Helsinki, Suid-Afrikaanse Riglyne vir Goeie Kliniese Praktyk en die Mediese Navorsingsraad (MNR) se Etiese Riglyne vir Navorsing.

U deelname aan hierdie studie is **ten volle vrywillig** en u kan enige tyd u deelname staak. Indien u nie deelneem nie, sal dit u op geen wyse negatief beïnvloed nie. U kan ten enige tyd van die program onttrek al het u ook ingestem om deel te neem.

### **Waarom word u versoek om deel te neem?**

Families wat in die begin van die studie deelgeneem het, is genooi om deel te neem in die program. As u toestem om deel te neem in die program, sal u ewekansig toegedeel word na ‘n eksperimentele of kontrole groep. U sal genooi word om ‘n werkswinkel by te woon, met ‘n opvolg oor drie maande. Al die deelnemers sal die behandeling ontvang het aan die einde van die opvolg-sessie.

### **Sal u voordeel trek uit deelname aan die program?**

Deur deel te neem aan die program, sal u belangrike vaardighede leer wat nodig is om u kind met ‘n gehoorgestremdheid beter te verstaan and te hanteer. Om hierdie vaardighede aan te leer sal u familie se funksionering bevorder en ‘n positiewe impak op u kind se ontwikkeling hê.

### **Is daar enige risiko verbonde aan die deelname aan die program?**

Geen risiko is verbonde aan die deelname in die program nie.

### **Indien u nie sou deelneem nie, wat is die alternatiewe beskikbaar?**

Indien u nie wil deelneem nie, kan u die nodige inligting en ondersteuning van professionele en ander ouers met kinders met gehoorgestremde ontvang.

### **Wie sal toegang tot u informasie hê?**

1 sielkundige sal die program bywoon om dit te evalueer. Al die informasie wat ontvang sal word, sal in streng vertroulikheid hanteer word. Alle data van die vraelyste sal gekodeer word en geen informasie sal in geen mate met u of u kind terug verbind kan word nie. Volle vertroulikheid word verseker.

### **Sal ek betaal word vir deelname in die program?**

As een ouer die program bywoon, sal hy/sy R100.00 ontvang, terwyl 'n egpaar R200.00 betaal sal word. Elke deelnemer sal ook R20.00 ontvang as bydrae tot hulle vervoer onkoste.

### **Is daar enige ander informasie wat ek benodig of moet doen?**

- Skakel Mev Ahlert by 021-945 4439 indien u enige navrae het of probleme ondervind.
- U kan die Komitee van Menslike Navorsing by 021-938 9207 kontak vir enige navrae.

### **Verklaring deur deelnemer**

Ek, ..... die ondergetekende  
 onderneem om deel te neem aan die program.

Ek onderneem dat:

- Ek gelees of gelees gehad het die informasie en magtigings vorm en dat dit in 'n taal is wat ek verstaan en gemaklik is mee.
- Dat ek 'n kans gehad het om vrae te vra en dat my vrae voldoende beantwoord is.
- Ek verstaan dat deelname aan die program volkome **vrywillig** is en daar geensins enige druk op my uitgeoefen is vir deelname nie.
- Ek ten enige tyd die program mag los en geensins gepenaliseer sal word nie.

- Dat ek gevra kan word om die program te los voor dit klaar is, indien die navorsers voel dit is in my belang, of indien ek nie die studie nakom volgens die voorgeskrewe ooreenkoms nie.

Geteken te (plek) ..... op (datum) ..... 2007

.....

.....

**Deelnemer**

**Getuie**

**Verklaring deur Onderzoekbeampte**

Ek (naam) ..... verklaar dat:

- Ek die inligting in hierdie dokument aan ..... verduidelik het.
- Ek hom/haar aangemoedig het om vrae te vra en voldoende tyd geneem het om vrae te beantwoord.
- Ek tevrede is dat hy/sy ten volle bewus is van alle aspekte rakende die studie soos uiteengesit hierbo.
- Ek het/het nie van 'n tolk gebruik gemaak.

Geteken te (plek) ..... op (datum) .....2007

.....

.....

**Onderzoekbeampte**

**Getuie**

## ADDENDUM E

# SOCIAL SUPPORT PROGRAMME

## FACILITATORS' TRAINING MANUAL

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## NOTE TO THE FACILITATOR

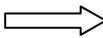
The birth of a child with a disability such as a hearing loss can cause significant stress for families and can significantly disrupt family functioning. Despite all the additional demands placed on the family as a result of the hearing loss, many families have been able to adjust and cope with the situation. In order to assist families with the adaptation to having a child with a hearing impairment, a programme has been developed that will enhance the utilisation of social support. Research has shown that social support is a specific characteristic that helps reduce stress and vulnerability in this high-risk situation and fosters healing and growth out of the crisis.

The programme focuses on developing the families' social support by empowering them to become more competent in mobilising their social support network. Participants will be helped to identify both existing sources of support and untapped, but potential, sources of support.

The **main aims** of the programme are to empower and strengthen families by:

- challenging and changing the existing *attitudes* that the participants have towards social support;
- providing *knowledge* about social support; and
- providing the *skills* required to mobilise family, friend and community support networks.

The programme itself will provide the participants with firsthand experiences of social support. Emotional support will be provided through the interaction with other parents who are going through similar experiences. Information support will be provided by giving the participants' information about available resources, thereby enabling them to access the services. Experiencing the benefits of support within the group setting may be a great motivator for the participants to actively seek out social support in their own environments.

The therapeutic model used for the design and development of this programme is psycho-education grounded in a family resilience orientation. This model was found to be the most appropriate because it focuses on strengths rather than deficits, and the participants are provided with practical information, concrete guidelines and problem-solving skills. This ensures that family resources are built to meet existing and new challenges more effectively. The facilitator's manual is meant as a step-by-step tool to guide you through the process. Teaching methods include lecturing, brainstorming, discussions, role-play and processing. Instructions to the facilitator are written in italics and the words spoken by the facilitator are indicated by an . Reference is made to previous research throughout the programme and is indicated by superscribed numbers. The complete reference list can be found at the end of the manual. Each participant will receive a workbook, which has been included as an addendum and can be reproduced for future workshops (refer to Addendum F). A Power Point presentation has also been designed and the following sign  will indicate when to proceed with a slide (CD provided).

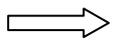
During the programme it is important to allow as much participant interaction as possible, as this will promote the learning process. The facilitator should be well prepared and must ensure that he/she knows the subject matter thoroughly and can deliver the information clearly. The facilitator must be flexible – be prepared to adjust activities to accommodate the size of the group and/or education level of the participants; be prepared to discard some items if there is less time than expected. Respect all participants and enjoy the mutual learning process that you will embark on.

## CHECK-LIST

The following material will be required for the workshop:

- Laptop
- Projector
- Screen
- Power point presentation
- Chairs and tables
- Whiteboard
- Marker pens and ballpoint pens
- Name tags
- Workbook
- Building material for bridge activity

### Key:



Words to be spoken by facilitator



Press enter to continue with slide show

### PROGRAMME FOR THE DAY

TIME	TASK
8:00-9:00	Registration Refreshments and sandwiches
<b>9:00-10:00</b>	<b>Session 1: Introduction</b> <ul style="list-style-type: none"> <li>• Brief introduction to the workshop</li> <li>• Participants give their consent to participate in the workshop</li> <li>• Participants' current social support is evaluated</li> <li>• Group norms are established</li> <li>• A general overview of workshop is given</li> </ul>
10:00-10:15	Tea and biscuits
<b>10:15-11:15</b>	<b>Session 2: My social support network</b> <ul style="list-style-type: none"> <li>• Define social support</li> <li>• Identify participants' present support system &amp; how it is helpful</li> <li>• Highlight the different types of support</li> </ul>
11:15-11:30	Tea
<b>11:30-12:30</b>	<b>Session 3: The benefits of social support</b> <ul style="list-style-type: none"> <li>• Importance and benefits of social support</li> <li>• Identify that basic needs can be met through ones social support network</li> <li>• Establish a plan to effectively use existing support networks to meet unmet needs</li> </ul>
12:30-13:30	Lunch
<b>13:30-14:30</b>	<b>Session 4: My beliefs about social support</b> <ul style="list-style-type: none"> <li>• Identify irrational beliefs about social support</li> <li>• Dispute and redefine the irrational beliefs</li> <li>• Develop skills to maintain existing supportive relationships</li> </ul>
14:30-14:45	Tea
<b>14:45-15:45</b>	<b>Session 5: Increasing my social support network</b> <ul style="list-style-type: none"> <li>• Develop skills to build supportive relationship</li> <li>• Identify available community resources</li> </ul>
15:45-16:00	Tea and biscuits
<b>16:00-17:00</b>	<b>Session 6: Conclusion</b> <ul style="list-style-type: none"> <li>• Conclusion and reflection</li> <li>• Evaluate the workshop and participants social support network</li> </ul>

# SESSION ONE:

## INTRODUCTION

### LESSON PLAN

**Aims:**

1. To establish group cohesion.
2. To familiarise participants with the groupwork process and content of the workshop.

**Objectives:** By the end of this session, participants will have:

1. Given their consent to participate in the workshop.
2. Completed the Social Support Index questionnaire as a pre-test measure.
3. Formulated group norms.
4. An overview of the programme for the day.

**Duration:** 45 – 60 minutes

**Materials:**

- Projector, laptop & screen
- White board & marker pens
- Workbook
- Consent form & Social Support Index
- Pens

**Style:** Informal, participatory and supportive

## PROCEDURE:

### 1. Introduction, objectives, consent and evaluation (20 minutes)

*Please note that the introduction below is specifically related to the current study and must be adjusted for future use.*

⇒ Thank you for attending the workshop today. I truly appreciate the time and effort you have put into coming and I hope that the day will be enriching and rewarding for you. As you all know, this workshop forms part of my doctoral study on which I am currently working. The aim of my study is to help parents cope better with having a child with a hearing impairment in their family.

Before we start with the actual workshop, we need to attend to some formalities. First of all, you need to complete a consent form. I will briefly highlight what the form states. You previously completed some questionnaires for me. I have since analysed them and have identified a number of important factors which have helped you to cope with your child with a hearing impairment. Since it is impossible to discuss all the factors in one day, I have decided to develop a programme that will only focus on one of the identified factors. I hope that through this programme you will discover and learn important new skills that will help you to cope even better with the demands and challenges placed on you and your family by your child with a hearing impairment.

Please note that your participation in this study is entirely voluntary. You are free to leave the programme at any time and will not be exposed to any risk or harm. By agreeing to take part in the programme, you will attend this one day workshop and will be asked to return for a follow-up meeting in three months time. This will give you an opportunity to discuss the progress you have made and any concerns you may still have. All the information obtained throughout the day will be treated with strictest confidentiality and the questionnaires you complete will be done anonymously. Have you got any further questions? We are now going to hand out the forms and if you agree to take part in the programme please sign your name on page 2 of the form. *(Facilitator is to hand out and collect Consent Form-refer to Addendum D-adjust for personal use.)*

I would like you to also complete this questionnaire *(facilitator to hold up the SSI-refer to Addendum C)* which will reflect your family's current level of social integration. Please answer all the questions honestly. Your name will not appear anywhere on the page. *(Facilitator is to hand out and collect all the forms.)*

Now that we have completed all of the formalities, I think it is important that we introduce ourselves. We will go around the circle and everyone can briefly state their name, where they come from and how old their child with a hearing impairment is. *(Give everyone an opportunity to introduce themselves).*

Although you are all from different backgrounds and communities, you have one important aspect in common, namely, that you have a child with a hearing loss. I believe that you will really be able to understand each other's concerns and problems and hopefully you will be able to learn much from one another today.

We are going to play a game now to help us relax and to start working as a team.

## 2. ICEBREAKER: THE HUMAN KNOT (10 minutes)

### Purpose of the activity:

1. To relax and gain confidence through having fun.
2. To identify the importance of working as a team.
3. To identify the benefits of accepting help and advice from others.

### Instructions to the facilitator for implementing the icebreaker:

1. Ask the group members to stand in a circle.
2. Let everyone lift their right hand and ask them to take the hand of the person standing opposite them.
3. Let everyone lift their left hand and instruct them to take the hand of *another* person (it may not be the same person whose right hand they took).
4. Instruct the group to unknot themselves without letting go of their hands.
5. Discuss what the participants may have learnt from the exercise.

## 3. NORMS (5 minutes)

⇒ We are going to spend the whole day together and will probably share quite a bit of personal information with one another. In order for everyone to feel safe in the group, we are going to set up a few rules. These rules will highlight your expectation of the group, will help you overcome anxieties related to sensitive issues and will encourage openness and communication.

We could, for example, make a rule that everyone should get an equal opportunity to speak and participate during the workshop. Can you think of any other rules that we should have?

*(Facilitator should record the answers on the white board. The following norms should be included:*

- *Confidentiality*
- *Respect for one another's feelings and opinions.*
- *Listen to one another.*
- *Being honest with yourself and others.*
- *Being punctual for the sessions.*
- *No smoking within the building.*
- *Switch off all cellphones.*

*Once all participants have voiced their opinions, ask every person to verbally agree to these 'conditions'. Leave the norms up throughout the workshop so that you can refer to them if necessary.)*

## 4. OVERVIEW OF THE WORKSHOP (10 minutes)

⇒ As I stated previously, much information was obtained from the questionnaires you completed. *Social support* was identified as one of the important factors that need to be present in order for families to cope effectively with a child with a hearing impairment. Today's workshop will thus be about enhancing your utilisation of *social support* networks.

The day is going to be divided into 6 sessions. We are going to have presentations, discussions, activities and opportunities to socialise with one another. The sessions will be approximately an hour long. Refreshments will be served in between and we will have an hour lunch break. We will have to watch the time closely so that we finish not later than 17:00. (*Facilitator to start with the power point presentation* ➡.)

Here is an outline of today's programme.

During this session:

- I gave you a brief introduction to the workshop.
- You gave your consent to participate in the workshop, we evaluated your current level of *social support* and established some group norms. ➡

In Session 2:

- I will describe what social support is and then we will try to identify who supports you.
- After that we will explore how these people are supportive and what different types of support one can receive. ➡

In Session 3:

- We will highlight the importance and benefits of social support.
- Then we will identify which of your needs are currently not being met and we will devise a plan on how you can use your existing support system to meet some of those needs. ➡

In Session 4:

- We will explore the false (irrational) beliefs you have about *social support*.
- Then we will dispute and redefine these false (irrational) beliefs so that you are motivated to seek *social support*.
- Then we will work through some tips that will help you to nurture your existing supportive relationships. ➡

In Session 5:

- We will discuss skills that are required when you want to build new supportive relationships.
- And then lastly we will explore what resources are available to you in the community and how these resources could provide you with *social support*. ➡

In Session 6:

- We will reflect on the day's work and evaluate the workshop.

You will find a copy of the programme in your workbook on page 268. I hope the programme sounds exciting to you.

We are now going to have a 15 minute tea-break. Please all be back punctually at 10:15.

# SESSION TWO:

## MY SOCIAL SUPPORT NETWORK

### LESSON PLAN

**Aims:**

1. Gain an understanding of the concept *social support*.
2. Develop awareness that *social support* enhances resilience.
3. Convey confidence that people can strengthen their *social support* network.

**Objectives:** By the end of this session participants will be able to:

1. Define *social support*.
2. Identify their present support system and possible need for additional support.
3. Identify how their present support system is helpful/supportive.
4. Identify the different types of support.

**Duration:** 50 – 60 minutes

**Materials:**

- Projector, laptop and screen
- White board & marker pens
- Workbook
- Pens
- 4 boxes containing building material for the bridge

**Style:** Informal, participatory and supportive

## PROCEDURE

### 1. Introduction and objectives (5 minutes)

☛ Facilitator is to welcome the group back and to start with the following introduction.

➡ During this session we are going to explore what *social support* is, who supports you and what different types of support you can receive.

The birth of a child is one of life's most natural and happy experiences and being a parent can be exciting, rewarding and at times quite challenging and demanding. Being told that your child has a hearing loss comes as a total shock and your dreams of a healthy child are immediately shattered. After such news, many parents feel sad, angry, confused and helpless. On top of that they have little or no knowledge about what a hearing loss is and what help is available to them. Such news can cause much stress for the whole family and involves increased financial costs, possible job losses and many hours spent at hospitals and clinics. In addition to these problems we also know that parents of disabled children experience the same difficult life events such as divorce or serious illness as do parents of non-disabled children.<sup>2</sup>

The above depicts a pretty bleak picture but research has shown that many families with a disabled child are able to adjust to the crisis.<sup>13</sup> So I asked myself, what characteristics or strengths do the families have that reduces their stress in this situation and helps them grow and heal? Previous research<sup>9,13</sup> and the results of my initial study have shown that *social support* is one of the important characteristics that reduces stress in these families and helps them be resilient. So today, we are going to focus on developing your *social support* network.

### 2. Definition of social support

➡ ☛ In essence, *social support* refers to all the positive interactions that you have with your family, friends, colleagues and community. ☛ It is a very important 'survival skill' that reduces your stress and helps you cope. Research has shown that the more support you have, the better your physical and emotional well-being.<sup>5</sup> By interacting with others you receive love, support and guidance, and learn about yourself and your purpose in life.<sup>5</sup>

I would like you to close your eyes and imagine that you are looking at a bridge. When we think of support, we can think of a bridge. What prevents the bridge from collapsing? The construction of strong pillars and support beams. The pillars and support beams are what makes the structure of the bridge so strong. Humans are the pillars and support beams that hold each other up. That implies that we are only as strong as the people we associate with.

We are now going to try and build bridges with different material and then see how important the support beams are for making a strong, stable bridge.

### 3. Activity: Build a bridge (15 minutes)

#### Purpose of the activity:

1. To visualise what the term *social support* means.
2. To identify the importance of a strong structure i.e. *social support* network.

#### Instructions for implementing the activity:

1. Divide the group in teams of 4-6 people.
2. Give each group a box with their building material.
3. Provide them with the following instructions: "I would like you to build a bridge with the material that I have given you in the box. The bridge must be the length of an A4 page and must have a support at each end."
4. Allow the participants approximately 5 minutes to build.
5. Compare the strength of the bridges by placing the same weight on each bridge and observing which bridges collapse and which remain standing.
6. Discuss this activity by exploring why certain bridges collapsed. Relate this to the number of 'support systems' used in building the structure.

#### Material required:

1. Box 1: ½ A4 (lengthwise), 2 rectangular blocks, 1 smaller rectangular block, prestik.
2. Box 2: ½ A4 (lengthwise), 3 rectangular blocks, 1 oval block, string.
3. Box 3: ½ A4 (lengthwise), 1 rectangular block, 1 triangle, 2 semi-circles.
4. Box 4: ½ A4 (lengthwise), 4 rectangular blocks, 3 squares.



*Social support* refers to having relationships that are rewarding, enriching and helpful. It is important to have a number of different supports at any given time in one's life. Having a whole network of supports ensures that the support you need will be available when you need it. I would like you to try and think now, who are the people that support you and why are they helpful to you. What do they do that you find supportive?

Can you all please turn to page 269 in your workbook.

#### 4. Activity: No one is an 'Is-land' (15 minutes)

##### Purpose of the activity:

1. To identify present support systems and the possible need for additional ones.
2. To identify how they are being supported.

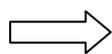
##### Instructions for implementing the activity:

1. Ask group members to look at the picture on page 269 in their workbook.
2. Provide them with the following instructions: "Over here we have a picture of a person on an island. All around him are planks on which he is floating. These planks lead him to a number. Next to the number there is a blank space. I would like you to imagine being this person on the island and to think who are the people in your life that support you. Write their names next to the numbers 1-5. Some of you may not have 5 names to write down and that is okay. Others may have more. Just try and think who are the people that help you in some way."
3. Give the group members some time to complete the question.
4. Then give them the following instructions: "Now I would like you to write down how the people that you mentioned are supportive. What do they do that helps you? Write your answer on the lines at the bottom of the page."
5. Give the members an opportunity to share their list of supporters and why they are helpful. Ask them to also state what relationship they have with this person e.g. sister, cousin, friend, minister etc.
6. Record some of the answers on the board under categories such as family, friends, colleagues.
7. Encourage group members to identify something he/she learnt from the activity.

##### Material required:

1. Workbook – page 269
2. Pen

#### 5. Sources and types of social support (15 minutes)



➡ Out of the discussion we can see that *social support* can be provided by a number of different sources. Some of you mentioned the names of families, friends or colleagues. Some of you could only think of a few names, while others possibly had more than 5 names.

↔ Some people benefit from a large and diverse *social support* system while others prefer a smaller circle of friends and acquaintances. Either way, it is helpful to have a number of friends to turn to so that someone is always available when you need them and that you do not burden only one person with all your worries, concerns and needs.

Out of our discussion it also became evident that there are different types of support that people can provide us with. Research has shown that the support we receive can be in the forms of emotional, informational, practical, esteem or tangible support.<sup>1</sup> ➤ *Emotional, practical and informational support* has been found to be the most important for parents who care for a child with a disability.<sup>3</sup>

➤ People are *emotionally* supporting us when they tell us that they care about us and think well of us. It involves acts of empathy, listening, and being there for one another.<sup>3</sup> For example, when you heard of your child's hearing loss, a close friend might have called every day just to hear how you are doing and to let you know that he/she cares. If you experienced this, it probably meant a lot to you and gave you some form of comfort or hope.

Let us look at some of the answers you gave during the last activity. Which ones would you say refer to emotional support?

➤ *Practical support* means that people who care about us give us practical help, for example, they cook or shop for us, baby-sit or give us money. This kind of support helps us with completing the basic day-to-day tasks in our life.<sup>3</sup> After your child was diagnosed with a hearing loss, you had to make many visits to the hospital, clinics, speech therapists etc. This took up much of your time and you probably struggled to keep up with all the housework. Any practical support, such as someone looking after your other children or cooking a meal for you, would have made the burden much easier to carry.

Which of these examples refer to practical support? (*Facilitator to refer to the answers from the previous activity.*)

➤ The last important type of support is *information support*. This happens when people in your social network provide you with the information you need.<sup>3</sup> For example, when you were informed that your child has a hearing loss, you had to acquire information to understand what the implications are, what help is available and what you need to do next. You needed information to decide on what mode of communication your child should use and to what nursery school you would like to send your child. I think you felt overwhelmed, helpless and hopeless before you received the information about what services are available to you.

Did you mention any information support in your answers? (*Facilitator to refer to the answers from the previous activity.*)

## 6. Conclusion

➡ Receiving any *emotional, practical or information support* is important. We, however, all have different opinions about what makes a relationship supportive. We also have our own perspectives about what we want from our relationships and whether we are satisfied with the number and quality of our relationships. If you look at your 'Is-land' and you realise you do not have as many people in your circle as you would like, or your relationships are not as close and supportive as you would like, I would like you to ask yourself the following questions:

- ✦ How would I like to change my social situation?
- ✦ Why is my social situation not like I would really like it to be?
- ✦ What changes can I make to get more social support in my life?

These 3 questions will guide us throughout the day and hopefully at the end you will be able to answer them confidently and even have a plan of what you are going to change and how you will do it.

We are now going to have a 15 minute tea-break. Please all be back at 11:30.

# SESSION THREE:

## THE BENEFITS OF SOCIAL SUPPORT

### LESSON PLAN

**Aim:**

1. Maximise the participants' utilisation of their personal social network as a source of support and resource for meeting their needs.
2. Empower participants so that they become more competent in being able to mobilise resources, get their needs met and achieve desired goals.

**Objectives:** By the end of this session, participants will be able to:

1. Identify the importance and benefits of *social support*.
2. Identify that their basic needs can be met through their *social support* network.
3. Establish a plan to effectively utilise their existing *social support* network to meet their unmet needs.

**Duration:** 60 minutes

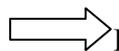
**Materials:**

- Projector, laptop, screen
- DVD player & video clip
- White board & marker pens
- Workbook
- Pens

**Style:** Informal, participatory and supportive

**PROCEDURE:****1. Introduction and objectives**

✦ *Facilitator is to welcome the group back and to start with the following introduction.*



During this session we are going to focus on why *social support* is so important in our lives and which of our needs are being met through our support network. Then we will also try and devise a plan so that we effectively use the support that is available to us.

**2. Video clip: Little Miss Sunshine (20 minutes)**Purpose of the activity:

1. To identify the meaning/role of *social support*.
2. To identify the importance of *social support*.
3. To identify ways in which *social support* can be expressed.

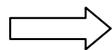
Instructions for implementing the activity:

1. Give group members the following background to the movie. “Take a hilarious ride with the Hoovers, one of the most endearingly fractured families in comedy history. Father Richard (Greg Kinnear) is desperately trying to sell his motivational success program...with no success. Meanwhile, ‘pro-honesty’ mom Sheryl (Toni Collette) lends support to her eccentric family, including her depressed brother (Steve Carell) fresh out of the hospital after being jilted by his lover. Then there are the younger Hoover’s – the 7 year old, would-be beauty queen Olive (Abigail Breslin) and Dwayne (Paul Dano), a Nietzsche-reading teen who has taken a vow of silence. Topping off the family is the foul-mouthed grandfather (Alan Arkin), whose outrageous behaviour recently got him evicted from his retirement home. When Olive is invited to compete in the ‘Little Miss Sunshine’ pageant in far-off California, the family piles into their rusted-out VW bus to rally behind her – with outrageous results”.<sup>4</sup>
2. Show the video clip.
3. Encourage participants to discuss what they learnt from the video clip. Explore what the support meant to each family member, how it was expressed and why it was important to have. Let them also relate this to their own lives.

Material required:

1. Video clip
2. DVD player, projector and screen

### 3. Why is social support important? (20 minutes)



➡ From the video clip and discussion that followed, I think it has become evident that *social support* is very important in our lives. I believe that it is even more important for you as parents of a disabled child. You probably often feel alone, frustrated and helpless because of all the extra burdens related to the hearing impairment. It is in these times that social support is especially important. Having adequate support can act as a buffer against these negative feelings and may even at times prevent you from feeling down in the first place. ➡ Having *social support* means that you have a shoulder to cry on when you are sad, and an ear that listens when you need to share positive or negative experiences. Talking about your feelings can greatly reduce your stress and helps you to work through your problems and to find possible solutions.

➡ *Social support* is also important because it provides us with a sense of belonging, an increased sense of self-worth and feelings of security.<sup>5</sup> A supportive relationship makes you feel good about yourself and more optimistic about the future. It provides you with positive feedback which helps you to maintain your motivation and commitment towards the long path that you are still going to walk with your child with a hearing impairment. Imagine how much it would help you if you had someone that would compliment you on your efforts and successes, and understand when you are discouraged and hurting. And having people call you a friend reinforces the idea that you are a good person and important to be around. Human beings need to feel a sense of belonging and acceptance. They need to love and be loved by others.

➡ *Social support* is also important because it can help meet some of our physical, emotional and social needs. As human beings, we all have specific needs that must be met in order for us to function effectively and to the best of our ability. ➡ Our needs include the following: (a) physiological needs such as the need to drink water, sleep and eat; (b) safety needs such as security of health and employment; (c) love/belonging/social needs such as having supportive family and friends; (d) esteem needs which include self-respect and respect from others; and (e) self actualisation needs which involve striving to become the best person you can.<sup>6</sup>

It is important that we take responsibility to meet these needs and if necessary, that we ask others for their help. Having a child with a hearing impairment places special and extraordinary demands on you and as a result you may have less time and energy to take care of yourself. This implies that you will have to make a conscious effort to make time for yourself and to focus on your own needs. This is so important because it is almost impossible to meet others' needs if your own needs are not met first.<sup>3</sup>

We are therefore now going to brainstorm in groups what our various needs are. Then you are going to try and identify which of your needs are not currently being met and what are possible ways of having them met by using your social support network. You will be amazed to see how many of your needs could actually be met by your current support network. You have got "Lifesavers" to help you.

#### 4. Activity: ‘Lifesavers’ (20 minutes)

##### Purpose of the activity:

1. To identify various means of support.
2. To establish a plan to utilise the designated support systems more effectively.

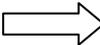
##### Instructions for implementing the activity:

1. Divide the group into smaller groups of 4-6 people.
2. Ask the group members to turn to page 270 in their workbook.
3. Explain the worksheet to them in the following way:  
 “As we have just discussed, we as human beings all have specific needs that must be met. I would like you to all now think of your physical needs and to think which of your physical needs are not currently being met. For example, you do not eat a healthy meal. Then I would like you to think why you do not eat a healthy meal. For example, you have no time to cook because you are looking after your children. Then I would like you to think how you could use your social support network to ensure that you can cook a healthy meal. You could for example ask your husband to look after the children. I would like you to think of some more examples and to write them down in the space provided. Then you can continue with the worksheet on page 271”.
4. Let them brainstorm and give feedback to the whole group once completed.
5. Ask what they have learnt from the activity. Help them identify what needs are not met, why they are not met and how they can be met.

##### Material required:

1. Workbook – page 270 & 271
2. Pen

#### 5. Conclusion


 The activity and discussion that we have just had, has highlighted how most of you seem to have the potential resources to meet your own needs but that many of the resources have up to now been unrecognised or have not been used effectively and sufficiently.  You can improve your well-being and independence by knowing when and how to utilise your supports. Hopefully this activity has given you some insight into how to effectively use your support system so that some of your needs can be met successfully. This in turn will help you to meet the needs of your child with a hearing impairment and other significant people in your life.  Remember that only once your own needs are met can you meet the needs of others.

We are now going to have a lunch break after which we will explore why we do not always use the support that is available to us. I would like you to all please be back at 13:30

# SESSION FOUR: MY BELIEFS ABOUT SOCIAL SUPPORT

## LESSON PLAN

**Aims:**

1. Cognitive restructuring and behaviour modification required to develop a *social support* network.

**Objectives:** By the end of the session, participants will be able to:

1. Identify their irrational beliefs that keep them from seeking social support.
2. Dispute and redefine their irrational beliefs.
3. Maintain their supportive relationships.

**Duration:** 50-60 minutes

**Materials required:**

- Projector, laptop, screen
- White board and marker pens
- Workbook
- Pens
- Scenarios for role-play

**Style:** Informal, participatory and supportive

**PROCEDURE:****1. Introduction and objectives**

*Facilitator is to welcome the group back and should begin with the following introduction.*

⇒ During the last session we focused on the important role that *social support* plays in your life. Now we are going to explore why some do not make use of their support and how they can keep the supportive relationships that they have.

**2. Irrational beliefs (5 minutes)**

⇒ I would like you to imagine the following scenario:

A first time mom and dad are worried because their new baby has its first cold. They decide to call a close family member for reassurance. Or maybe they call a friend or a clinic for advice. Did these parents do anything wrong by calling family or friends or by using a community resource? Most of us probably feel that these actions are perfectly acceptable and recommendable and that there is nothing wrong with seeking the help and support in time of uncertainty. If most of us think it is acceptable for parents to seek help and support from others, why then do most parents not actively seek out this support? Do parents feel that reaching out for help may imply that they are ‘weak’ or ‘needy’?<sup>10</sup>

I would like us to brainstorm and to write down the various beliefs that you think people have about asking for help or support.

**3. Activity: Brainstorm (5 minutes)**Purpose of the activity:

1. Identify irrational beliefs about seeking *social support*.

Instructions for implementing the activity:

1. Brainstorm as a big group and record answers on the white board.

Material required:

1. White board & marker pens

*(Below are possible other irrational beliefs that often keep parents away from seeking social support.)*

- ✦ ‘I should be able to do this on my own’.
- ✦ ‘It is a sign of weakness to ask others for support’.
- ✦ ‘It is embarrassing to let others know of my personal weaknesses’.
- ✦ ‘You should never burden anyone else with your feelings or personal concerns’.
- ✦ ‘People who know a lot about me or my life can take advantage of me’.
- ✦ ‘People don’t really care about me’.
- ✦ ‘Seeking help from family, friends or community resources will not help’.
- ✦ ‘They will not understand me so it won’t help’.

➡ We have identified a number of beliefs that parents in general have about asking for help or support. I would now like you all to turn to page 272 in your workbook. I would like you to think what *your* specific beliefs are about seeking support. Write these beliefs down in the space provided.

#### 4. Activity: Self-reflection (10 minutes)

##### Purpose of the activity:

1. To help group members identify their own specific beliefs about seeking *social support*.

##### Instructions for implementing the activity:

1. Let the group members reflect on their own beliefs and record their answers in their workbook on page 272.
2. Let them give feedback to the whole group and deal with what they have learnt from this activity.

##### Material required:

1. Workbook – page 272
2. Pen

➡ ❖ Would you say that all or any of the beliefs that we have mentioned are true? We can say with certainty, that many of them are not true, implying that they are irrational beliefs. This means that they are distorted and false. In order for us to really take action and to actively seek out *social support*, we will have to challenge these negative beliefs. We can detect and dispute these beliefs by asking ourselves the following questions:

- ❖ Are the statements logical? Are they true?
- ❖ If a friend held that idea, would I accept it?
- ❖ Are the statements scientific or reality based?
- ❖ Where is the proof?
- ❖ Does the outcome make me happy?
- ❖ Does it help me achieve my goals?

If we answer ‘No’ to these questions, then our beliefs are false or irrational. We should then reformulate them in more realistic terms and again ask ourselves the questions mentioned above. For example, we could challenge the belief ‘I should be able to do this on my own’ as follows: ‘I have tried my best to do this on my own but have not succeeded and should therefore ask for help’. This statement will not let you feel like a failure and acknowledges all the effort you have put into trying to cope. Thinking in this way will let you feel more positive and hopeful and it will be much easier to take action and ask for the support you require.

I would now like each of you to evaluate the beliefs that you wrote on page 5 of your workbook. Use the questions on page 273 of your workbook to evaluate whether the statements that you wrote down are logical, true or scientific. If they are not, then try and reformulate them so that they are accurate and truthful. You can write your answers on page 274 of your workbook.

### 5. Activity: Challenging yourself (10 minutes)

#### Purpose of the activity:

1. Dispute and redefine irrational beliefs.

#### Instructions for implementing the activity:

1. Let the group members try and redefine the beliefs they wrote down during the previous exercise. Let them record their answers on page 274 of their workbook.
2. Allow the group members to help one another if necessary.
3. Let them volunteer to give feedback to the group.
4. Discuss what they have learnt from the activity.

#### Material required:

1. Workbook – page 273 & 274
2. Pen

➡️ Your irrational beliefs may have up to now played a big role in preventing you from making use of the support in your family, circle of friends and community. You may, however, also lack *social support* because you do not know how to nurture the relationships that you have.

### 6. Maintaining relationships (20 minutes)

➡️ Throughout the day we have seen how your family and friends can be a source of support for you. Possibly, not all of you have good relationships with many of your family members and friends and it is therefore important that you nurture the existing relationships. Maintaining relationships involves commitment, hard work and a give and take process. We are going to try and identify ways in which you can ensure that the relationships that you have, remain strong and supportive. The following hints that I am going to give you may seem so obvious and easy, and they are. We, however, often forget to implement these very basic steps which help us nurture our relationships with others.

➡️ **Stay in touch** – Answer phone calls, respond to emails and invite each other for coffee or meals. It is important that you return your family and friends efforts and invitations because this lets them know that you care about them too.

➡️ **Be proactive** – Do not wait for the other person to always make the first move.

✦ **Don't compete** – Be happy instead of jealous when your family members or friends are successful, and they will celebrate your accomplishments in return.

✦ **Be a good listener** – Just listening can be a powerful tool. Often a friend only needs an ear that listens. We do not always have to talk or give advice. Listening shows that you really care.

✦ **Challenge yourself to become a better person** – Keep looking for ways to improve yourself e.g. complain less, be more generous, communicate more effectively. This will make you a more compassionate and appealing friend.

✦ **Don't overdo it, go easy** – Be careful not to overwhelm family and friends with phone calls and emails. Communication can be brief e.g. 5 minutes on the phone or several sentences in an email. Too much contact may be suffocating to the other person and may be an infringement in their personal space.

✦ **Adopt a healthy, realistic self-image** – Being vain and very critical of yourself can be unattractive to potential friends.

✦ **Avoid constant complaining** – Non-stop complaining is draining and irritating. At some stage it may just get too much for your family member or friend.

✦ **Adopt a positive outlook** – Try to find the humour in things and to see the positive side in life. This makes you a more fun person to be around.

✦ **Appreciate your family and friends** – Take time to say thank you. Tell them how important they are to you and how much you value and treasure their friendship and support.

✦ **Know when to accept or decline an invitation** – Do not decline an invitation because you feel shy or insecure. On the other hand, however, spending time with people who are not supportive can add stress and it is then important that you stand up for yourself and decline the invitation.<sup>7,8</sup>

Which of the following hints do you use at the moment? Which of the tips would you like to use in the future? Write your answers in your workbook on page 275.

Over the next few months you can try and add a new tip every week until you have a repertoire of behaviours which help you nurture your relationships. It may initially feel strange but keep on practicing and it will slowly become a natural part of your life.

## 7. Conclusion

➡ These skills are not so easy to develop and will take some time to practice. I would like you to make a commitment today to keep on practicing and approaching new people, until you feel that you have an adequate support network. You will eventually reap the rewards from all the hard work and will have a number of people that you can call friends.

We are now going to have a 15 minute tea break. Please all be back punctually at 14:45.

# SESSION FIVE:

## INCREASING MY SOCIAL SUPPORT NETWORK

### LESSON PLAN

**Aims:**

1. To develop skills to nurture and maintain existing relationships with significant others.
2. To build vital community networks.

**Objectives:** By the end of this session participants will have learnt skills to:

1. Increase their current *social support* network by applying the newly learnt knowledge and skills.
2. Identify available resources within their community.

**Duration:** 60 minutes

**Materials:**

- Projector, laptop and screen
- White board and marker pens
- Workbook
- Pens

**Style:** Informal, participatory and supportive

## PROCEDURE

### 1. Introduction and objectives

✦ *Facilitator is to welcome the group back and begin by sharing the objectives for this session.*

During the last session we discussed how one can nurture supportive relationships. Now we are briefly going to explore how one can build new relationships. Then we will also focus on what resources are available to you in the wider community.

### 2. Increasing your social support (5 minutes)

➡ ✦ Generally, 2 strategies can be used to increase your *social support*.<sup>11</sup> ✦ The one strategy is to increase the number of people with whom you have contact and ✦ the other strategy is to improve the quality of the relationships with the people with whom you already have regular contact. Ideally, a combination of the two strategies should be used.

We will now first look into how you can increase the number of people with whom you can have contact. The options are vast. You can turn to your spouse, children, relatives, neighbours, friends, colleagues or professionals for support. We have previously identified how you have not made use of all the available support because you may have had irrational beliefs about seeking help. You could, however, also lack certain skills required to connect with new people. As a result you may struggle to foster new relationships and your support network cannot grow.

So the question arises: ✦ How can you possibly make new friends? ✦ First of all, you need to find places where you can meet new people. I would like you to brainstorm in small groups where you could possible meet new people.

### 3. Activity: Brainstorm (10 minutes)

#### Purpose of the activity:

1. Identify places where one can meet new people.

#### Instructions for implementing the activity:

1. Divide the group into smaller groups of 5.
2. Let them brainstorm ideas and then choose one group member to give feedback to the whole group.
3. Record their answers on the white board.

#### Material required:

1. White board & marker pen

*(Facilitator is to write the answers on the board and add the following options.)*

✦ **Work out** - Join a class at a gym or start a lunchtime walking group.

✦ **Volunteer** – Hospitals, places of worship, community centres often need volunteers. You can form strong bonds when working with people who have similar values and interests. While volunteering you will feel that you are doing something positive for the world, which in itself can be therapeutic and relieve stress because you feel you have a purpose and are making a difference in people's lives.

✦ **Join a hobby group** – Find a group of people with similar interests who meet during the week and share ideas etc. (e.g. a gardening club, book club, crafts club).

✦ **Have a party** – If you invite all your current friends, ask them to each bring another friend along. This will ensure that you have a group of new people to meet.

✦ **Share telephone numbers here today** – You are all experiencing similar challenges and can really understand what the other person is going through.<sup>8,12</sup>

➡ In order for you to get to know somebody, you need to be able to make conversation with them. Starting and maintaining a good conversation requires a number of skills, namely,



1. you first need to find someone who is available to talk,
2. then you need something interesting to talk about, and
3. you need to show interest in the other person.<sup>11</sup>

When engaging in a conversation, look at the person because it shows that you are interested in what they are saying. Smile and nod your head to show them that you are listening. Ask questions and respond to what the person is saying and avoid immediately sharing too much personal information because this could make the other person feel uncomfortable. However, over time it becomes important to gradually tell people more about yourself and asking them intimate questions. In deciding how much to disclose about yourself, it is good to remember that two people who are close to each other, tell each other about the same amount of personal information.<sup>11</sup>

We are now going to role play some scenes and practice starting a conversation with people following the basic steps discussed above. Try and identify something interesting to talk about and show interest in the other person.

#### 4. Activity: Role-play (20 minutes)

##### Purpose of the activity:

1. To develop skills required to build relationships.

##### Instructions for implementing the activity:

1. Ask the group members to find a partner in the group.
2. Hand out the scenarios and let them practice meeting a new person and starting a conversation.
3. Discuss what they learnt and what they found difficult about the activity.

##### Material required:

1. Scenarios written on separate hand outs

*(Scenario 1: “You quickly pop into your local café to buy some milk. While paying, you drop your shopping list and the lady behind you picks it up for you. Act out how you could use this situation to meet a new person.”*

*Scenario 2: “You sit down at a bus stop next to a stranger. Act out how you could use this situation to meet a new person.”*

*Scenario 3: “You are at the beach with your children. You play soccer and your ball rolls to the people sitting next to you and knocks over their Coca-Cola. Act out how you could use this situation to meet a new person.”*

*Scenario 4: “You are sitting with your sick child at the doctor’s rooms. A person smiles at you and come to sit next to you. Act out how you could use this situation to meet a new person.”)*

## 5. Community resources (5 minutes)

➡ During this session we are focusing on ways that you can increase your *social support* network. You practiced meeting new people and now we will focus on what possible support is available in your community.

Families in our day and age are experiencing a tremendous amount of stress with high rates of unemployment, abuse, divorce etc. and sometimes the family members or friends cannot provide the help or nurturance that you need. In such cases you must be linked to a broader, more positive base of support found within the community itself. ↔

The neighbourhood in which you live could provide you with some support. ↔ If you feel unsafe and threatened in your community, it can impact on your happiness and levels of stress. ↔ Although you may not be able to change the neighbourhood in which you live, you can change the experiences you have there by getting more involved with those living around you and taking pride in the area in which you live. ↔ The following are some ideas that can help you feel more at home in your neighbourhood:

- **Get out more** – Take a morning or afternoon walk. It is a good stress reliever and provides you with an opportunity to get to know some neighbours and helps you feel more at home in your surroundings.
- **Smile** – Smile and give a friendly hallo to the people you encounter in your neighbourhood. Not everyone may return your friendliness but it is a quick way to get to know people and to build relationships.
- **Talk to your elders** – You will be surprised how much you can learn from the sweet old lady down the street.
- **Host a street party** – It is fun and easy and will give you a chance to get to know the people a little better.
- **Start a neighbourhood watch programme** – It will help you feel safer at night and will build a sense of community at the same time.<sup>12</sup>

There may also be a few available resources outside your immediate neighbourhood. Very often we are not aware of what is offered within the wider community. **↔** Community resources typically include churches, community organisations, self-help groups and formal services.

### **↔ Churches and clergy**

For many people the belief that there is a power greater than oneself, is a huge comfort. Furthermore, involvement with activities at church can lead to relatively instantaneous, strong and positive supports. The whole family is accepted into a larger social system and this acceptance in turn provides meaning, nurturance, affection and activities. In addition, your belief may help you in understanding and accepting that your child is hearing impaired.

### **↔ Community organisations**

Soccer and dancing clubs or organisations such as boys scout all provide an opportunity for social and physical outlets and can boost ones self-esteem. Being involved in clubs and organisations keeps children and teenagers off the street and can help prevent them getting involved in drugs and alcohol.

### **↔ Self-help groups**

Any form of self-help group provides social interaction and some form of support for families. Examples include support groups for alcoholics, abused women, pregnant teenagers etc. Within these groups one can learn important skills to cope better with ones situation and one feels understood.

### **↔ Formal services**

Professionals play a significant role in formal services. For certain problems, one needs expert advice and knowledge and the neutrality of a professional helper is sometimes necessary. Doctors, speech therapists, physiotherapist and occupational therapists all provided you with information, support and advice when you heard that your child was hearing impaired. This was more than likely a great comfort to you and you would not have been able to help your child as effectively without their support and advice.

I would now like you to all share with us what community resources you are aware of and are currently possibly making use of. We are going to try and make a long list so that when you leave here today, you are aware of what is being offered in the community.

## **6. Activity: There are community resources (20 minutes)**

### Purpose of the activity:

1. To increase awareness of community resources which may act to increase ones support system.

### Instructions for implementing the activity:

1. Let the participants share what resources they are aware of, and are possibly making use of, in their community.
2. Present the resource list displayed in their workbook on page 276-280.
3. Encourage them to make a list of the resources which they think will be most helpful to them. Let them write this in their workbook on page 281. The handout can then be a visual reminder and assist them with following through.

### Material required:

1. Workbook – pages 276 -281
2. Pen

## **7. Conclusion**

From the list that we have made, we can see that the resources are relatively limited in your communities. It is therefore of utmost importance that you actively make use of the few available to you.

I would like you to always have this list close to you so that you can refer to it if you feel you need some support, help or advice. The organisations are there to help. It is your responsibility to make use of them.

We are now going to break for the last time. Please could you all be back at 16:00 for the last session of the day.

# SESSION SIX:

## CONCLUSION & EVALUATION

### LESSON PLAN

**Aims:**

1. To reflect on the knowledge and skills obtained from the workshop.

**Objectives:** By the end of this session, participants will have:

1. Recapped the day's work.
2. Completed the Social Support Index questionnaire as a post-test measure.
3. Evaluated the workshop.
4. Been acknowledged for their participation in the workshop.

**Duration:** 45 minutes**Materials:**

- Projector, laptop and screen
- Workbook
- Pens
- Certificates

**Style:** Informal, participatory and supportive

## PROCEDURE

### 1. Introduction and objectives

✦ Facilitator is to welcome the group back and is to start with the following introduction.

➡ During our last session we are going to briefly recap what we have discussed and learnt throughout the day.

### 2. Review of discussions (5 minutes)

➡ Throughout the day we have focused on *social support* and how it can help you cope even better with your child with a hearing impairment. You as parents of a child with a hearing impairment child have a number of important roles to fulfil.

- You need to take care of your child's basic needs and well-being.
- You have to be an information seeker and find out everything about a hearing loss.
- You have to be a problem solver and find solutions to the challenges associated with a hearing loss.
- You have to act as a public educator to educate the people around you about a hearing loss.
- You have to be a spokesperson for the needs of your child who is unable to communicate his/her own needs.

These additional demands can generate much stress and it is therefore even more important that you have an adequate support network.

As has been highlighted before, *social support* is important for stress management and for your overall happiness. It is important to have someone to talk to if you are stressed, and to enjoy life with people who care about you. *Social support* provides you with physical and emotional comfort and helps you deal better with all the stressors in your life. It is a great source of comfort to know that you are cared for and loved, and part of a community of people who value and appreciate you.

✦ I hope that you have realised today that the utilisation of *social support* makes our lives richer, it helps us overcome stress and adversity and comforts us better than anything else. People who have close relationships with others tend to be healthier and live longer. People who suffer alone, suffer a lot.

In the beginning of the workshop I gave you 3 questions that I said would guide you through the day. I would like you to reflect on what you have learnt by answering the 3 questions in your workbook on page 282.

### 3. Activity: Self-reflection (20 minutes)

#### Purpose of the activity:

1. Participants reflect on their insight developed during the workshop.

#### Instructions for implementing the activity:

1. Instruct the participants to open page 282 in their workbook and to answer the three questions which were initially posed to them during session 2.
2. Ask participants to give feedback to the group and discuss what they learnt through this activity.

#### Material required:

1. Workbook – page 282
2. Pens

⇒ People have different needs and interests and therefore the nature and number of social ties with family, friends and others needed to achieve social health may vary greatly. ⇄ However, the best time to develop a support system is before you need it. It is pointless to first wait for the crisis to happen before you start looking for support. Nobody wants to run into the street when stressed or sad and tell a passer-by: ‘I have to tell you about my day!’ It would be much better to talk to a friend or family member whom you trust and can rely on. Do not judge yourself as being weak when you ask for support. In actual fact it is a sign of strength of character. Everybody feels stressed, helpless, angry, scared and frustrated at times and it is not a mistake to ask for help when feeling this way. ⇄ Having problems does not mean that you are weak, but rather means that you are a human being.

Ultimately the best way to develop a support system is to give support to others. When you know someone is upset, ask them if they want to talk about it and then listen to them. Visit someone who is sick or going through a rough time. Then when you need support you will have many people that will reciprocate your kindness and support.

⇄ Let us look at a summary of the main points discussed today:

⇄ *Social support* means having relationships that are positive, rewarding and helpful.

⇄ Supportive relationships can help reduce stress and improve your overall happiness and health.

⇄ It is important to have a number of different supports at any given time.

⇄ Emotional, practical and informational support is most important for parents with a child with a hearing impairment.

⇄ *Social support* can increase our sense of belonging, purpose, self-worth and feelings of security.

⇄ *Social support* can help meet some of our physical, emotional and social needs.

⇄ Seeking help and support is not a sign of weakness.

✦ *Social support* can be increased by connecting with more people and improving the quality of your existing relationships.

✦ Maintaining relationships involves a give and take process.

✦ Change the experiences you have in your neighbourhood by getting more involved with those living around you and taking pride in the area in which you live.

✦ Churches, clubs, self-help groups and formal services are important community resources available to you.

✦ It is important to develop a support system that works for you.

✦ Be proactive and use the help available to you.

You will find all these points in your workbook on page 283.

### **3. Evaluation: Social Support and Workshop (10 minutes)**

We once again need to attend to some formalities before we end.

Could you all please complete the SSI questionnaire and evaluate the workshop (refer to Addendum C and E). Both forms will be completed anonymously. Please answer honestly. Please feel free to ask any questions. (*Facilitator is to hand out and collect both worksheets. Adjust for personal use.*)

### **4. Conclusion (10 minutes)**

Thank you for your participation today. It has been a remarkable and enriching day. Thank you for all your input and enthusiasm that you showed throughout the day. It has been a great privilege for me to work with you and I truly wish you all the best with your child with a hearing impairment. Please remember that through the hardships that we experience, we grow and become a stronger person and believe in the statement that a problem shared is a problem halved.

*(The following paragraph is related to this specific study and can be adjusted as required.)*

We will meet again in November to have a follow-up on today's workshop. You will then all receive a certificate to acknowledge your participation in the workshop. Thank you once again for all your input and I hope that you all go home empowered and motivated to increase your *social support* network.

## References

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ADDENDUM F

SOCIAL SUPPORT PROGRAMME: WORKBOOK

SOCIAL  
SUPPORT  
PROGRAMME



**THIS WORKBOOK BELONGS TO**

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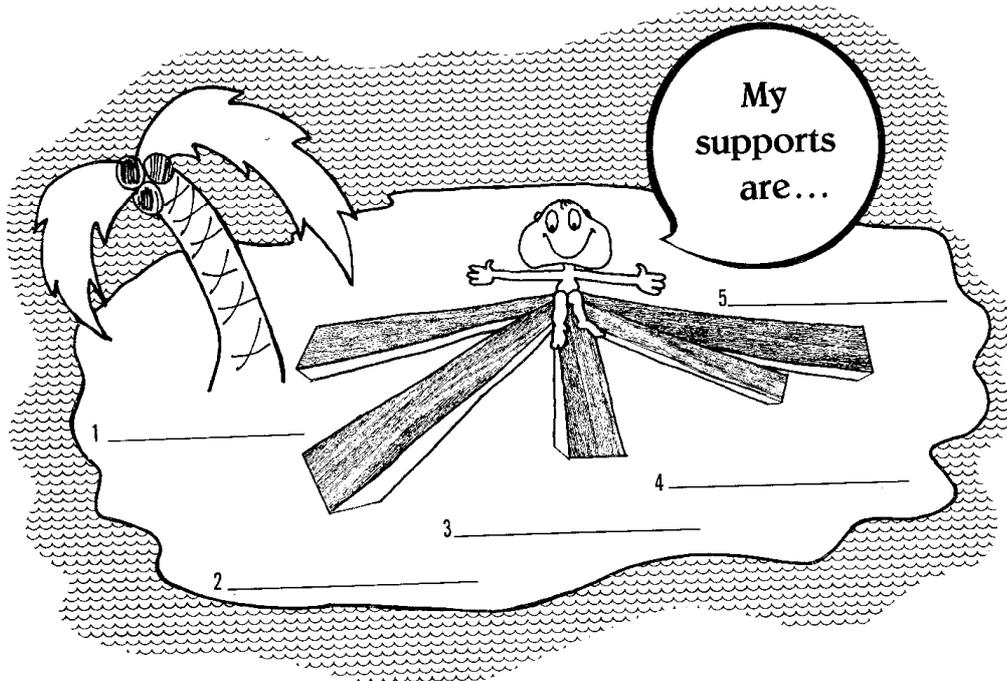




## PROGRAMME FOR THE DAY

TIME	TASK
8:00-9:00	Registration Refreshments and sandwiches
9:00-10:00	<b>Session 1: Introduction</b> <ul style="list-style-type: none"> <li>• Brief introduction to the workshop</li> <li>• Participants give their consent to participate in the workshop</li> <li>• Participants' current social support is evaluated</li> <li>• Group norms are established</li> <li>• A general overview of workshop is given</li> </ul>
10:00-10:15	Tea and biscuits
10:15-11:15	<b>Session 2: My social support network</b> <ul style="list-style-type: none"> <li>• Define social support</li> <li>• Identify participants' present support system &amp; how it is helpful</li> <li>• Highlight the different types of support</li> </ul>
11:15-11:30	Tea
11:30-12:30	<b>Session 3: The benefits of social support</b> <ul style="list-style-type: none"> <li>• Importance and benefits of social support</li> <li>• Identify that basic needs can be met through ones social support network</li> <li>• Establish a plan to effectively use existing support networks to meet unmet needs</li> </ul>
12:30-13:30	Lunch
13:30-14:30	<b>Session 4: My beliefs about social support</b> <ul style="list-style-type: none"> <li>• Identify false beliefs about social support</li> <li>• Dispute and redefine the false beliefs</li> <li>• Develop skills to maintain existing supportive relationships</li> </ul>
14:30-14:45	Tea
14:45-15:45	<b>Session 5: Increasing my social support network</b> <ul style="list-style-type: none"> <li>• Develop skills to build supportive relationships</li> <li>• Identify available community resources</li> </ul>
15:45-16:00	Tea and biscuits
16:00-17:00	<b>Session 6: Conclusion</b> <ul style="list-style-type: none"> <li>• Conclusion and reflection</li> <li>• Evaluation: SSI and workshop</li> </ul>

**NO ONE is an**  
**‘‘I<sub>s</sub>-LAND’’**



- One valuable ‘SURVIVAL SKILL’ is having supports in our lives to help us cope.
- Fill in the names of your ‘SUPPORTS’ above.
- How are they supportive?

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Adapted from ‘Life management skills: Reproductive activity handouts created for facilitators’, Vol. 1. (1991). K.L. Korb-Khalsa, S.D. Azok, & E.A. Leutenberg. Beachwood, Ohio: Wellness Reproductions.

## WHAT ARE YOUR 'LIFESAVERS'?



NEEDS	WHICH OF YOUR NEEDS ARE INFRINGED ON?	WHY?	WHAT ARE SOME WAYS TO GET THESE NEEDS MET?
<b>PHYSICAL</b>	1) Eating a healthy meal	No time to cook because am I looking after the children	Ask my husband to baby-sit
	2)		
	3)		
	4)		
	5)		
<b>SOCIAL AND BELONGING</b>	1) Going to church	I have no transport	Talk to the minister and ask for a lift
	2)		
	3)		
	4)		
	5)		

## WHAT ARE YOUR 'LIFESAVERS' (CONTINUED)



NEEDS	WHICH OF YOUR NEEDS ARE INFRINGED ON?	WHY?	WHAT ARE SOME WAYS TO GET THESE NEEDS MET?
<b>SELF-FULFILMENT</b>	1) Art classes	No-one to go with	Get a friend to go with you or decide to go by yourself
	2)		
	3)		
	4)		
	5)		

Adapted from 'Life management skills: Reproductive activity handouts created for facilitators', Vol. 2. (1991). K.L. Korb-Khalsa, S.D. Azok, & E.A. Leutenberg. Beachwood, Ohio: Wellness Reproductions.

**MY BELIEFS ABOUT  
ASKING FOR HELP OR SUPPORT**



**1)**

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**2)**

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**3)**

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**4)**

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**5)**

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**Are the statements logical?**

Are the statements true?

**Are the statements scientifically based?**

Does the outcome make me happy?

### REDEFINED BELIEFS

**ABOUT SEEKING**



**SOCIAL SUPPORT**

**1)**

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**2)**

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**3)**

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**4)**

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**5)**

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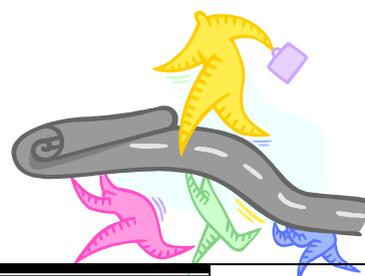
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➤ **WHICH OF THE FOLLOWING THINGS DO YOU CURRENTLY DO TO MAINTAIN YOUR RELATIONSHIPS?**



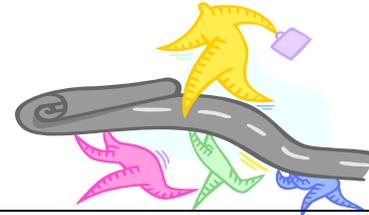
➤ **WHAT WOULD YOU LIKE TO DO MORE OF, OR TRY FOR THE FIRST TIME, IN ORDER TO MAINTAIN YOUR RELATIONSHIPS?**

	What I do	What I'd like to do
Stay in touch		
Be proactive – make the 1 <sup>st</sup> move		
Don't compete with your family or friends		
Be a good listener		
Challenge yourself to become a better person		
Go easy – don't be too demanding of their time		
Adopt a healthy, realistic self-image		
Avoid constant complaining		
Adopt a positive outlook in life		
Appreciate your family and friends – thank them for being there		
Know when to accept or decline an invitation		

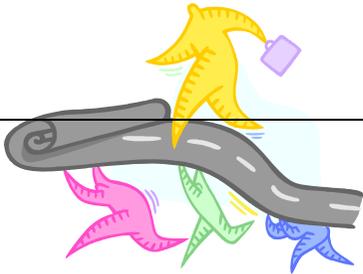


## RESOURCE LIST

ASSOCIATIONS		
<p><b>DEAFSA: Western Cape</b> Cnr Thicket &amp; Hemlock Roads Newlands PO Box 226, Newlands, 7725 Tel: 021 – 683 4665/6 Fax: 021- 671 2644 E-mail: <a href="mailto:deafsa2@iafrica.com">deafsa2@iafrica.com</a> <a href="http://www.deafsa.co.za">www.deafsa.co.za</a> Social Worker: Miss R.Lensen Contact: Mrs L. Viljoen</p>	<p><b>TOEVLUG REHABILITATION CENTRE</b> PO Box 515, Worcester, 6849 40 Noble Street, Worcester, 6850 Tel: 023 – 342 1162 / 3 Fax: 023 – 347 3232 E-mail: <a href="mailto:toevlugs@mweb.co.za">toevlugs@mweb.co.za</a> Contact: Mrs F. Bantom</p>	<p><b>CAPE TOWN &amp; DISTRICT ASSOCIATION FOR THE DEAF</b> 81 Station Road Observatory Tel: 021 – 448 2510</p>
<p><b>ASSOCIATION FOR PEOPLE WITH DISABILITIES</b> PO Box 1544, Milnerton, 7435 Tel: 021 – 555 2881 Fax: 021- 555 2888 E-mail: <a href="mailto:apd-ec@mweb.co.za">apd-ec@mweb.co.za</a> <a href="http://www.apd-wc.org.za">www.apd-wc.org.za</a> Provincial Director: Mr J. Joubert</p>	<p><b>WESTERN PROVINCE DEAF SOCIETY</b> PO Box 21109, De Tijger, 7499 Fax: 021 – 939 3682 Chairperson: Mr T. Heyns</p>	<p><b>DEAFBLIND ISLAMIC INSTITUTE FOR THE DEAF</b> Suite 2, Medical Centre, Fairbairn St, Worcester, 6850 PO Box 3105, Worcester, 6849 Tel: 023 – 347 7542 Fax: 023 – 347 7581 E-mail: <a href="mailto:natdir@deafblindsa.co.za">natdir@deafblindsa.co.za</a> <a href="http://www.deafblindsa.co.za">www.deafblindsa.co.za</a> Social Worker: Ms M. Els</p>
	<p><b>MFESANE WELFARE ORGANISATION</b> 9B Bellpark Office Plaza, cnr Durban &amp; De Lange Rds, Bellville, 7530 Private Bag X2, Bellville, 7535 Tel: 021 – 945 3992/5 Fax: 021 – 945 3989 E-mail: <a href="mailto:central@mfesane.org.za">central@mfesane.org.za</a> Contact: Ms P.Lirula</p>	<p><b>DEAF COMMUNITY OF CAPE TOWN (DCCT)</b> Cnr Thicket &amp; Hemlock Roads Newlands PO Box 226, Newlands, 7725 Tel: 021 – 671 6385 E-mail: <a href="mailto:dcct@worldonline.co.za">dcct@worldonline.co.za</a></p>



<b>SCHOOLS : Sign Language</b>		
<p style="text-align: center;"><b>SIZENZELE DEAF ASSOCIATION</b> Landsdowne Road Ext, Khayelitsha c/o Gospell Fellowship of the Deaf</p> <p style="text-align: center;"><b>LEWENSRUIMTE VIR DOWES</b> De La Bat Rd, Worcester, 6850 Private Bag X3101, Worcester, 6849 Tel: 023 – 342 0757 Fax: 023 – 342 0087 E-mail: <a href="mailto:community@deafcare.co.za">community@deafcare.co.za</a> Contact: Mr L. Lategan Social Worker: Mrs H. Jordaan</p> <p style="text-align: center;"><b>NATIONAL INSTITUTE FOR THE DEAF</b> De La Bat Rd, Worcester, 6850 PO Box 941, Worcester, 6849 Tel: 023 – 342 5555/6 Fax: 023 – 342 08866 E-mail: <a href="mailto:institute@deafcare.co.za">institute@deafcare.co.za</a> <a href="http://www.deafnet.co.za">www.deafnet.co.za</a> Executive Dir: Mr D de Villiers</p>	<p style="text-align: center;"><b>MARY KIHN SCHOOL FOR THE HEARING IMPAIRED AND DEAF LEARNERS</b> Low street, Observatory, 7925 Tel: 021 – 447 0310 Fax: 021 -448 1351 E-mail: <a href="mailto:head@admin.mks.wcape.school.za">head@admin.mks.wcape.school.za</a> Principal: Mr L. Brown</p> <p style="text-align: center;"><b>NOLUTHANDO SCHOOL FOR THE DEAF</b> Landsdowne Rd ext, Khayelitsha, 7784 PO Box 1856, Somerset West, 7129 Tel: 021 – 361 1160 Fax: 021 – 361 1161 E-mail: <a href="mailto:admin@nsd.wcape.school.za">admin@nsd.wcape.school.za</a> Acting Principal: Mrs T. Mavuka</p> <p style="text-align: center;"><b>DE LA BAT SCHOOL FOR THE DEAF</b> De La Bat Rd., Worcester, 6850 PO Box 98, Worcester, 6849 Tel: 023 – 342 2560 Fax: 023 – 342 5563 E-mail: <a href="mailto:hoof@delabat.wcape.school.za">hoof@delabat.wcape.school.za</a> Principal: Mr E. van Vuuren Social Worker: Mrs P. Smit</p>	<p style="text-align: center;"><b>NUWE HOOP CENTRE FOR THE HEARING IMPAIRED</b> Leipoldt Ave, Worcester, 6850 Private Bag X3047, Worcester, 6849 Tel: 023 – 348 2200 Fax: 023 – 348 2215 E-mail: <a href="mailto:head@nuwehoop.wcape.school.za">head@nuwehoop.wcape.school.za</a> Social Worker: Mrs Conradie</p> <p style="text-align: center;"><b>DEAF CHILDREN CENTRE PRE-SCHOOL AND GRADE CLASSES</b> c/o Mary Kihn School, Low Street, Observatory, 7735 Tel/Fax: 021 – 686 9323 <a href="mailto:admin@mks.wcape.school.za">admin@mks.wcape.school.za</a> Contact: Pumla</p> <p style="text-align: center;"><b>DOMINICAN SCHOOL FOR THE DEAF CHILDREN (WITTEBOME)</b> 6 Clare Road, Wittebome, 7800 PO Box 19027, Wynberg, 7824 Tel: 021 – 761 8046 Fax: 021 – 761 8578 E-mail: <a href="mailto:admin@dominikdowes.wcape.school.za">admin@dominikdowes.wcape.school.za</a> Principal: Mrs R. West</p>



**PIONEER SCHOOL WORCESTER DEAFBLIND  
BABIES-GR 12**

20 Adderley Street, Worcester, 6850  
Tel: 023 – 342 2313  
Fax: 023 – 342 3959  
E-mail: [pionbib@mweb.co.za](mailto:pionbib@mweb.co.za)  
Contact: Ms M. Meiring

**SCHOOLS : Auditory-Oral**

**CAREL DU TOIT CENTRE  
(Nursery – Gr 2)**

Tygerberg Hospital, Parow, 7500  
PO Box 19130, Tygerberg, 7505  
Tel: 021 – 938 5303  
Fax: 021 – 933 2774  
[root@careldtsen.ecape.school.za](mailto:root@careldtsen.ecape.school.za)  
[www.careldutoit.co.za](http://www.careldutoit.co.za)  
Principal: Mrs L. du Preez  
Social Worker: Dr H. Oosthuysen

**DOMINICAN GRIMLEY SCHOOL**

Hout Bay  
Tel: 021 – 790 1052  
Fax: 021 – 790 6241  
E-mail: [postmaster@dgs.wcape.school.za](mailto:postmaster@dgs.wcape.school.za)  
Principal: Sr. Macrina

**COLLEGE**

**DEAF COLLEGE SOUTH AFRICA**

De La Bat Rd, Worcester, 6850  
PO Box 941, Worcester, 6849  
Tel: 023 – 342 5555  
Fax: 023 – 342 8866  
E-mail: [dcsa@deafcare.co.za](mailto:dcsa@deafcare.co.za)  
Contact: Mrs de Villiers

**CHURCH SERVICES FOR THE DEAF**

**GOSPEL FELLOWSHIP OF THE DEAF**

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PO Box 44258, Claremont, 7735  
Tel: 021 – 683 7691  
E-mail: [deafway@webmail.co.za](mailto:deafway@webmail.co.za)

**DUTCH REFORMED CHURCH DE LA BAT**

29 Herta Louw Street, Loumar, Bellville,  
7530  
Tel/Fax: 021 – 948 5000  
E-mail: [dlb@wdsi.co.za](mailto:dlb@wdsi.co.za)  
Contact: Rev S Viljoen

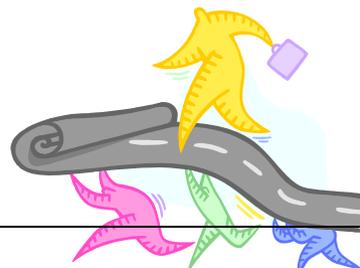
**CONGREGATION FOR THE DEAF**

Leipoldt Ave, Worcester, 6850  
Private Bag X3047, Worcester, 6849  
Tel: 023 – 347 2791  
Fax: 023 – 347 4607  
Contact: Rev Finck

**HOMES / HOSTELS**

**RUSOORD VIR DOWES**

8 Helpmekaar St, Meyerhof, Bellville, 7530  
Tel: 021 – 949 3282  
Fax: 021 – 948 5000  
Contact: Mrs Beukes



<b>PROFESSIONALS</b>		
<p style="text-align: center;"><b>CATHOLIC HOSTEL FOR THE DEAF</b>            PO Box 1, Bergvliet, 7864            Tel: 021 – 712 3007            Fax: 021 – 712 2008            E-mail: <a href="mailto:deafhostel@telkomsa.net">deafhostel@telkomsa.net</a>            Contact: R. Cronwright</p>	<p style="text-align: center;"><b>AUDIOLOGIST</b>            GA Jacklin            Room 201 Constantiaberg Medi-Clinic            Burnham Road            Plumstead            Tel: 021 – 797 3213</p> <p style="text-align: center;">C. Cox            Red Cross Children’s Hospital            Klipfontein Road            Rondebosch            Tel: 021 – 658 5406</p> <p style="text-align: center;"><b>SPEECH THERAPY</b>            NP Buttress            Suite 507 Sea Point Medical Centre            11 Kloof Road            Sea Point            Tel: 021 – 433 0340</p>	<p style="text-align: center;">Dr D Stroebel            11 Solway Street            Bellville            Tel: 021 – 945 2589            OR            Room 127 Panorama Medical Centre            Tel: 021 – 930 3136            OR            Milnerton Medi-Clinic            Tel: 021 – 552 4943</p> <p style="text-align: center;">D. Schalker            103 Fairfield Medical Suites            Wilderness Road            Claremont            Tel: 021 – 683 1393</p> <p style="text-align: center;"><b>OCCUPATIONAL THERAPY</b>            TE Brink            12 Serenata Crescent            Brackenfell            Tel: 021 – 982 0827</p>
<b>SPORT</b>		
<p style="text-align: center;"><b>WESTERN CAPE SPORT FEDERATION</b>            Fax: 023 – 347 3620            Contact: Noeline Vice</p>		
<b>CLINICAL FACILITIES</b>		
<p style="text-align: center;"><b>GROOTE SCHUUR HOSPITAL</b>            Audiology Unit            Tel: 021 – 404 5284/5</p>		





<b>NAME OF ORGANISATION</b>	<b>TYPE OF SERVICE</b>	<b>ADDRESS</b>	<b>TELEPHONE NUMBER</b>
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Adapted from 'Life management skills: Reproductive activity handouts created for facilitators', Vol.1. (1991). K.L. Korb-Khalsa, S.D. Azok, & E.A. Leutenberg. Beachwood, Ohio: Wellness Reproductions.





### **A SUMMARY OF THE MAIN POINTS DISCUSSED TODAY:**

- Social support *means having relationships that are positive, rewarding and helpful.*
- *Supportive relationships can help reduce stress and improve your overall happiness and health.*
- *It is important to have a number of different supports at any given time.*
- *Emotional, practical and informational support is most important for parents with a child with a hearing impairment.*
- *Social support can increase our sense of belonging, purpose and self-worth and feelings of security.*
- *Social support can help meet some of our physical, emotional and social needs.*
- *Seeking help and support is not a sign of weakness.*
- *Social support can be increased by connecting with more people and improving the quality of your existing relationships.*
- *Maintaining relationships involves a give-and-take process.*
- *Change the experiences you have in your neighbourhood by getting more involved with those living around you and taking pride in the area in which you live.*
- *Churches, clubs, self-help groups and formal services are community resources available to you.*
- *It is important to develop a support system that works for you.*
- *Be proactive and use the help available to you.*



## ADDENDUM G

### WORKSHOP EVALUATION FORM

1. What have you enjoyed the most about the workshop?

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2. What have you enjoyed the least about the workshop?

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3. Have you gained knowledge about social support?

YES	NO
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4. Did you feel you could freely express yourself in the group?

YES	NO
-----	----

5. Could you understand the information presented by the facilitator?

YES	NO
-----	----

6. Did you benefit by attending the workshop?

YES	NO
-----	----

7. Did the workshop change your attitude towards seeking help and support?

YES	NO
-----	----

8. Have you acquired some new skills to build your social support network?

YES	NO
-----	----

9. Did the facilitator present the workshop in a friendly, understandable manner?

YES	NO
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10. Can you face your challenges with more confidence after today's workshop?

YES	NO
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Comments

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## ADDENDUM H

### THREE MONTH FOLLOW-UP EVALUATION FORM

1. Did your family's social support network change in any way after having attended the social support workshop? *Het u familie se sosiale ondersteuningsnetwerk in enige manier verander nadat u die 'social support' werkswinkel bygewoon het?*

If yes, state how and why it changed. *Indien ja, verduidelik hoe en hoekom dit verander het.*

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If no, state why it did not change. *Indien nee, verduidelik hoekom dit nie verander het nie.*

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2. Did the social support workshop have any impact on your family's functioning? *Het die 'social support' werkswinkel enige impak op u familie se funksionering gehad?*

If yes, state how. *Indien ja, verduidelik hoe.*

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If no, state why not. *Indien nee, verduidelik hoekom nie.*

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