THE DEVELOPMENT OF GUIDELINES FOR HEARING PARENTS PARENTING CHILDREN WITH A HEARING LOSS

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“Blindness separates us from things but deafness separated us from people”

Helen Keller

ABSTRACT

Parenting children with a hearing loss presents hearing parents with unique parenting challenges. Adapting to and managing these challenges is dependent on parents' personal and social support as well as the resources available to them. There is limited research regarding hearing parents' personal and social support and access to appropriate resources. In order to bridge this gap, the aim of the study was to develop guidelines for hearing parents parenting children with a hearing loss.

A mixed methods approach with a sequential explanatory design using a two-phased approach was employed in this study. Phase 1 endeavoured to identify the problem and explore the needs of parents by using a staged approach. The sample in this phase included 103 participants in the quantitative study and 13 participants in the qualitative study. Phase 2 applied a consensus workshop made up of two rounds: Round 1 comprised a panel of experts, namely, academics in the field of child, family, and disability studies, and Round 2 included a panel of stakeholders comprised of hearing parents, professionals, Deaf mentors, and leaders working within the field of hearing loss. The purpose of the workshop was to reach consensus on the development of guidelines.

From this research, a number of guidelines emerged for parents, focusing on:1) early intervention programmes for hearing parents and children diagnosed with a hearing loss, highlighting guidance and counselling for parents on early identification and screening programmes; 2) the need for social and emotional support to deal with the emotional impact of the diagnosis on the family, the parents, as well as the child with a hearing loss; 3) access to resources and information which is comprehensive and unbiased, allowing parents to make informed choices; and 4) support for communication intervention whereby parents are offered unbiased support in terms of communication options for their children.

This study has important implications for the collaboration and partnerships between parents, social services (social workers), and health and family practitioners for the provision of family-centred practices.

KEYWORDS

Parents

Parenting

Children

Hearing loss

Parenting styles

Interventions

Family systems theory

Parenting style framework

DEFINITIONS OF KEY CONCEPTS

Disability: Disability is imposed by society when a person with a physical, psychosocial, intellectual, neurological, and/or sensory impairment is denied access to full participation in all aspects of life, and when society fails to uphold the rights and specific needs of individuals with impairments (White Paper on the Rights of Persons with Disabilities, 2015).

Hearing loss: “Disabling hearing loss refers to hearing loss greater than 40 dB in the better hearing ear in adults (15 years or older) and greater than 30 dB in the better hearing ear in children (0 to 14 years)” (WHO, 2012).

Parenting: Parenting is the process of parenting and supporting the physical, emotional, social and intellectual development of the child from infancy to adulthood. It is described as the activity of raising a child rather than the biological relationship with the biological parents (Draft Integrated Parenting Framework Department of Social Development, 2012).

Parenting approach: Parenting approach refers to the different approaches of parents (and the effects of these) in raising their children (Carr & Pike, 2012).

Parenting styles: The consistent pattern of interaction between parent and child (Baumrind, 1973).

Challenges: Challenges are described as barriers, difficulties, hardships and differences experienced by people (Lambert, 2014).

Interventions programmes: Intervention programmes are usually intended to support and enhance parents’ parenting competencies, for parents to feel competent and confident when experiencing child-related problems (Reedtz & Klest, 2016).

Parental self-efficacy: Parental self-efficacy is described as parents' personal beliefs and capabilities to cope with stressful demands and challenges (Coleman & Karraker, 2005).

Guidelines: Guidelines are described as any document covering recommendations for clinical practice (World Health Organization (WHO, 2014).

DECLARATION

I hereby declare that this dissertation, **DEVELOPING GUIDELINES FOR HEARING PARENTS PARENTING CHILDREN WITH A HEARING LOSS,** is my work and that all resources that were used or referred to by me during the research study are completely acknowledged through a complete reference or an acknowledgement statement.

Signature: Ronel Davids

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Student number: 8842015

Date: 30th September 2020

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DEDICATION

This study is dedicated to God Almighty for giving me the wisdom, courage and strength to successfully complete this study – only you, Lord, know my journey!

PUBLICATIONS AND DISSEMINATION

PhD by publication:

The PhD in Social Work Studies was submitted in the format of a PhD by Publication. The results presented in the doctoral study were viewed as important, particularly within the field of hearing loss, family, and parenting. It is envisaged that the findings of the study where published and presented on a public platform will assist social workers, family practitioners, and other mental health practitioners who work with families, parents, and children, including children with a hearing loss, with clinical practice application, theory, and research implementation. The research attempts to balance clinical and research relevance.

Some of the findings of this research were presented at the North-West University, Child Youth and Families Symposium, and at the University of the Western Cape, Department of Social Work: Interdisciplinary Child and Youth – Well-being Seminar. The findings were also presented at a university research day as well as published and accepted in three accredited journals, two of which are international journals accredited by the South African Department of Higher Education. The PhD by publication brought about a broader understanding of the subject matter explored and methodology applied, as well as contributed to the existing body of research knowledge.

The findings of this research were presented as follows:

Conferences and research days:

Davids, R., Roman, N. & Schenck, C. (2018). Interventions on parenting styles of hearing parents parenting a child with hearing loss: a scoping review. A paper presented at the North-West University, 18th March 2018, Child Youth and Families Symposium, Cape Town, South Africa

Davids, R., Roman, N. & Schenck, C. (2019). My research study: Developing guidelines for hearing parents parenting children with hearing loss. A paper presented at University of the Western Cape, 27th October 2019, Research Week 2019 Conference, Cape Town, South Africa.

Davids, R., Roman, N. & Schenck, C. (2019). Parents' safety and protection concerns for their children with hearing loss: A paper presented at University of the Western Cape, 19th February 2020, Department of Social Work: Interdisciplinary Child and Youth - Wellbeing Seminar, Cape Town, South Africa.

Journals published:

Davids, R.S., Roman, N.V. & Schenck, C.J. (2018). Interventions on parenting styles of hearing parents parenting children with a hearing loss: a scoping review. *Deafness & Education International,* 20:1, 41-58. DOI: 10.1080/14643154.2018.1445156

Journal accepted for publication:

Davids, R.S., Roman, N.V. & Schenck, C.J. (2020). The challenges experienced by parents when parenting a child with hearing loss. Journal of Family and Social Work. (Accepted, email attached as an appendix).

Davids, R.S., Roman, N.V. & Schenck, C.J. (2020). Horende moeders en vaders se benadering van ouerskap tot kinders met gehoorverlies. The Journal of Humanities/Tydskrif vir Geesteswetenskappe (Accepted, September, email attached as an appendix).

Under Review for publication:

Davids, R.S., Roman, N.V. & Schenck, C.J. (2020). Developing a framework for guidelines for hearing parents parenting children with hearing loss using a Consensus Workshop. Submitted to the African Journal on Disabilities.

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CHAPTER 1

INTRODUCTION

1.1 Introduction

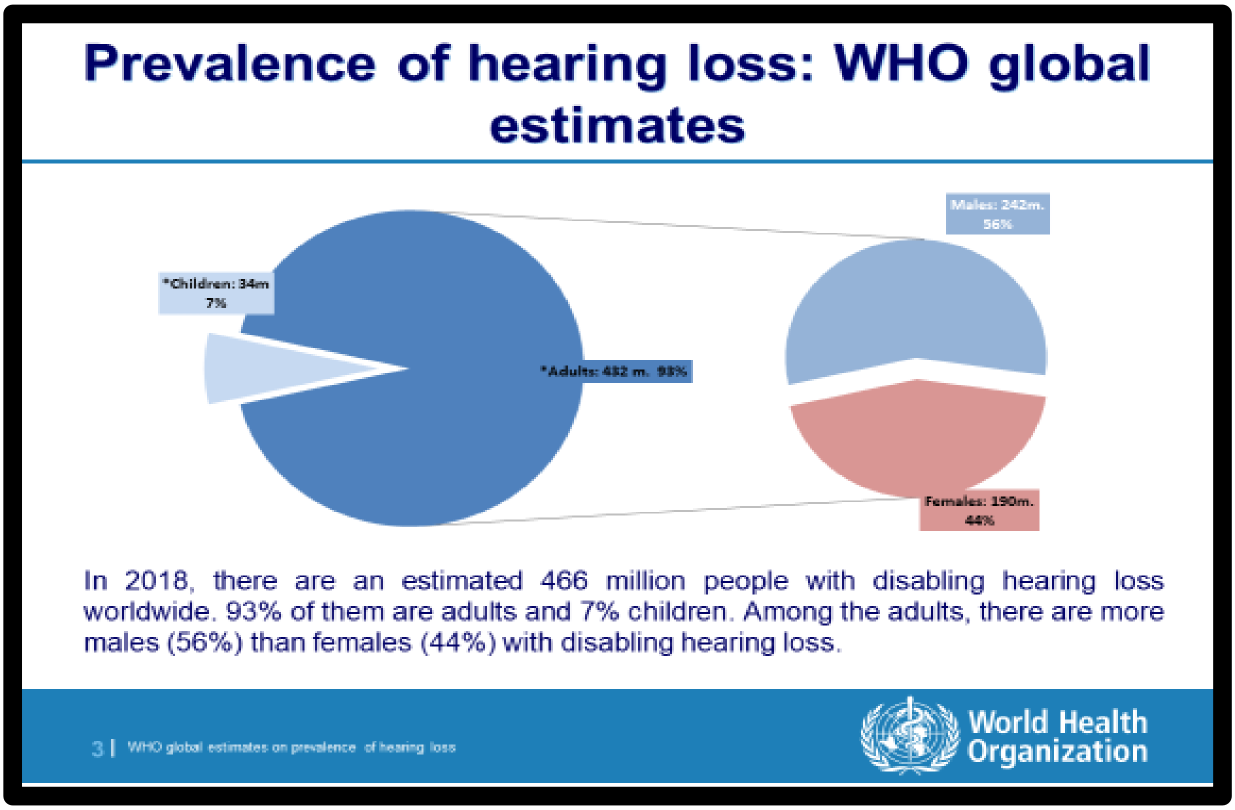
This introductory chapter begins with a short background on the prevalence of hearing loss, orientating the reader to the topic under study. A brief discussion around parenting children with a hearing loss is then put into context. This is followed by a description of the problem statement, together with the main research question and subsidiary questions. The aim, objectives, significance of the study, methodology, ethical considerations, and the outline of the thesis are also provided.

1.2 Prevalence of hearing loss

In 2011, the World Health Organisation/World Bank World Report on Disability ranked hearing loss as first in the category of health conditions associated with disability. More recently, the World Health Organisation (WHO) (2017) described hearing loss as the fourth leading cause of disability globally. To reflect on the prevalence of hearing loss, the WHO further states that around 466 million people worldwide have some sort of hearing loss, of which 34 million are children (WHO, 2018). The number of people with hearing loss is expected to grow and reach over 900 million by 2050. The projections of the British Medical Research Council (MRC) Institute of Hearing Research estimates that by 2025, approximately 900 million people worldwide will suffer from hearing loss. In short, that translates to one in every ten people (WHO, 2018).

Hearing loss is reported to be the most dominant sensory disorder, affecting roughly 6/1,000 births in developing countries annually in comparison to 2/1,000 in developed countries (Storbeck, 2012; Olusanya & Newton, 2007). Almost 2,000 babies are born each year with or acquire permanent infant hearing loss worldwide (Swanepoel, Storbeck & Friedland, 2009) with South Africa having 16–17 babies with hearing loss born daily (Swanepoel, 2008).

A study conducted by Ramma and Sebothoma (2016) on the global and regional hearing impairment prevalence in 29 countries reported that the occurrence of hearing loss in children and adults was substantially higher in middle and low income countries, like those in South Asia, Asia Pacific, and sub-Saharan Africa (WHO, 2012a), and that two thirds of the people with hearing loss in the world live in developing countries (Tucci, Merson & Wilson, 2010). Until recently there had only been limited information available on early detection and intervention services in sub-Saharan Africa (Olusanya, Wirz & Luxon, 2008). This was particularly due to restricted resources and the lack of tertiary education for audiologists or other hearing health care specialists (Swanepoel et al., 2009).



Prevalence of hearing loss: WHO global estimates

In 2018, there are an estimated 466 million people with disabling hearing loss worldwide. 93% of them are adults and 7% children. Among the adults, there are more males (56%) than females (44%) with disabling hearing loss.

3 | WHO global estimates on prevalence of hearing loss

World Health Organization

Figure 1.1: Global Prevalence of Hearing Loss

Source: World Health Organisation (2012b)

Figure 1.1 above presents the global prevalence of hearing loss as estimated in 2018 with a predicable 7% of children having some type of hearing loss.

In South Africa, the current data on the prevalence of hearing loss appears to be unreliable, as it is mainly founded on national census information, which tends to underestimate the prevalence of hearing loss (Ramma & Sebothoma, 2016). Statistics South Africa (2017), for example, although reporting on disability prevalence, excludes any statistics on child hearing loss under the age of five years old. The Deaf Federation of South Africa (DeafSA, 2010) asserts that 10% of the total population have some kind of hearing loss, stating that many hearing parents do not record their children with a hearing loss and that a large number of people with a hearing loss have never filled in a census form. With the sparsity of census on disability, and in particular on hearing loss, especially in children, the long-term effects of childhood hearing loss with congenital or acquired hearing loss, are not well documented. These long-term effects include impediments in speech and language development and cognitive development, leading to early difficulty in learning and poor schooling (Burke, Shenton & Taylor, 2012; Olusanya, 2011); problems with employment and societal integration in the long-term (Storbeck, 2012); and the need for early intervention strategies (Marcshark & Spencer (eds.), 2003). Therefore, there is a need to report on the prevalence of childhood hearing loss to ensure accurate reporting of data that is required for programme services delivery. More recently, studies specifically related to prevalence of hearing loss in the Cape Town Metropolitan area, the geographical location of this study, found that 11.4% of 174 children aged 0–3 years, and 4.3% of 430 children aged 4–9 years, were presented with hearing loss (Ramma & Sebothoma, 2016).

1.3 Parenting and child hearing loss

Parenting a child with a disability presents multiple challenges for parents. Some of these challenges may include less social support, impact on economic costs, and higher child-caring responsibilities (Sloper, Jones, Triggs, Howarth & Barton, 2003). Likewise, it includes dealing with social stigma associated with disabilities (Lecavalier, Leone & Wiltz, 2006). Parents may feel unprepared for the responsibilities of caring for a child with a disability. These responsibilities of caring for a child with a disability can be overwhelming and stressful and can make parents feel less competent because of the higher parenting demands and smaller social support network to help them cope. Studies have shown that some parents of children with disabilities have reported greater stress challenges than parents who do not have disabled children (Baker-Ericzén, Brookman-Frazee & Stahmer, 2005).

Naturally, when a child with hearing loss is born into a hearing family, it can be inferred that hearing loss does not only affect the child but the whole family (Hendersen & Hendershott, 1991; Seligman & Darling, 2009; Humphries, Kushalnagar, Mathur, Napoli, Rathmann & Smith, 2019). Luterman and Ross (1991:2) assert "that when a child with hearing loss is born into a family, to some extent, everybody in the family has a hearing loss". Childhood hearing loss is a defining issue in a family (West, 2012), as the presence of a child with hearing loss may affect family dynamics and family interrelations. These family dynamics and family interrelationships include family members' reactions to the child's disability, family beliefs, culture, adaptation to the disability, and social support among family members (Harper, Dyches, Harper, Roper & South, 2013; Haihambo & Lightfoot, 2010; Chukwu, Okoye, Onyeneho & Okeibunor, 2019).

Ninety percent (90%) of children born with a hearing loss are born to hearing parents (Cole & Flexer, 2015; Chaudhury, 2014; Smith, Shearer, Hilderbrand & Van Camp, 2014; Lederberg, Schick & Spencer, 2013) who often know nothing or very little about hearing loss (Kushalnagar et al., 2011). In addition, these parents may feel overwhelmed, stressed (Zaidman-Zait, Most, Tarrasch, Haddd-eid & Brand, 2016), inadequate, and less confident in their parenting abilities when faced with parenting their child with a hearing loss (Kurtzer-

White & Luterman, 2003). Research shows that hearing parents experience a number of unique challenges when parenting a child with hearing loss, including communication, education, emotional well-being, financial, healthcare, social support, and child safety (Quittner, Barker, Cruz, Snell, Grimley & Botteri, 2010; Kobosko & Zalewska, 2011).

In the context of the current study, research highlights the complex challenges and needs of hearing parent's when parenting a child with a hearing loss. These complex needs include the need for parents to have access to multifarious information; to learn about communication options; to be well connected with social and parents support networks; and to have collaborative partnerships with professionals (Jamieson, Zaidman-Zait & Poon, 2011; Most & Zaidman-Zait, 2001; Jackson, Traub & Turnbull, 2008; Ingber & Dromi, 2009).

There has been a paucity of research addressing these challenges and needs of parents parenting children with a hearing loss in South Africa. In South Africa, most of the research focussing on parenting children with a hearing loss include advocating for infants with hearing loss in Africa; intervention and early hearing detection; infant hearing loss; or maternal views on infant hearing loss (Swanepoel & Storbeck, 2008; Swanepoel et al., 2008; Storbeck, 2012; Storbeck & Pittman, 2008). Therefore, there is a gap in addressing these challenges and needs that contribute to the experiences of hearing parents parenting a child with hearing loss. This would include, for example, evidence-based parenting support programmes for parents. Evidence-based parenting support programmes can become powerful instruments for parents in order to gain specific knowledge and skills for parents of children with hearing loss. This has been proven through two support programmes undertaken by organisations like HI-HOPES and THRIVE. THRIVE is an advocacy and parent support group that provides support to families and early intervention for parents of children with hearing loss. One of their main programmes is the parent mentorship programme where parents support each other and walk alongside other parents on the same journey of parenting a child with hearing loss. HI HOPES, an acronym which stands for 'Home Intervention Hearing and Language Opportunities Parent Education Services', is the first South African home-based early intervention project launched in August 2006. This programme offers parents and families weekly homebased support that is both child-centred and family-directed. This programme was initiated due to the lack of support given to parents and families of infants with hearing loss in South Africa. However, these programmes are only offered in certain parts of the country. They therefore need to become more widespread to assist families in other regions.

1.4 Problem statement

The literature shows that hearing parents experience significant challenges when parenting a child with a hearing loss. These challenges are further exacerbated by the lack of social and professional support provided to parents, despite evidence showing that 90–95% of children with a hearing loss are born to hearing parents (Cole & Flexer, 2015; Chaudhury, 2014; Smith et al., 2014; Lederberg et al., 2013). Further evidence suggests that there is little understanding of these needs and experiences as parents navigate through various challenges, such as communication, social support, and access to information, causing parents to struggle to develop effective parent child-rearing approaches (Zaidman-Zait & Most, 2005; Calderon, Bargones & Sidman, 1998; Zaidman-Zait & Jamieson, 2004; Young, Hunt, Carr, Hall, McCracken & Skipp, 2005).

Adding to the complexities of parenting a child with a hearing loss is the lack of 1) data on the prevalence of child hearing loss in South Africa in order to provide efficient and effective programme delivery; and 2) local evidence-based parenting programmes focused on the specific needs and challenges of parents parenting a child with a hearing loss. Therefore, given the importance of the parent-child relationship, and seeking to bridge this identified gap in the literature, the study focused on exploring literature targeting interventions on parenting styles to provide an understanding of parents' challenges and needs with the overall aim being to develop guidelines for hearing parents parenting children with a hearing loss.

1.5 Research questions

The main research question of this study was:

"What guidelines can be recommended for parents parenting children with a hearing loss?

The following sub-research questions were formulated:

1. What literature on parenting interventions targeting parenting styles are in place for hearing parents?
2. What are the parenting styles of hearing parents parenting a child with hearing loss?
3. What are the challenges contributing to parenting a child with a hearing loss, including parental self-efficacy?
4. What are the challenges and social needs contributing to the experiences of hearing parents parenting children with hearing loss?
5. What guidelines need to be developed for parent interventions for hearing parents parenting children with hearing loss?

1.6 Aim and objectives of the research study

1.6.1 Research aim

The study aimed to develop guidelines for hearing parents parenting children with hearing loss.

1.6.2 Research objectives

To answer the main question, the following objectives were to:

1. Explore previous literature on interventions targeting parenting styles of hearing parents parenting a child with a hearing loss;
2. Determine the parenting styles of hearing parents parenting a child with hearing loss;

3. Determine the challenges that contribute to parenting a child with a hearing loss, including parental self-efficacy;
4. Explore the challenges and the social needs of hearing parents parenting children with hearing loss;
5. Develop guidelines on parenting for hearing parents parenting children with hearing loss.

1.7 Research methodology

The research methodology shows the path taken by the researcher to conduct his/her research (Sileyew, 2019). This study followed a mixed methods approach with a sequential explanatory design using a two-phased approach. The research methodology is discussed in more detail in Chapter 3.

1.8 Significance of the study

Given the paucity of research on parents parenting children with hearing loss, the present study has the potential to make several contributions aimed at 1) social work services, 2) parent and clinical professional collaboration, and 3) government policy and programme initiatives.

1) Social work services

This study has been designed with the intention of contributing to the knowledge base of the social work profession concerning hearing parent’s parenting a child with a hearing loss. The results of the study will facilitate the understanding of and provide insight into the domain of parenting. In turn, these insights obtained will improve the services provided in social work practice.

The guidelines developed herein will furthermore assist social work services to provide social work interventions at three levels – micro, meso, and macro. The results of the study will provide social workers with information on the challenges and needs experienced by parents when parenting a child with a hearing loss. From a family systems theoretical perspective, social workers may come to understand the importance of seeing a family together (as a whole), working with all parts of the family system, including spouses, parents, and siblings in order to maintain and find solutions to presenting problems (Winek, 2010). Likewise, these guidelines allow social workers to work with parents by enhancing parent's self-confidence and competence which, in turn, benefits the well-being and development of the child. Therefore, the theoretical frameworks underpinning the study will provide insight into the experiences of parents parenting a child with a hearing loss.

Furthermore, the guidelines will assist social workers to offer parents and family member's comprehensive family support and enable them to make the necessary referral for appropriate intervention. The results of the study also make a recommendation for social workers to encourage parents to be connected to support systems that offer parents social and emotional support. This social and emotional support can be in the form of parent to parent support groups or offered by other parents who have experienced the same journey of parenting a child with a hearing loss. These support groups can be offered by community organisations for the Deaf or by hearing parents of children with a hearing loss which promotes parent leadership. Support connections include parents and children with a hearing loss who have been connected to adult role models who also have a hearing loss. Furthermore, unbiased professional support offered to parents should reflect their experiences of challenges and needs. Professional collaborations must ensure that parents have access to a range of support and resources to meet their individualised and unique needs as well as that of their child. Thus, the current study explores, examines, and describes the kinds of challenges and needs that parents parenting a child with a hearing loss might experience.

2) Parents and clinical professional collaboration

Furthermore, as well as being relevant to the social work profession, the results of this study may contribute to the interdisciplinary clinical professions. Social workers together with other health care and clinical professionals, such as psychologists, or audiologists, can provide a more integrated service to and with parents and their child with a hearing loss. This study therefore calls for a partnership between parents and clinical professionals that is characterised by respect, open communication, unbiased information sharing, and mutual consensus. The findings of the consensus workshop showed that both parents and professionals in the field of hearing loss were able to reach consensus on 16 agreed upon guidelines. Parents are viewed as experts of their own parenting experiences when parenting a child with a hearing loss.

Of essential significance is the continued education of professionals in the form of core specialised knowledge and skills when providing services to parent's parenting a child with a hearing loss. This ensures that professionals are knowledgeable as well as have the requisite skills to assist parents and their child with a hearing loss. This promotes the development of the knowledge and skills of the members of the interdisciplinary teams regarding parents and parenting a child with a hearing loss.

3) Government programme initiatives

South Africa has a strong legal and policy framework around which preventative interventions are discussed. The legal and policy framework as mandated by Chapter 8 of the Children's Amendment Act (Act No. 41 of 2007) sets out preventative and early intervention measures to support and develop positive parenting. Section 144, in particular, focuses on developing and improving the parental capacity of parents to act in the best interest of their child. This has been promoted in this study with its engagements with parents by exploring their parenting experiences when parenting a child with a hearing loss.

In order to address this need, the current study makes a significant contribution by highlighting the kind of programme support and interventions that can be offered by government for parents parenting children with a hearing loss. The results of the quantitative inquiry of the study revealed the importance of programme interventions for parent's parenting a child with a hearing loss. The results of the study also provided insight into the kind of intervention that can be provided to parent's parenting a child with a hearing loss.

In summary, this study makes noteworthy contributions to the body of knowledge regarding hearing parents parenting a child with a hearing loss.

1.9 Ethics considerations

The following ethical guidelines were adhered to in this study: Permission to conduct the research study was obtained from the University of the Western Cape (UWC) Human Social Science Research Ethics Committee. Consent forms were provided to all participants, including the participating schools for the Deaf. Since this is a vulnerable and easily recognisable group, no names of organisations and schools were mentioned. An information sheet was provided to all participants detailing the purpose and procedures for conducting the study. Permission was obtained before audio-recording the interviews (a detailed explanation was first provided for the purpose of doing so). In addition, provision was made to ensure confidentiality – a confidentiality clause was included to ensure the confidentiality of all information during the interviews, and pseudonyms were used to conceal the identity of the participants (instead of using their names, alphabetical letters were assigned to the participants). The participants' identities were protected during the research as well as during the publishing of the final research report. Non-malificence means that researchers should not unintentionally cause harm to the participants of the study. The research posed no harm to the participants and if they were traumatised or became emotionally distressed, they were referred for counselling and to appropriate resources. It is envisaged that the research study will contribute to the existing body of knowledge in the field of disability concerning parenting, family, and hearing loss.

1.10 Chapter outline of the thesis

Chapter 1 orientated the reader to the research topic under investigation and described the key elements of the research.

Chapter 2 presents the conceptual framework. This study is located within the family-centred approach and the parenting style framework. The chapter looks at the theoretical assumptions and propositions, as well as the main constructs of family systems theory. It further expounds on the application of the theory to the current study providing a short description of its location within the ecological systems theory. A literature review is provided, summarising previous research done on the current topic.

Chapter 3 outlines the research methodology employed in the study. The specific techniques adopted to collect, analyse, and evaluate the data of the current study are described, along with the tools used to gather the data. The chapter also describes and provides illustrations of how the mixed methods approach with a sequential explanatory design using a two-phased approach was implemented. It further clarifies the research paradigm and presents the trustworthiness of the study. Finally, the ethical considerations and conclusion are presented.

Chapter 4 comprises Stage 1 of Phase 1 of this study, where a scoping review was conducted to explore previous literature on interventions targeting parenting approaches of hearing parents parenting children with hearing loss. This chapter was done in article form. The results are discussed and refined toward the end of the chapter, informing the next phase of the research: Stage 2 – the quantitative results.

Davids, R.S., Roman, N.V. & Schenck, C.J. (2018). Interventions on parenting styles of hearing parents parenting children with a hearing loss: a scoping review. *Deafness & Education International,* 20(1):41-58. DOI: 10.1080/14643154.2018.1445156

Chapter 5 describes Stage 2 of Phase 1 which determined the parenting approaches of hearing parents parenting children with hearing loss as well as the challenges contributing to parenting a child with hearing loss, including parental self-efficacy. This chapter was done in article form. At the end of the chapter, the results were further discussed and refined to inform the next phase of the research: Stage 2 – the qualitative results.

Davids, R.S., Roman, N.V. & Schenck, C.J. (2020). Horende moeders en vaders se benadering van ouerskap tot kinders met gehoorverlies. The Journal of Humanities/Tydskrif vir Geesteswetenskappe (Accepted).

Chapter 6 encompasses Stage 3 of Phase 1 which explored and described the challenges and social needs experienced by hearing parents parenting children with hearing loss. At the end of the chapter, the results were further discussed and refined to inform the next phase of the research, which is the consensus workshop.

Davids, R.S., Roman, N.V. & Schenck, C.J. (2020). The challenges experienced by parents when parenting a child with hearing loss. Submitted to Journal of Family and Social Work (Accepted).

Chapter 7 comprises two sections:

In **Section 7A**, a consensus workshop was conducted. It presents and describes the data analysis and findings of the different phases of the research. These phases include two rounds: Round 1 was conducted with a panel of experts in the field of child, family, and disability; Round 2 was carried out with a panel of stakeholders in the field of hearing loss.

Davids, R.S., Roman, N.V. & Schenck, C.J. Developing a framework for guidelines for hearing parents parenting children with hearing loss using a consensus workshop. Submitted to the African Journal on Disabilities (under review, 2020).

In **Section 7B:** provides the guidelines of the study. It is envisaged that with the formulation and the guidelines in the domain of parenting, the area of parenting children with a hearing loss will be strengthened.

Chapter 8: The final chapter concludes the study with a discussion of the findings in relation to the objectives as set out in Chapter 1. The implications and conclusions of the overall research study are also provided.

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CHAPTER 2

CONCEPTUAL FRAMEWORK

2.1 Introduction

Chapter 2 presents the conceptual framework of the study. The purpose of the chapter is to conceptualise the contribution of the family and parenting in the context of hearing parents parenting a child with a hearing loss. Family systems theory, which underpins the current study, describes family structure and family functioning with regards to the impact of child disability on the family. It further explores the impact of child hearing loss on a family and how families and parents adapt to caring for a child with a hearing loss. Lastly, it provides a brief description of the kind of family-centred services best suited to address family and parents' needs when parenting a child with a disability.

2.2 General Systems Theory (GST)

In the 1940's, biologist Ludwig Von Bertalanffy (1901–1972) was generally acknowledged as the founder of general systems theory. Von Bertalanffy's general systems theory played an important role in psychology, moving away from a reductionist approach towards a holistic approach (Moore, 2017). According to GS, systems consist of smaller sub-systems or parts (Moore, 2017). *General systems theory* is a term used to describe "a way of thinking about" or "a way of studying" complex systems (Hammond, 2010:104). The basic underlining assumption of GST is that all parts of the system are interconnected and consist of smaller sub-systems or smaller elements, but which in turn are also part of a larger supra system (Moore, 2017), and furthermore, that systems affect themselves through environmental feedback. It is about exploring the world through systems which are made up of interdependent and interacting parts to make a complete whole (Teater, 2015; O'Leary (ed.), 2011).

2.2.1 Features of General Systems Theory

Below are the features of a GST as described by Von Bertalanffy (1969) and Whitchurch and Constantine (2009):

1. The system is understood as a whole. For example, children with a disability, such as a hearing loss, cannot be assessed apart from the family.
2. Hierarchy within a family. This is usually determined by the sub-systems within the family. They are held together by rules and authority within the family.
3. Mutuality: this means that the parts of the system (family) are tightly interconnected and therefore cause and effect cannot be determined.
4. Boundaries: rules are made in line with the family's values.
5. Equilibrium: seeks a state of balance within a family. A change in the family system will cause instability that requires adaptation to return to its state of balance.
6. Equifinality: means that there is more than one way to reach a goal. Patterns of behaviour become redundant and the family becomes stuck in the way they behave and communicate.

GST is viewed as a theory of systems – a worldview that sees the interrelationships between objects (Whitchurch & Constantine, 2009). It therefore provides a theoretical framework (a lens) for the creation of various micro-level approaches, known as *systems theories* (Whitchurch & Constantine, 2009). *Family systems theory* is one of those theories, as applied by Seligman (1991) and Seligman and Darling (2009). These authors explain the family system in the context of parenting a child with a hearing loss and is therefore applied in this study.

2.3 Family Systems Theory (FST)

This research study was based on the family systems theory. FST was founded on the work of Murray Bowen (1976), a psychiatrist and pioneer of family psychotherapy. His work with families guided him to define the family as a multifaceted unit of systems and sub-systems. He believed that patterns of interpersonal relationships connect family members across three generational perspectives. The basic tenet of Bowen's theory is that the family is perceived as a system with each family member playing a critical part. Therefore, the family system is recognised as the primary and most powerful system to which a person belongs, and that if anything happens to one member of the family, the whole family system is affected (Seligman & Darling, 2009).

Families are complex, and therefore need to be understood within various interdependent layers, including each individual family member, dual relationships, broader family functioning, and the culture they adopt (Rasbash, Jenkins, O'Connor, Tackett & Reiss, 2011). Moreover, families are to be understood as uniquely different because of their interactions with each other and their collective history, which may include child disability. The latter has a profound effect on families and its functioning.

2.4 Family systems theory and the impact of child disability on the family

Disability places extra demands or challenges on the family system, often lasting for a long time, affecting relationships and the roles of each one in the family (Aksoy & Yildirim, 2008). The birth of a child with a disability can threaten the stability of a family system, causing family adjustments to be greater and more challenging (Luckner & Velaski, 2004). Childhood disability can challenge and test long-standing family roles and patterns of family organisation (roles/relationships/communication/boundaries), threatening the stability of the family system (Luckner & Velaski, 2004; Aksoy & Yildirim, 2008). The literature highlights the multifaceted problems accompanying disabled children and the impact on family structure and functioning, necessitating changes in family life to accommodate the needs of a child with a disability (Larcan & Cuzzocrea, 2008). The family's connectedness, interdependence, and interactions are challenged; disability thus makes interdependence explicit and amplifies the complexity of family relations (McDaniel & Pisani, 2012).

When a child with a hearing loss is born into a hearing family, it can be inferred that the hearing loss does not only affect the child but the whole family (Hendersen & Hendershott, 1991). Lutherman and Ross (1991:2) advances the point "that when a child with a hearing loss is born into a family, to some extent, everybody in the family has a hearing loss". These authors point out that a child with a hearing loss is part of the family system, and that the hearing loss belongs not only to the child but to the whole family. Hearing loss is a defining issue affecting all members in a family system as well as its structure and functioning (West, 2012). Parents have reported that their interactions with their child who has a hearing loss is different from their interactions with the other children in the family (Lam-Cassettari, Wadnerkar-Kamble & James, 2015).

Jackson and Turnbull (2004) and Movallali and Poorseyed (2015) therefore suggest that the FST may be useful to achieve a better understanding of the impact a child's hearing loss has on the family and parents, and how disability in one family member can affect the entire family system (Seligman, 1991:27).

The following sections discuss family structure and family functioning in relation to the impact disability has on a family as well as the impact of hearing loss on the family.

2.4.1 Family structure, family functioning and disability

Family structure refers to the different family characteristics that make up a family (Seligman & Darling, 2009). These characteristics can be made up of its members (membership) as families differ in their configuration. In addition, many of these characteristics extend beyond the typical family homogeneity of a nuclear family. The following changes take place in families over time, for example: 1) family size increases with the birth of a new family member or decreases through death or divorce; 2) cultural beliefs based on ethnicity, race, and religious beliefs within a family; and 3) family ideological styles.

The family's general cultural and religious beliefs, attitudes, and ideological styles further affect the way a child with a disability is accepted and interacted with in a family. Too often cultural beliefs and ideological styles give way to societal stigma and discrimination when a child with a disability is born into the family, especially in Africa. Haihambo and Lightfoot (2010) report that among some African ethnic groups, fathers often desert their families when a child with a disability is born because of these beliefs and ideologies. In some instances, marriages may fail because of accusations of evil spirits when a child with any form of disability is born (Harper et al., 2013). Because of the superstition that witchcraft or evil spirits cause disabilities, families may experience isolation due to ostracisation from the community and even extended family members (Harper et al., 2013), impacting negatively on the child and his/her family system.

Similarly, the family is made up of interactions or functions. Individual members in families are reactive – they are interconnected, interdependent, and interactive (Goldenberg & Goldenberg, 2004; Turnbull & Turnbull, 2001). Good family functioning is considered important for individual and family well-being, and how the family functions is crucial for its stability and helping family members to cope with adverse life experiences (Haines, Rifas-Shiman, Horton, Kleinman, Bauer, Davison, et al., 2016). Family functioning is a multidimensional concept that encompasses communications and relationships between family members, organisation, how families collaborate to achieve their goals, cohesion, and adaptability (Roman, Schenck, Ryan, Brey, Henderson, Lukelelo, Minnaar-McDonald &

Saville, 2016). Cohesion and adaptability within the family system is described as the emotional bonding, level of family support, family bonding, and the family’s ability to respond to changes and developments (Briggs & Morgan, 2017; Gonzales, Dumka, Millsap, Gottschall, McClain, Wong & German, 2012). However, when the family system is experiencing changes, for example, due to a disability, the family functioning is disrupted, which has the potential to bring disequilibrium or an imbalance in the family system until adjustment can occur (Martire & Helgeson, 2017).

Such disruptions in family functioning may affect, among others, the existence of 1) sub-systems within the family system, 2) boundaries, 3) communication patterns, and 4) family adaptability (Seligman & Darling, 2009; Goldenberg & Goldenberg, 2008; Seligman, 1991) when the family is faced with a child with a disability.

2.4.1.1 Sub-systems

The nuclear family comprises the following three sub-systems.

The first sub-system, the *spousal subsystem*, is defined as the relationship between husband and wife. Any dysfunction between husband and wife are bound to affect the whole family. This sub-system further demonstrates to children that spouses provide each other with an opportunity to grow and develop (Greenberg & Greenberg, 2008). It also models to children how to deal with conflict and negotiate differences (Seligman, Benjamin & Darling, 2007), as spousal conflict often contributes to children’s worry and stress. The traditional spousal or supportive sub-system is where wives and husbands can rely on each other for support and understanding (Greenberg & Greenberg, 2008). Furthermore, the spousal system teaches children different roles in families, how to deal with conflict, and how marital partners accommodate and meet each other’s needs.

However, the presence of child disability may threaten the husband and wife dyad. Unresolved grief, the demanding nature of raising a child with a disability, and feelings of guilt and blame may produce extreme challenges for couples. Child disability may destabilise marriages and decrease the quality of the couple’s relationship. Mothers and fathers may also react differently to the child’s disability, impacting on the parental relationship, as well as spousal and parent-child relations. Research shows that couples may experience less marital satisfaction and may encounter a higher incidence of single parenthood (Hogan, Msall, Goldscheider, Shandra & Avery, 2012). Conversely, others reported having a child with a disability as bringing happiness, cohesion, a source of strength, a sense of family, personal growth, and maturity (Greer, Grey & McClean, 2006; Strecker, Hazelwood & Shakespeare-Finch, 2014).

The second sub-system, the *parental subsystem*, is defined as the interaction between parents and children. The tasks of this sub-system are to provide guidance, nurturance, and discipline (Greenberg & Greenberg, 2008), as well as promote the physical, emotional, social, spiritual and intellectual development of a child. It is this sub-system that shapes our future adults.

For children with disabilities, parents have been described as the one constant in their lives (Austin, 2000). Parents play a key role in helping their child with a disability identify life and providing them with opportunities to attain their goals (Austin, 2000). However, having a child with a disability poses a significant threat to the parent sub-system, as well as parents’ physical and emotional well-being (Singer, 2006). These threats, for example, may stem from different racial and ethnic family and parent backgrounds, diverse cultures, as well as the support and resources available to parents (Magaňa & Smith, 2006).

Furthermore, this sub-system is challenged by the unpreparedness and overwhelming task of caring for a child with a disability and their specific needs (Austin, 2000). Parents of children with disabilities have reported feeling greater stress and experiencing more challenges than parents who do not have a child with a disability (Ha, Hong, Seltzer & Greenberg, 2008). They have described their parenting journey of parenting a child with a disability as "their greatest joy and their greatest heartache" (Myer, Mackintosh & Goin-Kochel, 2009:9). Parents may feel unsure of how to parent a child with a disability, and consequently experience anxiety, stress, helplessness, guilt, and chronic sorrow. They may also harbour feelings of jealousy towards a "typical" family and fret about the impact of the disability on the wider family members (Griffin, 2019). Equally, parents have reported their positive experience of parenting a child with a disability. These positive experiences include their own personal growth as a person, particularly in terms of their own strength, understanding, and empathy, and their appreciation for what is important for them and their family (Griffin, 2019).

The third sub-system is the *sibling sub-system*. Siblings rely on each other for comfort and camaraderie and are one of the longest and most important relationships in a person's life (Öz Soysal, 2016). Through this sub-system, children learn from their parents. They also learn social proficiencies in their interaction with their parents and siblings, and by observing family interaction with others (Dunn, 2006). In addition, they learn how to negotiate with each other, support each other, and thereby develop social skills (Seligman et al., 2007).

Family intervention services typically focus on the parent-child dyad, often ignoring or neglecting to include intervention with siblings. Some of these neglected areas overlook that siblings of children with disabilities may assume greater responsibility in caretaking roles, such as substitute parenting, or assuming a parental assistant role, especially when growing up in families where parental roles are non-existent or when there is a lack of familial social support networks (Smyth, Cass & Hill, 2011). A study conducted by Knecht, Hellmers and Metzing

(2015) on the perspective of siblings of children with chronic illness, for example, argue that the different caretaking roles done by siblings should be looked at more closely as there is little research into these children's experiences of providing informal support and care to families (Smyth et al., 2011).

2.4.1.2 Boundaries

Family boundaries protect the integrity of a family, determining who is an insider and who is an outsider (Greenberg & Greenberg, 2008). For this reason, clear boundaries need to be set. Boundaries communicate who has the authority and power in a family. Sometimes boundary lines can become blurred, causing conflict among family members. For example, grandparents may overstep the boundary lines when asserting their authority and power, and especially when undermining the parent's role in child management.

Rules need to accompany boundaries. Clear boundaries with appropriate rules should be set. However, if rules are too rigid or too blurred, confusion may arise, increasing the risk of family instability and dysfunction (Greenberg & Greenberg, 2008). More importantly, rules need to be communicated to family members so that they know what is expected and how to behave. Through rules, family members learn what is permitted or expected. Rules, in essence, facilitate family stability and help them to function as a family. In addition to creating family cohesion, rules help families to establish their own family identity. A family's identity can be easily affected by child disability. For example, one parent may have to give up their employment to care for the child with a disability, or the family may have to move away from extended family members who form part of their support structure to be nearer to resources to cater for the educational and medical needs of their child with a disability. Unclear and blurred boundaries in terms of caring for a child with a disability can put strain on relationships within families. Mothers often assume the role of caring for a child with a disability; however, when the boundaries concerning roles and responsibilities are ambiguous, tension and confusion often arises within the family (Seligman & Darling, 2009).

2.4.1.3 Communication patterns

Patterns of communication in families are linked to relationships, as it is through communication that relationships are formed. It expresses what is going on in the family, both negatively and positively. It further includes close and open communication patterns indicating the power and authority of different members within a family. Communication connects and empowers family members. Walsh (2006) views clarity, open expression, and collaborative problem solving as key to healthy communication patterns in families. Frequent communication and information sharing with regards to decision making leads to healthy families (McDaniel & Pisani, 2012).

Communication breakdown in a family usually indicates a problem in the family system and not in the person per se, as communication patterns among family members have a significant impact on the quality of life of family members and affects the behaviour and performance of each member of the family (Koerner & Schrodt, 2014). It is not uncommon for family members to blame the child with a disability for the communication problems or breakdown in the family. Often communicating with a child with a disability is not seen as a priority as this communication may require more time and explanations which can cause frustration and tension (Kolucki & Lemish, 2011).

This section is further expanded on later in the chapter under the impact of child hearing loss on the family.

2. 4.1.4 Family adaptation

The family's ability to change in response to a crisis – to make decisions and negotiate differences – is called *adaptability* (Seligman & Darling, 2009). For example, a family with a rigid structure and controlling function will find it difficult to adapt to the demands of caring for a child with a disability (Turnbull & Turnbull, 2001). Family reactions and family adaptation to a child's disability can cause a child to be thought of as different as well as to think of themselves as being different. Parent's adaptation to a child's disability can also depend on the family's cultural and ideological beliefs, as mentioned earlier. The goal is to achieve as much equilibrium in the family as possible; however, this can be difficult to achieve when parents have to see to the needs of their child with a disability, other family needs in the family, as well as their own needs. The equilibrium or balance of the family system comes under threat when the family's self-regulating efforts to maintain stability is threatened (Davies, 2016; Greenberg & Greenberg, 2008). To get to a state of balance again, the family may need to adapt or make accommodations in one area of family life, causing an impact on the rest of the family.

2.5 The impact of hearing loss on the family and its adaptations

Prior to the 1970s, very little was understood about the family's adjustment and adaptation to the unique needs of a child with hearing loss. This was because, over the years, most researchers and practitioners focused more on hearing families' experience of grief in reaction to the diagnosis of their child's hearing loss (Feher-Prout, 1996). Only recently has attention been given to understanding the impact of child hearing loss on a family and parenting, and the diversity and complexities in family responses to a child with a hearing loss (Krywko, 2012).

In order to understand the impact of hearing loss on the family and its adaptation, roles and relationships, rules, and boundaries are discussed interchangeably under communication in this section. Furthermore, this section describes hearing parents parenting styles in trying to adapt to parenting a child with a hearing loss. Likewise, it provides a description of the kind of challenges hearing parents experience and the impact these have on parental self-efficacy, including limited access to social support and resources, which influences how families cope with and adapt to parenting their child with a hearing loss (Jackson et al., 2008; Zaidman-Zait et al., 2016).

2.5.1 Communication

Communication has often been described as the main challenge that families of children with hearing loss struggle with (Zaidman-Zait & Most, 2005) as the flow of communication is disrupted (Arnold, Heller, & Kramer, 2012; Goldenberg & Goldenberg, 2003; Seligman & Darling, 2007; Smith, Romski, Sevcik, Adamson & Bakeman, 2011). Communication difficulties can cause tremendous stress, as well as soaring emotions and tensions between family members and between parents. Hearing parents are confronted with the differences between themselves and their child (Sardar & Kadir, 2012) as communication difficulties challenge interaction between them and their child, affecting parenting **roles and responsibilities** negatively (Tamis-LeMonda, Uzgiris & Bornstein, 2002). Insufficient explanations for decisions made in the family or by parents may lead to children with hearing loss not understanding **rules**, **boundaries, and decisions** (Davids & de Jager, 2014), affecting family cohesion. For hearing members in a family, rules may be explicit, but for a child with a hearing loss, these rules may be vague. It can be inferred that a child with a hearing loss is presented with fewer opportunities to learn from others (Marcshark & Spencer, 2011), to learn what is wrong, and how to correct such behaviour. They are afforded little opportunity to learn and resolve their own problems. Parents who struggle to communicate with their child with a hearing loss may model avoidance parenting (Marcshark & Spencer, 2011).

In struggling to adapt to the communication needs of their child with a hearing loss, a study conducted by Humphries, Kushalnagar, Mathur, Napoli, Rathmann and Smith (2019) identified that the vast majority of questions parents ask doctors and professionals in assisting them in their **parenting roles** is about communication challenges. These questions included seeking clarity on everyday problems they would experience in communicating with their child.

Further studies have found that youth with a hearing loss are likely to grow apart from their hearing families and do not experience a sense of belonging as they cannot communicate with their families, affecting their quality of life and emotional well-being negatively (Kushalnagar, Mathur, Moreland, Napoli, Osterling, Padden & Rathmann, 2010). Youth with hearing loss also reported feeling less satisfied with life, their friendship, and family because of communication frustration experienced in families (Gilman, Easterbrook & Frey, 2004). Conversely, a study conducted by Leigh, Maxwell-McCaw, Bat-Chava and Christiansen (2009) with 57 adolescents with hearing loss found that these adolescents were satisfied with communication at home with hearing parents, which promoted their social competence and increased their self-esteem and overall life satisfaction.

2.5.2 Parents adapting their parenting styles

Over the years, researchers have studied different parenting approaches in raising children (Carr & Pike, 2012) and have examined a variety of parenting styles and the effects these may have on child outcomes. Each parenting style comprises different characteristics and brings about diverse reactions in children. Parenting has been extensively defined in academic literature. The most effective way of examining parenting is through the concept of *parenting styles* (Darling, Flaherty & Dwyer, 1997), which conveys parents' attitudes towards their child.

Jackson and Turnbull (2004) and Koester and Meadow-Orlands (1999) show that the presence of a child with a hearing loss may affect, among others, the parenting styles of hearing parents. These parents may experience difficulties in developing effective parental child-rearing styles causing parents to be unsure of the manner in which they raise their child with a hearing loss (Calderon & Greenberg, 1999; Calderon, Bagones & Sidman, 1998). Some hearing parent's parenting styles have been described as being overprotective when parenting their child with a hearing loss (Raya, Ruiz-Olivares, Pino & Javier Herruzo, 2014; Jackson & Turnbull 2004). This is seen as an impediment to the independent development of children with hearing loss, exerting high levels of control on the part of the hearing parent (Calderon & Greenberg, 1999). In a UK study, Gregory (1979) interviewed 122 young mothers of children with hearing loss and found that mothers were unreasonably overprotective of their children, unnecessarily restricting their children's social life, resulting in maternal intrusiveness and restricted child autonomy (Meadow-Orlans 1990; Vaccari & Marschark, 1997). Additional studies focusing on mothers showed more negative parenting behaviour and inconsistent discipline towards children with a hearing loss, including being authoritative, strict, and using punitive measures, such as physical discipline (Movallali & Poorseved, 2015; Antonopoulou, Hadjikakou, Stampoltzis & Nicolaou, 2015; Sullivan, 2004).

Some of the few studies focusing on fathers parenting children with hearing loss observed that fathers were also overprotective of their children and less democratic and disciplined in their approach, compared to fathers of hearing children (Sahli 2011; Antonopoulou et al., 2015).

In parenting a child with hearing loss, Lewis (1981) propagates that it is not the high control of authoritative parents with rules that helps children to develop independence, but rather shared communication and the modification or adaptation of parental rules through argumentation that allows for the outcome of independent children. This would suggest that, for example, parenting a child with a hearing loss may be different and may require parents to rethink their parenting styles. Parents may have to make accommodations for a child with a hearing loss by adapting, adjusting, and accommodating the specific needs of their child. This may require hearing parents to modify their parenting behaviour, learn new communication methods, and become more engaged in their parenting style towards their child with hearing loss.

2.5.3 Lack of support

Furthermore, limited access to social support influences how families cope and adapt with a child with hearing loss (Jackson et al., 2008). Family adaptation to the various challenges experienced is affected by parents' personal and social coping resources available to them to manage these challenges (Zaidman-Zait et al., 2016). As stated, 90–95% of children with a hearing loss are born to hearing parents who have never come into contact with a child with a hearing loss until the birth of their child (Blose & Joseph, 2017). Parenting in situations such as these “can make some of the most common parenting demands more challenging, thus establishing a completely new set of unique, daily demands” on parents (Zaidman-Zait, 2007:140). Therefore, one of the most-cited social challenges experienced by parents is the need for parental social support systems. Families with strong social support systems are able to cope with and adapt to the challenges more effectively than families with few supports (Dunst & Trivette, 1994; Hintemair, 2006; Zaidman-Zait, 2007; Asberg, Vogel & Bowers, 2008). Social support serves as a buffer against the effects of stressful situations and also helps parents to cope (Zaidman-Zait et al., 2016). Research findings suggest that strong social support would act as protection, provide emotional support (that is, encouragement, praise, and understanding), and at the same time lower stress among parents (Lederberg & Golbach, 2002; Asberg et al., 2008).

Studies have shown that **mother’s roles and relationships** are particularly affected when experiencing less support (Lederberg & Golbach, 2002; Jackson, Wegner & Turnbull, 2010). These studies have shown that mothers often feel socially isolated, lonely, report reduced levels of social and intimate relationships, and take on the primary communication responsibilities in the home, so that there is conversational interaction in families to avoid misunderstandings. Mothers often become the most effective communicator in the family; however, they may become tired and burdened by this responsibility (Luterman & Ross, 1991). In addition, mothers lived experiences of their roles in the family may include, among others, full time employment, taking care of other children, single parenthood, medical visitations, and financial cost.

A study by Dempsey and Keen (2009) found that the correct management as well as the need for counselling and other family supports were related to reducing parent stress and helping them to adapt to parenting a child with a hearing loss. Parents with strong social support from family and friends are able to adjust to managing challenges more effectively than families with few supports (Dunst & Trivette, 1994). Support and resources may assist families in functioning optimally and facilitate a state of equilibrium in the family.

2.5.4 Parental self-efficacy

Among the personal and social resources reported as affecting parents' adaptation and coping are their beliefs about their own competencies when parenting a child with a hearing loss. Among the views and attitudes affecting parenting styles of hearing parents parenting a child with a hearing loss is parent self-efficacy. Literature on parental self-efficacy has shown that there is a direct link between parenting and parental self-efficacy and quality of care provided to children (Sanders & Woolley, 2005). *Parenting self-efficacy* refers to parents' beliefs in their abilities to function proficiently and competently in their parenting responsibilities (Coleman & Karraker, 2005; Jones & Prinz, 2005). It is further defined as parents' personal beliefs and capabilities to adapt to stressful demands and challenges (Coleman & Karraker, 2003; Luszczynska, Gutierez-Dona & Schwarzer, 2005). Desjardin and Eisenberg (2007) found self-efficacy a valuable resource, although it has not received much attention as a potential coping resource for parents parenting a child with a hearing loss. Parents may find that they lack competencies in parenting the child (Freeman, Dieterich & Rak, 2002) and find typical parenting activities difficult, especially when trying to accommodate the diverse needs of parenting a child with a hearing loss.

There is limited research on parental self-efficacy when parenting a child with a hearing loss, with most research focusing on mothers (Desjardin & Eisenberg, 2007). Luterman (1979) maintained that the self-confidence of parents, particularly of the mother, is the decisive key to the child's success. The assumption is therefore that parents who lack a sense of self-efficacy may be unable to adapt and put their parenting knowledge into action, as they may feel tirelessly burdened by the extra responsibilities and challenges faced when parenting a child with a hearing loss (Coleman & Karraker, 2003).

2.5.5 Information to assist with adaptation

The provision of information on parenting a child with a hearing loss can build parents' confidence in their adaptation and ability to raise and parent a child with hearing loss (Bemrose, 2003). Young's (2003) study on the topic observed that parents found it difficult to access information, which impacted considerably on their experiences of parenting. They recommend that parents be provided with information on parenting a child with hearing loss during the early stages of their life.

When parents receive information that is reliable and accurate, it contributes to their ability to adapt and cope and assists them in their decision-making processes (Zaidman-Zait & Jamieson, 2004; Young et al., 2005). Research showed that when parents are provided with advice and information from professionals, they are able to adapt to their parenting approaches and make informed decisions about their child's hearing loss, his/her practical communication needs, and become aware of services available to them (Bruin & Nevoy, 2014; Crowe, Fordham, Mcleod & Ching, 2014; Guiberson, 2013).

2.6 A family-centred approach with families and parents parenting children with a hearing loss

Professionals who work with families who have children with disabilities have found it beneficial and effective to understand the family as a system in an attempt to manage the stress imposed by the child's disability. As Seligman (1991:27) points out, "A disability in one family member affects the entire system and in turn affects the disabled person".

In recent years, there has been a gradual acknowledgment of the importance of building the capacity for parents parenting children with a hearing loss, recognising the importance of building family (parents) capacities in service provision. The principle of family-centred services has become widely accepted, especially as it recognises the family and parents as the experts on their child. A family-centred approach balances the needs of the family with the best interest of its individual members. It is sensitive to family complexity, responds to family priorities, treats each family as unique, and supports parents behaviours that promote the learning and social development of the child (Brotherson, Summers, Bruns & Sharp, 2008; Shonkoff & Meisels, 2000; Burns, Dunn, Brady, Starr & Blosser, 2008).

A family-centred approach makes use of assessments in collaboration with families where the challenges or problems within families are contextualised rather than assigning individual blame. What is happening in the family is the focus of attention, rather than what is wrong with the individual. It promotes family members' ability to reflect on their actions and develop a plan of action together with family practitioners. A family-centred approach creates a positive family environment where family members support and accept each other and together engage in a plan of action that facilitates child development. Families are encouraged to make input into these action plans. These plans treat families as unique; focus on identified concerns and not on child therapies alone; and builds on family's strengths to meet the family's needs as a whole (Burns et al., 2008).

In addition, research by Dunst, Trivette and Hamby (2007) shows that a family-centred approach to delivering services results in greater family satisfaction, increased family involvement, greater family empowerment, enhanced family self-efficacy, improves child behaviour and functioning, increases family well-being, and improves parenting.

A family-centred approach also facilitates a partnered environment between parents and professionals and promotes receiving interdisciplinary care whereby professionals with the requisite skills are matched to the diverse needs of the child and family. For example, social workers together with other health and clinical professions, such as psychologists, and audiologists, can provide a more integrated service to parents and their child with a hearing loss. Furthermore, social work services must include emotional and social support and the facilitation of parent group sessions where families have the opportunity to connect with other parents and share their experiences. A strength-based focus is seen to be in line with a developmental approach to social work based on the premise that parents should be provided with support and services that will enable them to care for and parent their children within the family (Mullins, Cheung & Lietz, 2012:265). Together with this, the social worker should acknowledge the strengths, resources, and social support in the families. Strengthening families can lead to positive family functioning, better communication, improved parenting skills as well as the overall improvement of parent-child relationships. A family systems approach is about strengthening families, providing them with opportunities, and connecting them to support networks so that they can become functional and self-reliant (Department of Social Development (DSD), 2011).

2.7 Conclusion

In this chapter, the family systems theory was discussed in relation to building a theoretical understanding of the family and parenting a child with a disability, particularly a child with a hearing loss. It is envisioned that social workers together with healthcare practitioners within the field of hearing loss and family, being cognisant of the context in which hearing parents parent children with a hearing loss, will have the core competencies to support these families, their child, and promote family and parent-child well-being.

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CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The previous chapter described the conceptual framework that underpins the study. Attention now shifts in the current chapter to the methodology used in this study, which includes the mixed methods and a methodological framework, research worldview, and different mixed methods. The process and steps followed are also described, along with trustworthiness and the researcher's reflexivity during the research process.

3.2 Research aim and objectives

The overall aim of the current study was to develop guidelines for hearing parents parenting children with hearing loss. The following objectives were key in meeting the aim of the study. They were to:

1. Explore previous literature on interventions targeting parenting styles of hearing parents parenting children with hearing loss.
2. Determine the parenting styles of hearing parents parenting children with hearing loss.
3. Determine the challenges contributing to parenting a child with a hearing loss, including parental self-efficacy.
4. Explore the challenges and social needs experienced by hearing parents parenting children with hearing loss.
5. Develop guidelines on parenting for hearing parents to parent children with a hearing loss.

3.3 Methodological framework

The study used a mixed methods approach with a sequential explanatory design using a two-phased approach.

3.3.1 Mixed methods

A mixed methodology approach was best suited for this study as it sought to combine quantitative and qualitative approaches, "where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or languages into a single study" (Johnson & Onwuegbuzie, 2004:17). The notion of mixing different methods was prompted by Campbell and Fiske (1959) when they applied multiple approaches to study the validity of psychological traits and soon encouraged others to use the same approach to gather data in their studies by using methods such as observations and interviews (qualitative) combined with traditional surveys (quantitative). A mixed methods study involves the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected concurrently or sequentially, it is given a priority, and involves the integration of the data at one or more stages in the research process (Onwuegbuzie & Combs, 2011).

Of significance is that the research question is fundamentally linked to the research methodology used as the research methodology assists in answering the research question(s) (Creswell & Plano Clark, 2011:60). Mixed method research requires high levels of proficiency in philosophy of science, research ethics, quantitative research methods, and qualitative inquiry approaches (Bryman, 2007; Leech & Onwuegbuzie, 2010; Badiee, Wang & Creswell, 2012). Simons and Lathlean (2010) describe the three main purposes of mixed methods research as follows:

> ***Triangulation*** refers to a process of adopting two or more methods to corroborate the findings from one method with the other. Cross-checking using multiple methods enhances confidence in the study.
>
> ***Facilitation***, or development, is where one method is used to facilitate the following stage of the research. Examples of this may be when designing the sampling strategy for instrument development as a process evaluation within a randomised controlled trial, or to develop or improve health interventions.
>
> ***Complementarity*** is grounded in the idea that the weaknesses of one method can be offset by combining them with an alternative method that offers different strengths – that is, methods are combined to complement one another. This process may aid completeness or comprehensiveness of understanding of an issue. It can provide both a broad brush and a detailed context. It can also help enhance the explanations for the findings.

Hence, the mixed methodology approach was best suited for Phase 1 of this study, as it sought to 1) identify and explore research that was previously conducted on parenting styles and practices of hearing parents parenting children with hearing loss through a scoping review; 2) question (by means of a questionnaire) a larger group of hearing parents on what type of parenting styles they use when parenting their child, and discover the challenges that contribute to their parenting styles; and 3) have unstructured interviews to explore the challenges and social needs experiences of hearing parents parenting a child with hearing loss. This formed part of Phase 1 of the study. According to Creswell and Garret (2008:322), mixing both approaches affords a better understanding of the research problem than when either approach is carried out alone, which is what this study sought to do. The value is that it provides a more thorough understanding of a research problem (Creswell & Plano Clark, 2011). Of particular importance to this study is the view espoused by Mertens (2012) that the mixed methods approach can serve the purpose of advocacy and transformation for marginalised groups, such as people with disabilities.

Furthermore, three practical considerations have been identified as major contributing points for integrating quantitative and qualitative data and results in a study. Creswell, Fetters, and Ivankova (2004), and Plano Clark and Ivankova (2015) indicate three reasons to consider when employing mixed methods, namely: priority/weighting, timing/implementation, and integration. These are described in more detail below.

Priority/weighting	Priority refers to the weighting or attention given to the data collection and data analysis process of the study (Creswell, 2013). Priority or weighting is determined in research when the emphasis is placed on quantitative data, qualitative data, or an equal priority shared between the two forms of data in a mixed method (Creswell, 2013; Plano Clark & Creswell, 2015). In summary, where is the emphasis on the research process placed, or do the research processes have equal emphasis.
Timing/implementation	This refers to whether the researcher collects and analyses quantitative and qualitative data simultaneously (concurrently) and/or at different times (sequentially). In concurrent timing, the results of the mixed methods are combined during the interpretation stage (Plano Clark & Creswell, 2015; Baran, 2016). On the other hand, sequential timing involves the collection and analysis of quantitative and qualitative data in a particular sequence. It signifies that one method follows or may depend on the other one to progress.
Mixing	Mixing is significant for mixed methods. It refers to combining quantitative and qualitative data (Creswell et al.,

2004). The mixing of the data occurs in various stages of the research process, including data collection, data analysis, interpretation, and /or discussion. Mixing of data occurs in one of three ways (Creswell & Plano Clark, 2011), namely, the data sets are either merged, connected, or embedded. *Merged* studies integrate the two data sets either during data sets or during the final interpretation or discussion. *Connecting* data means that the analysis of one data set is used to lead into or build into the second data set (Creswell, 2014). In *embedding*, one data set – involving quantitative, qualitative, or combined data – is embedded/nested within a bigger design (Creswell, 2014).

3.3.2 Pragmatic worldview

A pragmatic approach is generally associated with mixed methodology (Feilzer, 2010), as it involves using the methods best suited to answering the research question(s), and even the research problem. This means that the researcher uses different methods to understand the problem. Emphasis is on application – "what works" – and solutions to the problem (Patton, 1990). Tashakkori and Teddlie (2003) opine that pragmatism is the best paradigm for mixed methods. They note that the soundness of mixed methods is further underscored by at least thirteen renowned mixed methods researchers who insist that pragmatism is the best philosophy underpinning mixed methods research,

Pragmatism can be viewed as providing solutions to the 'paradigm wars' (Feilzer, 2010) between quantitative and qualitative methods, and thus draws on both quantitative and qualitative methodologies (Creswell, 2013; Feilzer, 2010) so that pluralistic approaches are used to gain an understanding about the problem (Morgan, 2007; Tashakkori & Teddlie (eds.), 2010). Pragmatism provides a foundation for the following knowledge claim in that it is "not the abstract pursuit of knowledge through inquiry, but rather the attempt to gain knowledge in the pursuit of desired ends" (Morgan, 2007:67-70). Mertens (2012) states that mixed methods provide, firstly, for a better understanding of the research problem by merging numeric information from quantitative data, and specific information from qualitative data; secondly, through the use of existing instruments or the development of new ones, identifying variables that may be measured; thirdly, by identifying individuals who may expand on the qualitative data and results subsequently obtained through statistical, quantitative data and results from a population sample; and fourthly, to express the needs of marginalised individuals, persons, or groups.

In planning a research study, Creswell (2013) states that researchers must think through their philosophical ideas, i.e. worldview – the beliefs and assumptions they bring to the study. Philosophical assumptions consist of a basic set of beliefs that guides the inquiry (Guba & Lincoln, 2005) and action. Creswell and Plano Clark (2011:39) define these assumptions as a "worldview", meaning that the researcher generates a "worldview", embracing his/her beliefs and assumptions, which informs the study to be conducted.

The pragmatism worldview is discussed based on the basic beliefs related to axiology, ontology, epistemology, and methodology. Axiology, ontology, epistemology and methodology are terms in research that denote underlying beliefs that shape every research, theory and methodology approach. *Axiology* refers to the beliefs about the role of values and morals in research; *ontology* are the assumptions about the nature of reality; *epistemology* are the assumptions about how we know the world, how we gain knowledge, and the relationship between the knower and the known; and *methodology* refers to the shared understanding of the best means for gaining knowledge about the world and the language of research (Creswell, 2009; Lincoln & Guba, 2011).

Given that mixed methods researchers often borrow from multiple research paradigms within one study, it is important to define each briefly. The four worldviews widely discussed in the literature are post-positivism, constructivism, transformative, and pragmatism (Creswell, 2013a). Through a *post-positivist* lens, characteristically viewed as an approach to quantitative research, the researcher is seen as independent and separate from the phenomenon under study. Knowledge is gained through careful observation and measurement, making sense of the world through a scientific process, taking into account quantitative methods and statistics (Creswell, 2013a; Somekh, Burman, Delamont, Meyer, Payne & Thorpe, 2005). In contrast, *constructivism* is typically seen as an approach to qualitative research where individuals seek to understand the world in which they live, developing objective meaning of their experiences (Creswell, 2003; Somekh et al., 2005; Creswell, 2014). An alternative group of researchers aspire to the philosophical assumptions of the *transformative* approach. This approach employs both quantitative and qualitative methods and seeks to empower and transform participants from oppressive conditions (Ponterotto, Mathew & Raughley, 2013), affording participants with a voice to improve their own lives (Creswell, 2014).

Table 3.1. The Basic Beliefs/Philosophy Underpinning the Current Study

Basic Beliefs	Pragmatic
Axiology	Gained knowledge in pursuit of desired ends as influenced by the researcher's values and politics
Ontology (nature of reality)	Asserts that there is a single reality and that all individuals have their unique interpretation of reality
Epistemology (nature of knowledge, the relation between knower and would-be known)	Relationships in research are determined by what the researcher deems to be appropriate to that particular study
Methodology (approach to systematic inquiry)	Match methods to specific questions and purposes of research; mixed methods can be used as the researcher works back and forth between various approaches

(Source: Denzin & Lincoln (eds.), 2005; Guba & Lincoln, 2005)

3.4 Mixed methods designs

According to Creswell, Plano Clark, Gutmann, and Hanson (2003), mixed methods are conducted in two main categories, namely, concurrent and sequential.

3.4.1 Concurrent procedures

Concurrent designs are also known as convergent parallel mixed methods which includes the mixing or merging of quantitative and qualitative data to deliver a full investigation of the research problem (Creswell, 2013a). The researcher collects both sets of data simultaneously or roughly at the same time and then combines the information in the interpretation of the overall results (Creswell, 2003; 2013a; Creswell & Plano Clark, 2011). Priority is often given to one form of data collection (Castro, Kellison, Boyd & Kopak, 2010). Contrasting and ambiguities are further explained or explored in this design (Creswell, 2013a). The concurrent designs are applied to discuss the extent to which the data merges and are useful for "attempting to confirm, cross-validate and corroborate study findings" (Hanson, Creswell, Plano Clark, Petska & Creswell, 2005:229). Concurrent mixed methods designs are grouped in three categories, namely: (1) concurrent triangulation design, (2) concurrent nested design, and (3) concurrent transformative design.

In the *concurrent triangulation design,* the qualitative and quantitative data is collected and analysed simultaneously in one phase. An example might be collecting both sets of data at the same time through a survey and interviews, and then comparing the results. Concurrent triangulation designs are used to confirm, cross-validate, or corroborate findings, especially when a researcher is trying to confirm findings in a research study and more accurately define relationships among variables and interest (Hanson et al., 2005; Castro et al., 2010). In the *concurrent nested design,* both qualitative and quantitative data are collected at the same time; however, one form of data takes priority over the other (Hanson et al., 2005). For example, a qualitative phase can be embedded or nested within a predominantly quantitative study, or vice versa, as the one form of data plays a supportive role to the other form of data (Creswell & Plano Clark, 2011). The concurrent transformative designs are theoretically motivated through an advocacy lens. It initiates social change and is driven by the purpose of the study (Creswell & Plano Clark, 2011; Castro et al., 2010). Data are collected concurrently with priority being equal in some instances or unequal in other instances (Creswell & Plano Clark, 2011).

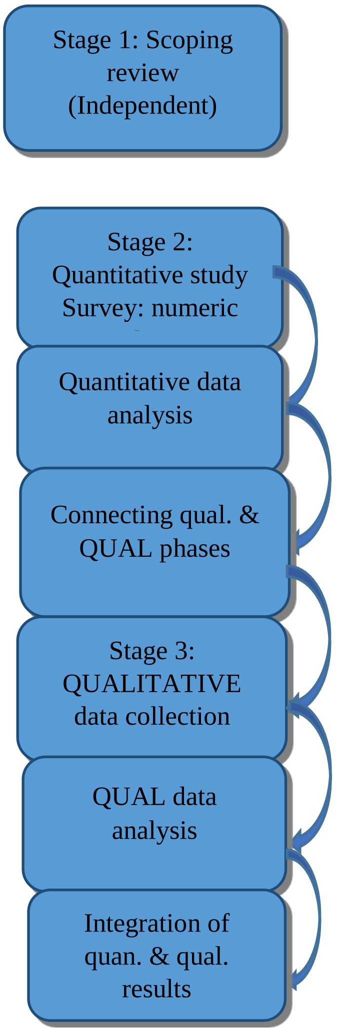
3.4.2 Sequential procedure

Sequential mixed methods designs make use of several options to explore a research question. These include (1) sequential explanatory design, (2) sequential exploratory design, and (3) sequential transformative design. The *sequential explanatory design* is characterised by first collecting the quantitative data and then collecting the qualitative data. The quantitative data has priority over the qualitative data and helps explain or elaborate on the quantitative data (Creswell & Plano Clark, 2011). The quantitative data and results present a general picture of the research problem, whereas the qualitative data refines or explains the general picture (Subedi, 2016). The integration of data happens in the interpretation and discussion phase. On the other hand, according to Creswell and Plano Clark (2011), the purpose of a *sequential exploratory design* is to gather qualitative data to explore a phenomenon and then collect quantitative data to explain the relationships found in the qualitative data. This means that the importance of the design is placed on the qualitative data as it is collected first and uses the quantitative data to explore and understand the qualitative data. *Sequential transformative designs* are characterised by the collection and analysis of either qualitative or quantitative data first. The design is sequential and unequal in priority and is based on the needs and preferences of the researcher and the study. The results of both methods are integrated during the interpretation phase of the study.

3.5 The research design of the current study

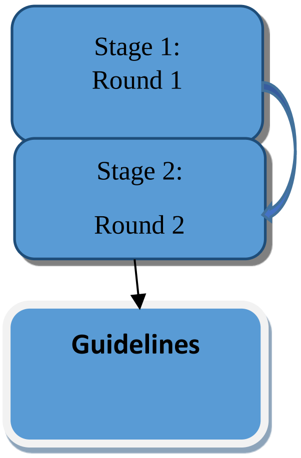
To address the current research question, this study used a *sequential explanatory design*. The sequential explanatory design consisted of two distinct phases (Creswell, 2013a) where the results of one method were used to inform another method. Figure 3.1 is a diagrammatical representation of the sequential steps taken in the research study.

Implementation of the different phases of the study



Phase 1: Identification of problem	Procedure	Results
Stage 1: Scoping review (Independent)	Research on previous research	Literature review
Stage 2: Quantitative study Survey: numeric	Questionnaires	Numeric data
Quantitative data analysis	SPSS quantitative software	Descriptive statistics
Connecting qual. & QUAL phases	Purposeful selecting & developing QUAL interview questions	Interview protocol
Stage 3: QUALITATIVE data collection	Individual interview	Text/audio data
QUAL data analysis	Thematic analysis	Themes
Integration of quan. & qual. results	Interpretation of results	Recommendations for guidelines

Phase 2: Consensus workshop
Development of guidelines



Stage	Procedure	Results
Stage 1: Round 1	Workshop with experts	Recommendations
Stage 2: Round 2	Workshop with stakeholders	Consensus on Recommendations
Guidelines		

Figure 3.1. Diagrammatical Representation of The Sequential Steps Taken in the Research

The current study used a mixed methods approach with a sequential explanatory design using a two-phased approach.

Phase 1 of the sequential explanatory design was the identification of the problem in three stages: (1) a scoping review, (2) a quantitative descriptive study, and (3) an exploration of parents' experiences of challenges and social needs when parenting a child with hearing loss.

Phase 2 of the sequential explanatory mixed method design was the consensus workshop which was conducted in two stages to design and develop guidelines for hearing parents parenting children with a hearing loss. The sequential explanatory mixed methods research design was used so that the findings from the first phase could be used in the second phase.

3.6 Study context

3.6.1 Research setting

The research study was set in the Western Cape, a Province of South Africa, situated in the south-western part of the country. The study was conducted with parents coming from a range of areas such as Worcester, Paarl, Khayelitsha, and the broader Cape Town region.

3.7 Implementation of the current study

3.7.1 Phase 1: Stage 1: Scoping review (Chapter 4)

a) The objective of the scoping review:

Objective 1: To explore the limited previous literature on interventions targeting parenting styles of hearing parents parenting children with hearing loss.

A *scoping review* is often defined as "mapping" – a summary of a wide range of evidence that was searched on a topic (Levac, Colquhoun & O'Brein, 2010). It is further defined as identifying gaps and future research needs that seek to address very specific questions; it is also used as a technique to map relevant literature in a particular field of interest and assesses the quality of the included studies (Arksey & O’Malley, 2005). Furthermore, it seeks to identify the current state of things that we know and don’t know (Anderson, Allen, Peckham & Goodwin, 2008) by synthesising and analysing an extensive body of research to provide better understanding and clarity about a specific topic (Davis, Drey & Gould, 2009). In essence, it seeks to explore the research question.

The main characteristic of a scoping review is to provide an overview of a broad topic being researched (Moher, Stewart & Shekelle, 2015) with the aim to 1) examine the extent and range of the research; 2) summarise and disseminate the research findings; and 3) identify research gaps in present literature in a particular field of interest (Arksey & O'Malley, 2005; Levac et al., 2010). A scoping review in the present study addressed the interventions of parenting styles and practices of hearing parents when parenting a child with a hearing loss. It sought to determine what research has already been published on the topic.

A *systematic review*, on the other hand, according to Dickson (2005), aims to appraise and synthesise data gathered from scientific studies. The systematic review “brings together and assesses all available research evidence” (Dickson, 2005:44). The systematic review is based on a detailed and comprehensive plan. A clear question identifies relevant studies related to the question, appraises the quality of the studies, and summarises the evidence through the use of an explicit methodology, which includes a search strategy by identifying, appraising, and synthesising all relevant studies on a particular topic (Hemingway & Brereton, 2009; Uman, 2011; Wright, Brand, Dunn & Spindler, 2007). “A systematic review endeavours to order all empirical evidence that fits pre-specified eligibility criteria to answer a specific research question. A systematic review uses clear systematic methods that are selected to minimize bias, thus providing findings that are reliable from which conclusions can be drawn and decisions made" *(*Liberati Altman, Tetzlaff, Mulrow, Gotzsche, Loannidis, Clark, Devereaux, Kleiunen & Moher, 2009*)*. Furthermore, the systematic review is well planned to answer a specific question whereby it identifies, selects, and critically evaluates the results, making sense of the data collected (Rother, 2007), and thereby increases understanding of a particular topic (Harden, 2010). It selects only those studies that meet the criteria to confirm the rigour of the evidence produced by these selected studies. Thus, a systematic review is a way of identifying, evaluating, and interpreting all available research relevant to a particular research question, or topic area, or phenomenon of interest under research (Kitchenham & Charters, 2007).

As stated, the objective of the current scoping review was to explore the limited previous literature on interventions targeting parenting styles of hearing parents parenting children with hearing loss. The question posed was: What are the interventions, programmes, best practices, or approaches targeting parenting styles of hearing parents parenting children with hearing loss? This question was answered and is discussed in detail in Chapter 4.

b) Databases selected

The following databases were selected for the review:

- Ebscohost (Academic Search Complete, MedLine, PsycARTICLES, SocIndex, Greenfile, Masterfile Premier) is a database that provides a platform to access just over 24 different database platforms that can be searched individually.
- Science Direct, which explores scientific, technical, and medical research.
- Springer Link, which provides researchers with access to scientific documents from journals, books, series, and reference works.

c) Selected search terms

The key terms that were considered for conducting the scoping review were:

Interventions: the search term "intervention" produced numerous articles on early identification of hearing loss and universal newborn hearing screening intervention which did not apply to this study. A noteworthy point is that the eligible interventions did not speak directly to the present study topic. However, they did relate to the support for hearing parents parenting children with a hearing loss.

Other search terms included: *programmes, parenting practices, hearing parents, and children with a hearing loss*, and *parenting styles*. When searching these terms, it became evident that there is limited literature on the parenting styles of hearing parents parenting deaf children. Literature tends to focus mostly on actors relating to parenting a deaf child, e.g. stress, communication difficulties, and so on.

Table 3.2. Databases Search and Search Terms

Databases	Keywords	No. of articles	Hits
1. Ebscohost: a) Academic	Interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches, deaf children	84	1
b) MedLine	Interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches, deaf children	58	5
c) PsycARTICLES	Interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches, deaf children	3	0
d) SocIndex	Interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches, deaf children	1	0
e) Greenfile	Interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches, deaf children	0	0
f) Masterfile Premier	Interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches, deaf children	1	0
2. Science Direct	Interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches, deaf children	75	0
3. SpringerLink	Interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches, deaf children	54	0
4. PubMed	Interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches, deaf children	1	0
4. Journal of Deaf Studies & Deaf Education	Interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches, deaf children	62	1

d) Inclusion and exclusion criteria

The inclusion and exclusion criteria for the current study used a set of predefined characteristics to identify eligible participants or those disqualified from the research. The *inclusion criteria* for this review comprised all articles that reported on interventions with a primary focus on assisting hearing parents in terms of parenting styles and parenting practices, and were published internationally, in Africa, and South Africa. No specific years were included in the research simply because of its focus on hearing loss and the sparsity of research done in the area of hearing loss/deafness (Mulwafu, Kuper & Ensink, 2016). Regardless of the research design, articles met the inclusion criteria if they 1) were written in English; 2) focused on hearing parents; 3) focused on deaf children, and 4) focused on ideas central to parenting and parenting styles/practices.

The reasons for the exclusion of a large number of articles were that the search term “intervention” produced many articles on early identification and universal hearing screening interventions which did not apply to this study.

e) The methodological quality appraisal tool

In assessing the quality and strength of the literature, an in-depth appraisal of the selected studies (Ham-Baloyi & Jordan, 2016) was undertaken. This included the quality of the conduct of the review and the strength of evidence in the review (Smith, Devane, Begley & Clarke, 2011). To allow for the comprehensive assessment of the scope of the review, the information provided the following: the extent to which literature was sourced; years searched; the restrictions that were applied; and which reviews influenced the conclusions of the review (Smith et al., 2011). Furthermore, the set of criteria appraised the reliability and validity of these studies (Gough, Thomas & Oliver, 2012; Ham-Baloyi & Jordan, 2016).

The methodological evaluation tool that was used to appraise the literature was the RE-AIM framework. Literature was reported and processed according to the components of the RE-AIM framework adapted from Glasgow, McKay, Piette and Reynolds (2001).

The RE-AIM framework systematically broke down the evaluation of each intervention into their **R**each, **E**ffectiveness, **A**doption, **I**mplementation, and **A**doption dimensions (Glasgow, Vogt & Boles, 1999).

R*EACH*: the study looked at the recruitment of participants in the interventions. It took into account the eligibility criteria and demographics of participants as well as the number of participants participating in the interventions (Brace Padilla, Dejoy, Wilson, Vandenberg & Davis, 2015).

E*FFECTIVENESS*: the effectiveness of the interventions was determined by the impact on important outcomes made by the interventions. The study used certain measures to determine the effectiveness of the interventions, e.g. parenting styles, parenting dimensions, and hearing parents parenting a child with hearing loss. Furthermore, effectiveness focused on the goals attained in a "real-world" setting, referred to as pragmatic interventions (Gartlehner, Hansen, Nissman, Lohr & Carey, 2006).

A*DOPTION:* the study accessed the interventions adopted by individuals and organisations. It identified the enablers/facilitators and barriers to the adoption of interventions (Glasgow et al., 2001).

I*MPLEMENTATION:* an evaluation of the implementation of the interventions was done to determine the practicality of the interventions and to determine whether the intended intervention was delivered (Glasgow et al., 2001).

***M**AINTENANCE:* the continuation of interventions by organisations was measured, thereby evaluating the effects of the intervention over time. This dimension will also identify the enablers and barriers that facilitate/hinder the sustainability of the interventions (Brace et al., 2015).

The framework assisted with the evaluation of the possible interventions identified. With the application of the methodological quality appraisal tool, each article was given a score concerning the information provided; was tabulated as percentages; was categorised as being between satisfactory and good; and if it was considered for possible inclusion in the review (See Chapter 4 for a more in-depth discussion of the methodological appraisal procedure employed).

f) Data extraction using the: RE-AIM framework

The filtering of information was done by identifying the relevant publications to obtain conclusive findings for the present study. The filtering of information will be orientated towards specific publications in which this diversity will be reflected. A list of more influential peer-reviewed journals was considered to capture the various publications on the present study (Berghs, Atkin, Graham, Hatton & Thomas, 2016). Assessing the quality and relevance of the retrieved data, a quick assessment was done by reading the titles and abstracts and comparing them against the criteria for inclusion. Relevant articles were stored on a spreadsheet and were later read in full to determine its relevance for the present study. Publications were classified concerning the topics of the study whereby the researcher extracted and organised the main ideas relevant for the study (Berghs et al., 2016).

Table 3.2 provided the databases searched, the keywords used together with total articles, and relevant articles utilised.

The reviewed process consisted of three phases. In the first phase of selection, articles considered most relevant in meeting the search terms resulted in hits based on the titles. In the second phase, the articles were further reduced by removing duplicates of articles on the databases. In the third phase, the full texts of the articles were further screened by title and abstract leading to full-text screening. In establishing the reliability of eligible studies at the full-text stage, the last articles were screened by the researcher's supervisors and the results focusing on inclusion and exclusion were discussed. The researcher determined the nature of the interventions and identified the reach, efficacy, adoption, implementation, and maintenance of the intervention. The process was reviewed by two research study supervisors.

The data extraction gathered the following information about the interventions: author(s) name, study design, participant demographic details (population and sample), country, duration, the reach, efficacy, adoption, implementation, and maintenance of the interventions (discussed as an article in Chapter 4). The data analysis included a title search, reading of the abstracts, and finally a full review of the final articles selected.

g) Results established in the review

After the review was completed, the findings were collated and presented on a spreadsheet. As part of the dissemination of the findings (Chapter 4), the review was also presented as an article, which was published in 2018.

(All tables referred to are found in the article – Chapter 4).

3.7.2 Phase 1: Stage 2: Quantitative inquiry (Chapter 5)

a) *The objective of the quantitative study was to:*

1. *Determine the parenting styles of hearing parents parenting children with hearing loss.*
2. *Determine what factors contribute to parenting a child with a hearing loss, including parental self-efficacy*

This stage involved the collection of numeric information (Creswell, 2003).

b) Population and Sample

The participants in the current study involved 103 (n = 103) hearing parents from the Western Cape, South Africa. The participants constituted a heterogeneous group in terms of age, household, relationships, educational, and socio-economic profiles. Hearing parents were between the ages of 35 and 50 years of age, and their children, who had hearing loss, were between the ages of 10 and 17 years. Most of the parents were female (77/74.8%), Coloured (mix race) (46/44.7%), with the majority having female children (62/60.2%). Recent *population* census shows that the *coloured* demographic group represents more than 50% of the total *population* of the *Western Cape* (Alexander, 2018). The majority of singlehood parents were mothers (38/77.6%). The number of answered questions on the questionnaire by females and males varied. Participants had the right to omit answering any question if it made them feel uncomfortable.

c) Instruments

To address the overall aim of the research study, which was to develop guidelines for hearing parents parenting children with hearing loss, and to answer the research question, various instruments were examined. To determine which instruments to use, the researcher used the following variables: parents, parenting styles, parenting dimensions, and parent efficacy. The two instruments below were then decided upon:

i. The Social Context Questionnaire (PSCQ)
ii. Parent Self-Efficacy Instrument (PSE)

A self-administered questionnaire was made up of three sections that included (a) parents demographic details; (b) the adaptation of the Parents as Social Context Questionnaire (PSCQ), which assisted with determining the parenting approaches to understand the nature of the parenting styles of mothers and fathers; and (c) the adaptation of the Parent Self-Efficacy Instrument [PSE] which looked at what were the contributing factors and parental self-efficacy when parenting a child with hearing loss (Appendix 6).

d) Instrument piloting

Once the questionnaire was drafted, a pilot study was conducted to determine the reliability of the instruments. A pilot study is a small-scale study employed to test the feasibility of the instruments before the intended study is conducted (Van Teijlingen & Hundley, 2001:1). It further helps refine the research question(s) and test the research instruments to ensure the success of the study. The pilot study served to evaluate the reliability of the questionnaire by exploring language options, clarity of questions, and providing insight into the data collection process. It also made sure that the questions were clear, brief, unambiguous, and that 'double questions' were avoided.

Once ethics clearance was obtained from the University (Appendix 1), two hearing parents were contacted to schedule a mutually agreed appointment to discuss the intent of the study and their assistance with the piloting of the quantitative instruments.

The intent of the research was shared with both parents (information sheet; Appendix 3). After reading the information sheet, both parents were allowed to ask questions about the research. They were then asked to complete the consent form (Appendix 4) as an indication of their voluntary participation in the study. The questionnaires were self-administered and took approximately 30–45 minutes to complete (Appendix 6). Both parents completed the questionnaires at a time and venue that was convenient for them. Piloting the questionnaire was important to check how respondents may interpret the questions.

e) Questionnaire modification

After the completion of the pilot study, the quantitative data instrument was checked and double-checked by both study supervisors. The following modification was made: 1) to include the age of the parent(s) in the demographical information section of the questionnaire.

f) The final data collection instrument

A questionnaire is defined as "the collection of information from a sample of individuals through their responses to questions" (Check & Schutt, 2012:160). The questionnaires were back to back translated from English to Afrikaans and isiXhosa, as these are the three dominant languages in the Western Cape. The translation of the questionnaires was done to increase the validity and reliability of the responses of the participants. The questionnaire was easy to complete as it consisted of 'closed questions' with checkboxes providing the relevant options that respondents could simply tick or rate with a numerical number. The questionnaire consisted of three sections: (a) Demographical information, (b) The Social Context Questionnaire, and (c) Parent Self-Efficacy Instrument (Appendix 6).

i. **The Parent Social Context Questionnaire**: The Parents as Social Context Questionnaire (PSCQ) is used to understand parent and child relations. However, Addo, Aslund and Nilsson (2017) argue that this tool needs to be further examined in different populations to ensure the validity and reliability of the scale. The questionnaire consists of three bipolar dimensions (warmth and rejection; structure and chaos; autonomy support and coercion). The respondents were requested to answer the questions about the bipolar dimension on a four-point Likert scale, ranging from "not at all true", "not very true", "sort of true", and "very true".

Parent Self-Efficacy Instrument: The Parent Self-Efficacy Instrument [PSE] (Bandura, Adams, Hardy & Howells, 1980) describes a parent's belief in their ability to accomplish the role of parenting. The PSE included 10 items that reflected both general parenting tasks and specific tasks relating to parenting children with a hearing loss, producing a task-specific measure of parental self-efficacy. A rating scale was used to rate parents' responses from 0 = Low to 6 = High.

Descriptive statistics in terms of percentages, means, frequencies, and standard deviations were used to summarise demographic data, type of parenting styles, and challenges contributing to parenting styles, including parental self-efficacy. Mann-Whitney U-test was used to analyse data. The results were presented using Cronbach's alpha for internal consistency. The two instruments were applicable to be used in a South African context.

g) Data collection

Permission was granted from the WCED (Appendix 2) to request the school principals to assist with the distribution of the questionnaire to parents of children with hearing loss between the ages 10 and 17. The principals informed the researcher that it may be difficult to get a response from parents as they do not respond to school notices. A total of 280 questionnaires were provided to the three schools for the deaf; however, only 33 parents in total responded.

For example, 120 questionnaires were sent out from one school requesting parents to complete the questionnaire and return it to the school by a certain date. However, only 18 parents completed the questionnaires and returned them to the school. Another school sent out 60 questionnaires; again, only 10 parents responded and returned the questionnaires to school. The third school sent out 100 questionnaires, with only 5 questionnaires being returned. This lack of response called for a different strategy to collect data and expand participation. Table 3.3 provides a breakdown of how the questionnaires were distributed and the number retrieved.

Table 3.3. Distribution of Questionnaires

School	Questionnaires sent out	No. of responses
School A	120	18
School B	60	10
School C	100	5
Total from schools	**280**	**33**

Presented with a problem in terms of collecting data, the researcher then decided to recruit six community workers working among and with people with a hearing loss and families of children with a hearing loss to assist with data collection. All of the community workers agreed to volunteer their time in the evenings or over weekends to assist with collecting data.

The researcher met with the six data collectors with the purpose of preparing and training them on the 1) information sheet, 2) consent form, and more importantly, 3) the questions of the questionnaire. The researcher wanted to make sure that the community workers understood the process of collecting data (permission, consent) and, especially, the questions on the questionnaire. The researcher went through each section of the questionnaire with the community workers, which included Section A: the demographics of the participants; Section B: The Social Context Questionnaire; Section C; The Emotion-Related Parenting Styles Scale t and Section D: The Parental Self-Efficacy Scale (the parenting ladder) (Appendix 6). The aim of doing this exercise was to ensure that the community workers 1) understood the questions, and 2) can provide clarity to participants where necessary. Each community worker agreed to recruit 10 parents in the communities where they lived or worked (see Table 3.4). Data was collected either by home visitations or at the community workers' homes.

With no further participants making themselves available for the study, the decision was taken to stop further recruitment for the study. This decision was based on the timeframe that the study needed to be completed by as well as the difficulty of recruiting further potential respondents.

The researcher too collected data from another 10 parents who were recruited from a parent support group. This parent support group consisted of both mothers and fathers whose children have a hearing loss. The researcher informed the group of the purpose of the research (information sheet), after which they willingly agreed to participate in the study.

Table 3.4. Summary of Where the Volunteers Collected Data

Volunteers	**No. of responses**
Mr. E: recruited parents from Khayelitsha and surrounding areas	10
Ms N: collected data in Khayelitsha and the surrounding area	10
Ms Y: recruited parents in the Paarl community	10
Mr C: recruited parents in Gugulethu	10
Ms A: recruited parents in the Worcester community	10
Ms A. Recruited parents from Mitchells Plain and Retreat area	10
Researcher. Recruited parents from a parent support group	10
Total recruited	70

Overall, 350 questionnaires were sent out to parents of children with a hearing loss. In total, 103 respondents completed the questionnaire. The final sample, therefore, for the quantitative assessment of this study was (n=103) parents of children with hearing loss between the ages of 10–17 years old. These respondents constituted a heterogeneous group in terms of age, race, household, relationships, educational, and socio-economic profiles.

h) Data analysis

The numerical data drawn from the quantitative study was analysed to help arrive at the study's conclusion (Albers, 2017). The data obtained from the questionnaires were entered into the Statistical Package for Social Sciences (SPSS version 25). Subsequently, the data were coded, cleaned, and checked for errors. Descriptive statistics that included frequencies, means, inferential statistics (and standard deviation were used to present the data, Mann-Whitney U-test) were used in the analysis of the data. A Mann-Whitney U test is used to compare the differences between two independent groups. In the case of this study, between hearing mothers and hearing fathers. This is further discussed in article form in Chapter 5.

i) Validity and reliability of the quantitative inquiry

Validity is traditionally defined as "the degree to which a test measures what it claims, or purports, to be measuring" (Brown, 1996:231). Joppe (2000:1) explains that "validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are". In other words, does the research instrument allow you to answer the research question? The construct of the questionnaires chosen allowed the researcher to draw conclusions about the associations between the variables and whether the sample (hearing parents) was a true representation of the population from which it was drawn. The current research used constructs to measure parenting styles and factors contributing to parenting styles. It allowed the researcher to conclude the associations between the variables.

Joppe (2000:1) defines *reliability* as: "The extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable".

To establish the reliability of the instruments, Cronbach's alpha (a statistical method to determine reliability) was used to determine the scores obtained by PSCQ and PSE. The results of the analysis showed that the items indicated the satisfaction level of construct validity and internal consistency of this modified questionnaire (Taber, 2017). Cronbach's alpha for PSCQ was 0.95 and PSE was 0.90. Therefore, the questionnaire can be considered reliable as it reflects good internal consistency.

Based on the results of the pilot study, the research instrument was reliable, valid, and suitable for the main study.

3.7.3 Phase 1: Stage 3: Qualitative inquiry

a) Objective of the qualitative inquiry:

Objective 4: Explore the challenges and social needs of hearing parents parenting children with hearing loss (Chapter 6)

The results of the quantitative data collection and analysis informed the qualitative data collection and data analysis. Therefore, the results of the quantitative inquiry were further investigated by a qualitative inquiry, through a more robust process.

b) Participants

The researcher again recruited some of the participants from a parent support group. This parent support group consisted of both mothers and fathers whose children have a hearing loss. The researcher informed the group of the purpose of the research (information sheet), after which the parents willingly agreed to participate in the research study. In addition, the snowballing technique extended the sample to other hearing parents in the support group and referred the researcher to additional participants. A sample of 13 hearing parents was included in the study when data saturation had taken place. Before the commencement of the interviews, the researcher made copies of the information sheet and the consent forms. All the interviews were recorded with the permission of each participant, and hand-written notes of the participants' responses were recorded throughout the interviews.

Nine hearing mothers and only four fathers of a child with hearing loss were eventually interviewed (13 participants in total). Initially, six fathers agreed to participate but then two withdrew their participation, citing work commitments as their reason for withdrawing. Hearing mothers were more ready and willing to participate in the study than hearing fathers. Originally, 15 parents agreed to participate in the research study; however, as stated during the research study, two fathers declined participation citing work commitments. Hearing parents who took part in this study were between the ages of 35–55 years. Six of the participants were between the ages of 35–40 years; five between the ages 41–50 years; and two between the ages of 51–55 years. The first language of three of the hearing parents who took part in the study was isiXhosa and one in Afrikaans; however, all of them were conversant in English. Three of the participants' home language was English. The languages predominantly spoken during the interviews were English and Afrikaans. Fortunately, the researcher is fluent in both languages, thus accommodating an easy flow of conversation. Two of the hearing parents had attended university, while three parents had attended college. Five of the parents matriculated, and one had left school without passing matric. (Appendix 8, the participants' demographics is added to the research study).

c) Data collection:

Before the commencement of the interview, the researcher reviewed the quantitative results that informed the qualitative part of the study. A few questions were drafted as an interview schedule (Appendix 7) which consisted of four (4) open-ended questions to assist in reaching the aim and objectives of the study. The following interview questions focusing on parents' challenges and social needs were asked:

1. Tell me about your experience of parenting a child with hearing loss;
2. Tell me about the communication, information, and social support challenges you experience when parenting your child with a hearing loss;
3. Tell me how these challenges affect your experience as a parent of a child with hearing loss; and
4. What kind of support do you think parents need to assist them in their parenting role when parenting a child with a hearing loss?

The interview schedule was used as a guide to suggest and assist with the interview process, it was not prescriptive. The study supervisors reviewed the interview schedule and provided guidance to ensure that the objective of the qualitative part of the study was met through these questions. The data was gathered directly from participants through individual in-depth interviews. The in-depth interviews were unstructured (open-ended interviews) to allow the freedom of participants to talk about their experiences in a natural conversation. In-depth interviewing is conducted with the intention of revealing in-depth details of the participants' experiences and perspectives of the research question (Voutsina, 2017).

The reason for selecting this method was to engage with hearing parents; understand how they experience parenting a child with a hearing loss; and identify what they would consider are the contributing factors that contribute to their parenting style, including suggestions for interventions and possible guidelines.

d) Research setting

Each participant who had agreed to participate in the study was contacted telephonically by the researcher. Participants were informed of the purpose of the research and objective of the qualitative study, and after consenting verbally, the participants decided upon the time and venue for the proposed interview. Ten of the interviews took place at the homes of the participants. Due to criminal activities in three of the participant's communities, the three participants and the researcher agreed to meet at the nearest offices of an organisation for the deaf. Before commencing with each of the interviews, the researcher introduced herself by name and explained the purpose of the study. The researcher also explained the information sheet and provided each participant with a copy. The researcher then went over the consent form, explained that participation was voluntary, and ensured them that confidentiality and anonymity (pseudonyms would be used instead of their real names to protect their identity) would be upheld. It was also explained that participants could withdraw from the interview at any time. With the permission of the participants, the interviews were recorded, and handwritten notes were taken by the researcher. The duration of the interviews lasted between 40–60 minutes. The researcher documented observations in field notes during the interviews, particularly noting tone of voice, emotions, and body language. Often the descriptions of the participants' experiences determined the mood of the interviews. For example, one parent recalled her challenges with a heavy heart, often tearing up at times. Conversely, another parent was more positive about their challenges, especially about learning sign language and being able to communicate with their child with a hearing loss. The interviewing process was particularly emotional for two of the participants with the result that the researcher referred both participants for debriefing to the social worker at the local organisation for the deaf. However, it turned out that both participants were already receiving counselling from the social worker.

e) Data analysis

Data analysis is the process of making sense of the verbatim text taken from participants, providing understanding and meaning to the larger amount of data gathered (Creswell & Creswell, 2018). It is a process described as bringing order, structure, and interpretation to the mass of data collected (Marshall & Rossman, 1999). The qualitative stage of the research made use of thematic data analysis. The thematic analysis searched for general statements and identified, analysed, and reported patterns or relationships (themes) within the data (Braun, Clarke & Weate, 2016).). The thematic analysis captured important data concerning the qualitative question of the overall research.

The following data analysis took place according to Creswell (2007:183-190) and Klenke (2008:231):

1) The researcher organised and prepared the data for analysis. This included typing up all the transcripts as well as replaying the recorded tapes to correlate the information for accuracy.
2) The researcher became immersed in the data, reading and re-reading the transcripts, getting a sense of what the participants had said, reflecting on the written notes and the participants' personal feelings and experiences, and integrating this into the study.
3) The process of coding took place in which data was grouped into themes to describe the participants' experiences. This entailed searching for themes that could be "validated by the re-emerging and repetition of specific ideas" (Klenke, 2008: 231).
4) Fourthly, the themes were clustered according to themes and sorted into sub-themes to give a descriptive representation of the phenomenon.

Furthermore, the data was sent to an independent coder to improve the coding in the qualitative data analysis and verification of themes and sub-themes. The use of an independent coder contributed to the conformability of the data. Conformability means that the data accurately represents the information that the participants provided, and interpretations of those data are not invented by the researcher (Polit & Beck, 2012).

3.7.4 Phase 2: Development of guidelines using a consensus workshop (Chapter 7)

a) The objective of the consensus workshop

Objective 5: to make recommendations for the development of guidelines for hearing parents parenting children with hearing loss.

The consensus workshop was implemented as Phase 2 of the study. The consensus workshop was best suited for consensus building and was based on the prediction that "two heads are better than one" (Dalkey, 1972:15).

Phase 2 was conducted in two rounds. A consensus workshop was implemented towards advancing the development of guidelines for hearing parents parenting children with hearing loss. Before the commencement of the consensus workshop, the researcher drew up a table that presented the key findings of Phase 1. This table represented 22 proposed guidelines emanating from the findings of Phase 1 of the research. From these 22 proposed guidelines, duplications made in the research findings were removed and were tabulated by using themes and sub-themes. Finally, 12 preliminary guidelines were drafted and tabled by the researcher. These 12 preliminary guidelines were further tabulated into 4 themes and sub-themes.

In summary, the consensus workshop used four simple consensus steps to arrive at building consensus around the development of guidelines for hearing parents parenting children with hearing loss. These four steps included:

1. In Rounds 1 and 2: the panel of experts and stakeholders discussed the proposed guidelines which were documented by the researcher.

2. The two panels clustered the proposed guidelines by related themes.

3. The panel named each of the themes.
4. The panel reflected and reached consensus on the proposed guidelines made.

   This technique worked as it created a shared understanding and built consensus around the recommendations.

b) Participants

This is discussed under heading 3.6.1.2 and will therefore not be repeated here.

c) Data collection: Stage 1: Round 1

A panel of 10 academic experts from the University of the Western Cape in the field of family, children, and disability studies were invited to participate in Round 1 to identify unclear or ambiguous guidelines as proposed in Phase 1 of the research study. The aim and the objectives of the study were shared with the panel of experts. The process that led to the 12 preliminary guidelines that were drafted into four themes and sub-themes were also presented to the panel of experts.

Subsequently, the panel of experts were asked to respond to a set of questions in line with the guidelines proposed. These included: 1) What is your opinion regarding the content of the 12 guidelines proposed?; 2) What are the themes that resonate with the findings of the research study as well as on its usefulness for implementation?; 3) Reflect on language usage in the research study, particularly disability-friendly language; 4) Do you have any additional guidelines to add that were not addressed by the researcher?

At the end of the process, the panel of experts reached consensus on all the guidelines. However, two additional recommendations were added as sub-themes.

d) Stage 2: Round 2

The panel of stakeholders, social workers, audiologists, development workers in the deaf community, two directors of local NGO's, and hearing parents were invited to Round 2 of the consensus workshop. Some stakeholders – hearing parents – were recruited from members who participated in Phase 1 of the study. Other stakeholders were recruited based on working and providing professional services to hearing parents.

The aim and objectives of the overall research study as well as the aim and objectives of the consensus workshop was explained to the panel of stakeholders. Likewise, the outcome of each stage of the research process was explained, including the 22 proposed guidelines, based on the findings of the research; the removal of duplications resulting in 12 guidelines; and the recommendations made in Round 1 with the panel of experts. The panel of stakeholders was also asked to respond to a set of questions in line with the proposed guidelines made. These included: 1) what are the themes that resonate with the proposed guidelines made by the research study?; 2) how important are the guidelines made in the context of the research study – priority of topics?; 3) reflect on language use in the research study, especially disability-friendly language; 4) do you have any additional guidelines to add that were not addressed by the researcher? At the end of the process, the panel of stakeholders reached consensus on the 12 proposed guidelines. Two additional recommendations were added to the four themes (discussed under data analysis).

e) Data analysis

Data were analysed through thematic analysis in response to the specific questions. Four themes were identified, namely:

1) Early intervention programmes
2) Parent social and emotional support

3) Information and resource support, and
4) Communication intervention

These themes are discussed and supported with verbatim comments made by both panels for inclusion in the proposed guidelines in Chapter 7 Section A, in article form.

3.8 Trustworthiness

Trustworthiness in qualitative research simply poses the question of whether the findings can be trusted (Lincoln & Guba, 1985). Trustworthiness is seen as the backbone or strength of the qualitative analysis (Creswell, 2009). The study had to reflect the accuracy of the information that was provided by the participants and these accounts needed to be trusted and seen as credible (Creswell & Plano Clark, 2011). There are four criteria used to measure the trustworthiness of data: credibility, dependability, transferability, and confirmability.

These four criteria as explained by Lincoln and Guba (1985) are:

1. *Credibility*: The confidence that can be placed in the truth of the research findings. One strategy of ensuring the credibility of the research study is data triangulation. *Data triangulation* refers to the use of more than one approach when researching a question and therefore increases confidence in the findings (Heale & Forbes, 2013). Data triangulation was used by gathering data through different data collection methods such as a scoping review, questionnaires, unstructured interviews, field notes, and a consensus workshop. Furthermore, two study supervisors were involved in the organisational aspects of the study and the process of data analysis. In addition to the above, data were analysed by an independent coder.
2. *Transferability*: Transferability concerns the aspect of applicability. In the current research study, the researcher provided a rich account of descriptive data, such as the context in which the research was carried out, where it was set, the sample, sample size,

sample strategy, demographics, interview procedure, and excerpts from the interview guide.

3. *Dependability*: Dependability includes the aspect of consistency and involves participants' evaluation, interpretations, and recommendations of the findings, and is supported by data (Korstjens & Moser, 2018). In the current research study, the interpretation or viewpoints of the data is not that of the researcher but is grounded and embedded in the analysis of the data.
4. *Confirmability*: Confirmability concerns the aspect of neutrality. Confirmability is widely used in triangulation to ensure the credibility of qualitative research (Walle, 2015) and make sure it is not based on the researcher's imagination but is a result of the data. To ensure confirmability in the current study, the researcher made use of an independent coder to assist with the triangulation and credibility of the data.

3.9 Reflexivity

Qualitative researchers must be aware of the pre-conceived assumptions they bring to their research (Mauthner & Doucet, 2003). Core to the reflexivity process was that the researcher became aware of her influences on the research process, her feelings and role (Berger, 2015) as a volunteer in the community with persons with hearing loss, and also taking into account that these influences may act as the researcher's analytical resource (Tracy, 2012). Throughout the research study, the researcher stayed in contact with her study supervisors who advised, mentored, and assisted by checking the credibility of the whole research process.

3.10 Conclusion

This chapter discussed the methodological framework implemented in this study. The study used a mixed methods approach with a sequential explanatory design using a two-phased approach. The chapter outlined the two-phased approach, each with different stages of the research process. In summary, Phase 1 defined the problem by implementing a scoping review in Stage 1; Stage 2 implemented a quantitative inquiry; and Stage 3 implemented a qualitative inquiry. Phase 2 of the research process included a consensus workshop conducted in two stages. Stage 1 implemented a pilot study with a panel of experts, and Stage 2 implemented the actual consensus workshop with a panel of stakeholders.

The following chapters – Chapters 4, 5, 6 and 7 – are written in an article format, providing the results of the scoping review, the quantitative and qualitative data analysis, as well as the results of the consensus workshop.

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INTRODUCTION TO THE FINDINGS OF THE STUDY

The findings of Chapters 4, 5, 6 and 7 Section A are presented in article form, while Chapter 7 Section B is presented as a written document in the thesis.

Chapter 4: A scoping review on interventions for hearing parents parenting deaf children. The term ‘deaf’ was used as a preference by the journal instead of the term ‘children with hearing loss’. This scoping review was carried out to address Phase 1 of the research study. This phase was done to meet the first objective of the study which was to *explore previous literature on interventions targeting parenting styles of hearing parents parenting children with hearing loss*. This article was published in the Journal on Deafness and Education International.

Chapter 5: The quantitative inquiry was done to meet objectives 2 and 3, which were to *determine the parenting styles of hearing parents parenting children with hearing loss* and to *determine the challenges that contribute to parenting a child with a hearing loss, including parental self-efficacy,* respectively. This article was accepted in Afrikaans by Tydskrif Vir Geesteswetenskappe Suid Afrika/Journal for Humanities and is presented in Chapter 5. The English version of the chapter is added as Appendix 8.

Chapter 6 presents Stage 3 of the last stage of Phase 1. The qualitative inquiry was done to meet objective 4 of the study which was to *explore the challenges and social needs of hearing parents parenting children with a hearing los*s. The article was submitted and accepted by the Journal of Family and Social Work.

Chapter 7 Section A presents Phase 2 of the study – the consensus workshop. The consensus workshop was conducted, completing objective 5 of the study, which was to *develop guidelines for hearing parents parenting children with a hearing loss.* The chapter was submitted to the African Journal on Disabilities for publication, and is therefore written in article form according to the aim, scope, and format of the Journal.

Chapter 7 Section B of the study provides the guidelines related to programme and service provider initiatives to assist parents and professionals with the understanding of parenting a child with a hearing loss.

CHAPTER 4: FINDINGS: SCOPING REVIEW

INTERVENTIONS FOR HEARING PARENTS PARENTING DEAF CHILDREN: A SCOPING REVIEW

Davids, R.S., Roman, N.V. & Schenck, C.J. (2018). Interventions on parenting styles of hearing parents parenting children with a hearing loss: a scoping review. *Deafness & Education International,* 20:1, 41-58. DOI: 10.1080/14643154.2018.1445156

4.1 Introduction

In the previous chapter, an overview of the research methodology was presented. Chapter 4 addresses Phase 1 of the research study to meet objective 1, namely, to *explore previous literature on interventions targeting parenting styles of hearing parents parenting children with hearing loss.* A scoping review was conducted using various databases in the EbscoHost, Science Direct, and Springer Links search engines. The findings of the scoping review provided significant information on interventions targeting parenting styles of hearing parents parenting children with hearing loss.

4.2 Publication Details

This chapter, which looked at interventions for hearing parents parenting children with a hearing loss: a scoping review, has been accepted and published in the Journal on Deafness and Education International.

Title	Interventions on parenting styles of hearing parents parenting children with a hearing loss: a scoping review
Authors	Davids, R.S., Roman, N.V. & Schenck, C.J. (2018).
Journal	Deafness & Education International
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Status	Published
Permission from Journal/editor to use in the PhD thesis	**Correspondence with the editor on the 6th of April 2020** Yes, this is fine, Ronel Good luck with your thesis Best wishes Jill Jill Duncan, PhD Australian Editor Deafness & Education International (jill.duncan@newcastle.edu.au)

4.3 Deafness & Education International Journal

Deafness & Education International is an international peer-reviewed journal that publishes high-quality original research about the education of children and young people who are deaf.

It provides researchers in the field of deaf education, which covers many disciplines, including education, sociology, psychology, anthropology, linguistics, cultural studies, and speech science, with the opportunity to contribute to the knowledge base of research in deaf studies.

4.4 Conclusion

This scoping review was intended to understand and identify potential intervention strategies that advanced support and positive outcomes for hearing parents and their deaf children. It advances the argument that intervention programmes for hearing parents are essential, and reinforced the need for more research on parents with disabled children, more specifically, on the parenting styles employed by parents of children with hearing loss (Antonopoulou, Hadjikakou, Dagla & Maridaki-Kassotaki, 2015). The positive findings revealed that the effective delivery of programmes with competent staff can be beneficial to the effectiveness and maintenance of these programmes. This scoping review also highlights the limited research and publications in the area of parenting deaf children. Therefore, a strong recommendation is made that the implementation of the RE-AIM framework is considered as an effective practice tool to facilitate consistent and useful information when reporting on interventions.

INTERVENTIONS FOR HEARING PARENTS PARENTING DEAF CHILDREN: A SCOPING REVIEW

Ronel Davids, Nicolette Roman, Catherina Schenck

ABSTRACT

Many studies on parenting styles/practices with disabled children exist; however, hearing parents parenting deaf children is still under-researched. Therefore, the aim of this review is to explore previous literature on parenting interventions, targeting this phenomenon. Data was extracted from search engines, such as Ebscohost (Academic Search Complete, MedLine, PsycARTICLES, SocIndex, Greenfile, Masterfile Premier), Science Direct and Springer Link.

Five studies were eligible for this review: two in the United Kingdom and three in Israel, Germany and South Africa, respectively. The final articles validate the existence of interventions that provide hearing parents with specific knowledge and skills to parent deaf children.

Keywords: Hearing parents, deaf children, intervention, parent practices, parenting styles.

INTRODUCTION

Parenting can be extremely challenging, as well as rewarding. The concept of parenting is multifarious and includes the relationship of the parent and the child (dyad), as well as individual characteristics of each (Sams, 2012). Parenting cannot be viewed in isolation, and includes aspects of discipline, nurturing, child engagement and child development outcome, as the relationship between the parent-child dyad is ever changing and transactional (Locke & Prinz, 2002; Sams, 2012). Baumrind (1971) alludes to parenting as, seeking a balance of behaviour by conforming to social standards, while at the same time encouraging individuality. For these reasons, parenting is one of the most difficult tasks, in which parents hope to succeed. Parenting forms the basis of any social development for any child, as it is where the child is nurtured, learns to socialise, and finds his/her sense of belonging.

Although parenting has been defined to a great degree in literature, the most effective way of examining parenting is through the concept of parenting styles (Darling, Flaherty & Dwyer, 1997), bearing in mind that parenting styles convey the parents' attitudes towards the child. Parenting styles have been among the variables studied extensively in human development (Baldwin, Mclntyre & Hardaway, 2007) and could be understood as normative patterns of behaviour and tactics that parents use to influence a child's behaviour (Wentzel, Baker & Russell, 2009; Jago, Davison, Brockam, Page, Thompson & Fox, 2011). Darling and Steinberg (1993) describes parenting styles as a constellation of parents attitudes communicated towards the child, creating an emotional climate in which parents' behaviours are expressed. Parenting styles are further described as important determinants of several aspects of children's outcome (Gadeyne, Ghesquiere & Onghena, 2004). Kordi and Baharudin (2010), as well as Freud (1933), in their studies on parenting attitudes or styles, and its effect on children's school achievement, refer to parenting styles as the behaviour and attitude of parents, who, as a psychological construct, use these strategies to raise their children.

For more than fifty years, researchers have studied different approaches to parenting, while raising children (Carr & Pike, 2012; Kerr, Stattin & Özdemir, 2012), and examined the relationship between parenting styles and child development outcomes. Earlier works from Baldwin (1948), Rogers (1960), Schaefer (1959), Symonds (1939) and Becker (1964) examined a variety of dimensions of parenting styles, including responsiveness/ unresponsiveness parenting, democratic/autocratic parenting, emotionally/uninvolved parenting, control/non-control parenting, acceptance and rejection parenting, dominance/ submission parenting, and finally, restrictiveness and permissiveness parenting. Studies conducted by these early researchers revealed that parents, who provided their children with warmth, responsiveness, independence and firm control, nurtured children with higher levels of competence and social interaction (Spera, 2005).

Parenting is challenging; however, parenting a child with a disability requires extra effort, and may necessitate parents to adjust their parenting styles, to accommodate the child, as the experience of raising a disabled child is different (Woodgate, Edwards, Ripat, Borton & Rempel, 2015; Sams, 2012). Additionally, parents may have to alter their parenting skills, which could affect the quality of the parent-child relationship (Raya, Ruiz-Olivares, Pino & Herruzo, 2014). Parents may often hold different views and attitudes towards their disabled children, which could influence their parenting treatment style (Elhageen, 2004).

During the past decades, many studies have been conducted to gain an understanding of parenting styles with disabled children (Woolfson & Grant, 2006; Gau, Chiu, Soong & Lee, 2008; Howe, 2006; Gau, Chou, Lee, Wong, Chou, Chen & Wu, 2010), as well as parenting styles associated with deaf children's academic achievement and self-confidence (Marschark, 2007); however, deafness has not been fully understood, especially, in terms of the interaction between hearing parents and a deaf child. Important questions still remain unanswered, in terms of the limited, or lack of empirical research on hearing parents and their parenting styles with deaf children (Antonopoulou, Hadjikakou, Dagla & Maridaki-Kassotaki, 2015).

Research, encompassing parental perspectives and experiences of parents with deaf children, provides evidence of the importunate need for parent support (Henderson, 2015), and, although evidence indicates that 90-95% of deaf children are born to hearing parents (Garcia & Turk, 2007, Lederberg, Schick & Spencer, 2013; Fitzpatrick, Stevens, Garritty & Moher, 2013), very little is known about hearing parents' parenting styles and practices with a deaf child, as well as the need for applicable and timely support and intervention for these families (Henderson, 2015). Cassettari, Wadnerkar and James (2015) state that a gap remains in understanding the value of the parent-child relationship between hearing parents and deaf children, or that childhood deafness usually challenge these relationships (Meadow-Orlans, 1997). Therefore, Haslam, Mejia, Sanders and De Vries (2016:2) maintains that "parenting programs are interventions that aim to improve child and family outcomes by equipping parents with effective parenting skills", while Eyberg, Nelson and Boggs (2008) assert that parenting training should be the desired approach for treating children. Additionally, these programmes highlight the role of parents' involvement as vital to the child's progress, because they are seen as interactive partners of children, as well as important contributors of opportunities and social activities for their children (Zaidman-Zait, Most, Tarrasch & Haddad, 2017; Reedz & Klest, 2016).

Parental involvement in early childhood interventions has been established as powerful indicators for parenting practices, in terms of specific knowledge and skills when parenting a deaf child (Desjardin, 2003). It could be argued that intervention programmes are essential in reducing negative perceptions related to raising deaf children (Cassettari, Wadnerkar-Kamble & James, 2015), as these intervention programmes could be perceived as supporting and enhancing parents' parenting competencies, for parents can feel competent and confident when experiencing child problems (McWilliam & Scott, 2001; Reedtz & Klest, 2016).

Against this background, a scoping review was undertaken with the aim of identifying previous research on interventions pertaining to hearing parents parenting styles and practices, when parenting deaf children. In this scoping review, the researcher sought to address a specific question, as well as use the scoping review as a technique to map relevant literature on the topic and assess the quality of the included studies (Arksey & O'Malley, 2005).

METHOD

Research strategy

The scoping review was conducted across nine databases (Ebscohost, Academic Search Complete, MedLine, PsycARTICLES, SocIndex, Greenfile, Masterfile Premier, Science Direct, Springer Link), as well as specific journals (Journal for Deaf Studies and Deaf Education). The electronic search was conducted, using the terms, interventions, programmes, hearing parents parenting, parenting styles, parenting practices, parenting approaches and deaf children. In the first round of selecting articles, considered most relevant in meeting the search terms, resulted in 339 hits, based on their titles. In the second round, the 339 hits were further reduced by removing duplicates of articles on the databases, resulting in 12 articles. The subsequent process involved exploring the full text of the 12 articles to further establish whether the articles incorporated the topic under research. This process was reviewed by two senior supervisors, both rated researchers. One article was included through interaction with a specialist in the area of intervention programmes for families with deaf children. Ultimately, a total of five articles were retrieved for this review.

Inclusion and exclusion criteria

The inclusion criteria for this review comprised all articles, which reported on interventions with a primary focus of assisting hearing parents, in terms of parenting styles and parenting practices, and were published internationally, in Africa and South Africa. No specific years were included in the research. Regardless of the research design, articles met the inclusion criteria if they focused on:

1) articles written in English;

2) hearing parents;

3) deaf children; and

4) ideas central to parenting and parenting styles/practices.

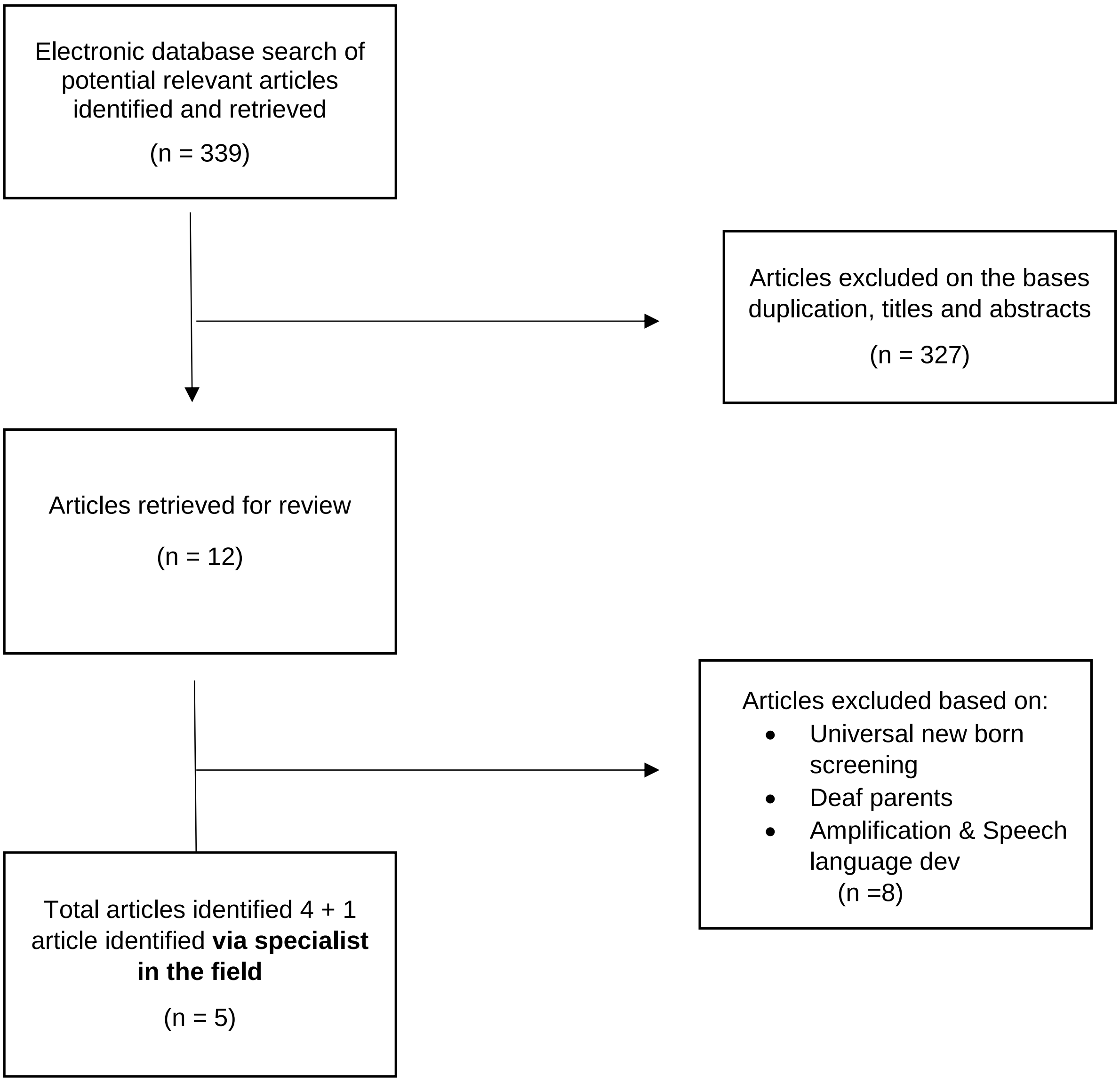
The reasons for the exclusion of a large number of articles were that the search term "intervention" produced many articles on early identification and universal hearing screening interventions, which were not applicable to this study.

Data extraction using the: RE-AIM framework

The search generated 339 articles from the nine databases (Ebscohost, Academic Search Complete, MedLine, PsycARTICLES, SocIndex, Greenfile, Masterfile Premier, Science Direct, Springer Link), as well as specific journals (Journal for Deaf Studies and Deaf Education). The final articles were selected on the basis of their title, abstracts and full text. A data extraction sheet (Table 2) was designed and populated with relevant information, such as author, year of publication, country, population sample and size (age and gender), intervention duration, intervention, who the intervention reached, the efficacy of the intervention, the adoption, implementation and maintenance of the interventions. Overall, the articles searched and identified did not address the research question of this current study, however, the final five articles retrieved, contained relevant data that assisted with the investigation. Titles, abstracts and full text were retrieved by the researcher.

In Figure 1, the stages undertaken in the scoping review, leading to the final five articles identified, are illustrated.

Figure 1: Study selection process



The RE-AIM framework was applied to appraise the articles, as it systematically analysed and collated information in relation to the framework headings of Reach, Effectiveness, Adoption, Implementation and Adoption dimensions (Glasgow, Vogt & Boles, 1999). It allows the effectiveness of the intervention, at the individual, institutional and community level, to be explored (Frantz & Chandeu, 2011). In addition, the RE-AIM framework was seen as a valuable tool to simplify, as well as translate research into practice, by supporting the development of effective interventions. Besides, if effective interventions are to be implemented, the implementation of the Re-aim framework could aid many stakeholders to understand the range of issues an effective programme must address, in order to ensure a lasting impact (Frantz & Chandeu, 2011).

To assist with the analytical process of applying the RE-AIM framework, certain questions were solicited (see Table 1) to evaluate the intervention.

Table 1: RE-AIM Appraisal Tool

RE-AIM Dimensions	Definitions	Questions /examples of measure
Reach	This definition affects the target population who would use the intervention.	• Does the article report on the representativeness of the target population? • Does the article indicate who the program is intended for (inclusion and exclusion criteria) • Does the article report on participation rate?
Efficacy	The impact is defined based on the program relevance, importance, limitations and specified primary and multiple outcomes	• Did the program achieve the intended objectives? • Do they report on the limitations of the intervention? • Reports on at least one outcome of the intervention • Reports on attrition
Adoption	This dimension defines the setting where the programme is initiated, the evaluation and adoption of the intervention, access to the intervention who delivered the intervention	• Is the setting clearly described? • Does the evaluation report on the adoption of the intervention by the participants or the organization? • Reports on who delivered the program
Implementation	It defines the extent to which the intervention was delivered	• The duration and frequency of the intervention being described • The staff/participants of the organization/intervention been involved in delivering the program? (cost implications) Reports on intended and delivered interventions
Maintenance	It defines the long term sustainability of the intervention	• Does the article report on long term effects of the intervention (after 6 months) • Do they report on the indicators used for intervention follow-up?

Based on the data extracted, the results are presented within a RE-AIM framework. Overall, the interventions were specifically designed for hearing parents, parenting deaf children, with one intervention including parents, who were hard of hearing. The interventions were implemented in the following countries: Israel (Feigen & Peled, 1998), the United Kingdom (Garcia & Turk, 2007; Cassettari *et al.*, 2015), Germany (Reichmuth, Embacher, Matulat, Zehnhoff-Dinnesen & Glanemann, 2013), and South Africa (Storbeck & Pitman, 2008). The interventions varied in study design, ranging from a cross-exploratory/case study (Garcia & Turk, 2007), a short-term longitudinal design (Cassettari *et al.*, 2015) and a descriptive research design (Storbeck & Pitman, 2008). The total sample of participants was difficult to ascertain, as the groups were mostly described and not the total number of actual participants e.g. groups of ten. However, the participants mainly consisted of female parents of both male and female children.

SUMMARY OF THE INTERVENTIONS

The article by Feigen and Peled (1998), reported on an intervention, which aimed to develop and describe a group intervention model that would assist parents in managing the difficulties of raising their preschool, deaf child. This intervention model was used to improve the communication and interaction between parents and their deaf children. The parent groups focussed on the parents' individual experiences, their feelings and conflicts as individuals and couples, which included how they coped with their children's difficulties. The groups not only provided parents with the opportunity to speak about the difficulties of raising a child with disabilities, but also provided them with skills and tools, as well as re-enforcing mutual support for hearing parents. The article did not provide the total number of participants, or rate of participation in the programme, but only stated that groups had an average of 10 participants, which largely consisted of the mother's participation, with the occasional participation of fathers, or couples. The parent's ages ranged from twenty-five to fifty years. The ages of their children were pre-school children from infancy to the first grade.

Garcia and Turk's (2007) article reported on the Webster-Stratton Parenting Programme, adapted for deaf children, with the aim of enabling parents to enjoy their children, and to assist them to develop a positive and confident parenting style. The design of the intervention was to improve parenting skills and provide parents with peer support. Its main inclusion criterion was hearing parents of deaf children; however, it reported on a pilot phase, focusing on one participant, with the aim of exploring whether the approach used in the intervention could be justified further with more comprehensive evaluative research. In addition, the article reports on the description of the group (13 families), who participated in the intervention; however, the results reported on the therapeutic process of the intervention and how it affected one child and his carers.

Reichmuth, Embacher, Matulat, Zehnhoff-Dinnesen and Glanemann (2013) reported on the Muenster Parental Programme (MPP), which aimed to empower parents to communicate with their child, who is hard of hearing, to build parent confidence. The intervention focused on empowering parents to communicate with their deaf child, by allowing them to become responsive intuitive parents; thereby, building confidence in their own parental resources. The target group for the study was hearing parents with children with a hearing loss, aged 3-18 months. Mothers were the only participants, with fathers accompanying mothers and children to the single training and counselling sessions. The groups targeted four to six families, but this could comprise 4-6 participants, but never less than three, or more than eight. The decision to include this intervention in the current study was based on the responsiveness and intuitive parenting style that it promoted. Parents, who exhibit this kind of parenting styles, could assist the deaf child to develop, in terms of his/her language, cognitive, emotional and social development (Brady, Warren & Sterling, 2009).

Although the study by Cassettari *et al.* (2015) examined the effect of a family-focused psychosocial video intervention programme on parent-child communication, in the context of childhood hearing loss and not parenting styles, it had much to offer on the understanding of how parents would parent, in terms of sensitivity, responsiveness and involvement.

Storbeck and Pitman (2008) used a descriptive research design approach to explore and report on the first South African home-based intervention project (Hi-Hopes), which aimed to assist parents to allow their deaf child to reach their best possible growth and development level, by ensuring that families are fully informed and supported, to enable them to make informed choices, in the best interest of their deaf child. Subsequently, in South Africa, there has been a significant focus on the detection of hearing loss, along with medical and therapeutic intervention (Swanepoel, Hugo & Louw, 2006). The intention of Hi-Hopes is to include such intervention, in addition to providing the entire family with support and unbiased information, thereby encouraging informed choices (American Speech-Language Hearing Association [ASHA], 2008). The uniqueness of this programme lies in its ability to compensate for the cultural and linguistic diversity of the South African population, which has 11 official languages. Thirty-two families, with their infants, participated in the intervention. Staff members included deaf mentors, who provided families with an understanding of the life experiences of deaf persons.

Table 2: Summary of the interventions

Ref	Author	Study design	Population & sample size	Country	Duration	Reach	Efficacy	Adoption	Implement	Maintenance
1	Feigen & Peled, 1998		Hearing parents ages 25-50 Children ages: 2 years old	Israel	10 groups of parents participated in the programme. Groups meet for 15 90 minute sessions every other week.	Target group are parents, mostly mothers attended. The participants were aged 25-50 years and came from various socioeconomic and educational backgrounds. The article indicates whom the programme targets, however it does not report on the participation rate.	The programme attained its goals and objectives. The pilot programme highlighted the community's involvement in this process. The aim of the programme was to improve parent adjustment. No reporting done on the limitations of the group intervention. No attrition rate reported.	The setting is described as the MICHA Centre that cares for pre-school deaf children from infancy to grade 2. This study is evaluated and accepted by participants. Two experienced social workers worked with the parents. The programme will hopefully become part of all therapeutic and educational programmes.	The study reports that the groups has 15 sessions of 90 minutes each but does not report on frequency of attendance of participants. 2 social works were involved in conducting the group sessions. Delivery of the intervention was successfully implemented. No cost implications were discussed	No follow-up was reported, but recommendation is made that the intervention can become part of family therapeutic and educational frameworks, focusing on communication skills to enhance family interaction
2	Garcia & Turk, 2007	Exploratory /Annotation and case study	Hearing parents ages Children ages: 4-15 years old	UK	Consists of 12 sessions, each of 2 hours duration, the group ran for 13 weeks with sessions taped.	Hearing English speaking parents of deaf children between the ages 4-15 years. Other inclusion criteria: child having an ICD-10 diagnosis of a conduct, oppositional defiant or hyper- kinetic disorder or autistic spectrum disorder with or without additional	Outcome was positive, suggesting that modified Webster-Stratton approaches may well be of use in deaf children of hearing parents. No attrition rate was reported. The limitations of the intervention was not reported on.	This was a pilot project which included two trained facilitators per session and clinicians. Participants evaluated the intervention. Setting: National Deaf Services Children and Young Persons Clinic, Few families participated. The programme needs to be adjusted to include other	This pilot phase focused deliberately on one participant. The group ran for 13 weeks with sessions taped. The staff were involved in delivering the program. The intended intervention was reported on.	The study reports on the long term effects and indicators for intervention follow-up i.e. allowing parents the opportunity to describe and share grief reactions and feelings related to late identification of deafness; Communication difficulties in families and additional social and communicatory

						comorbidity;		criteria to suit the deaf child		issues identified and treated.
3	Reichmuth *et al.,* 2013		Hearing parents with Children ages: 3-18months	Germany	The total time of all sessions comprises 26½ h. The duration of the study is described: sessions in weekly intervals flanked by one individual preparatory and one closing counselling session for each family. Additionally, there is one refresher single training session when the child becomes 24–30 months.	Parents of children with moderate to profound hearing loss. Exclusion: parents need to have sufficient language skills i.e. speak German and oral language, sufficient hearing ability themselves, no interpretation services are provided	Intended objective was achieved and reports on the outcome i.e. The report does not report on the limitations of the interventions. No report on attrition.	The setting is described as the duration of the programme in the clinic with on-going evaluation. The MPP is conducted by a certified MPP-trainer. / Therapist have to complete a certified 5-day MPP trainer-course.	The programme consists of six group sessions and two single training. Staff are trained and certified to participate or deliver the intervention. The study reports on the intended and delivered interventions.	The study reports on the long term effects of the intervention: e.g. Positive effects on the parental responsiveness towards their infants and on the infants' vocalisation behaviour have been demonstrated. It does not mention the indicators used for follow-up interventions.
4	Cassettari *et al.,* 2015	Short-term longitudinal	Hearing mothers of Deaf children ages: 3yrs & 4 months as well as 1yr & 4 months	UK	Three sessions of video interaction guidance intervention	The article does not report on the representation of the target population. The only exclusion criterion was children who were not at a paralinguistic stage of development and could produce more than 50 signed/spoken words as reported by the parent. Participants were compensated for their travelling cost.	The intervention achieved its intended objective i.e. to examine the effect of a family-focused psychosocial video intervention program on parent–child communication in childhood hearing loss. It does not reports on the limitations of the intervention. It reports on the outcomes. No report on the attrition rate.	Pilot study use observational and self-report measures to show there is a need for a video feedback intervention programme.	The intervention used video feedback of parent–child interactions to increase responsiveness to a child's communicative cues, and promote attuned behaviour between parent and child	This study examined the quality of parent–child interaction and parental self-esteem pre-lingual childhood deafness. Recommendation for future studies include: studies should focus on social outcomes, such as maternal stress, parenting self-efficacy, and social competence in the child.
5	Storbeck & Pitman, 2008	Descriptive research design	32 Deaf infants and 32 families	South Africa	12 month programme offering families weekly home-based support that is both child-centred and family-directed.	Parents of deaf children, does not talk to inclusion or exclusion	Parents of deaf children, does not talk to inclusion or exclusion	The setting is clearly described, all the provinces in SA, evaluation is done by the participants, and the report is clear as to who does the interventions (deaf mentors, = interventionist)	The duration is explained, weekly visitation), the staff is explained as to who does the delivery of services and it reports on the intended delivered interventions	The report speaks to the long term effects of the intervention and

SUMMARY OF THE FINDINGS ACCORDING TO THE RE-AIM FRAMEWORK

Reach:

The representativeness of the target population was reported as adequate in all the interventions, however, there were inconsistencies with the overall numbers of participation. The recruitment process for all interventions was specifically directed at hearing parents of deaf children, although Storbeck and Pitman (2008) make reference to families, in general, and not specifically hearing families. Hearing parents constituted both mothers and fathers, however, hearing mothers appear to be the bigger representative. The participants' age groups varied from 20-50 years old. One intervention, specifically, was focused on mothers of deaf children (Cassettari *et al.,* 2015). Only one intervention included hard of hearing parents. The participants came from diverse socioeconomic and educational backgrounds from high school to academia. The participation rate varied per intervention, for example, in one intervention 13 families were originally approached; however only a few agreed to participate, citing financial and practical difficulties, including distance, which eventually left the intervention with a sample of 3 participants (Garcia & Turk, 2007).

Although the intervention was geared towards hearing parents' participation, the inclusion criteria of the participants' children varied in age from 1 year and 4 months to 15 years old. An additional inclusion criterion was that all the children of the participants had to be deaf (hard of hearing, profound hearing loss). Special reference was made to language as an inclusion criterion in two interventions (English and German). Four of the interventions did not refer to the participation rate of participants.

Efficacy:

The efficacy of the interventions did not directly address the research question, i.e. interventions regarding parenting styles, parenting practices and best practices. However, the effectiveness in achieving the intended objectives was reported for all the interventions. The limitations of the intervention was reported on in only two interventions i.e. in one intervention the potentially limited generalizability of the significant results obtained was recognised and in the other, participation, as well as problems experienced by participants, was viewed as possible limitations. It is encouraging to note that, in all the interventions, at least one outcome was observed and expanded on to reveal how the interventions could be of future benefit to hearing parents. Very little reporting was done on the attrition rate.

Adoption:

This dimension speaks to the characteristics of the populations, and refers to the various types of settings, as explained by Brace, Padilla, Dejoy, Wilson, Vandenberg & Davis (2015) that representativeness of settings can refer to settings like work sites, health departments, or communities. In four of the interventions (Feigen & Peled, 1998; Garcia & Turk, 2007; Storbeck & Pitman, 2008; Cassettari *et al.,* 2015) the setting of the intervention is mentioned. The adoption of the intervention is addressed in three interventions, with the ongoing evaluation of the intervention referred to in two interventions (Storbeck & Pitman, 2008 and Reichmuth *et al.,* 2013). In these two interventions, the participants evaluated the effectiveness of the intervention and underscored the importance of continued support. In addition, Reichmuth *et al.,* (2013) do not indicate its adoption and suggest that the intervention could become part of/adopted by the state-funded special pedagogic interventions in Germany. The importance of the positive outcomes of the interventions is underscored in all five interventions (e.g. the intervention with parent groups of preschool children with hearing loss [Feigen & Peled, 1998]), as well as the intervention effectiveness and the anticipation of it being part of further therapeutic and education frameworks. Similarly, the results of Garcia and Turk's

(2007) intervention on the applicability of the Webster-Stratton Parenting Programmes to families and their deaf children with emotional and behavioural problems, as well as autism, provide evidence that it has a place in the therapeutic management of behavioural, emotional and developmental challenges facing this type of client. Similarly, the intervention of Cassettari *et al. (*2015) on enhancing the parent-child communication and parental self-esteem with a video feedback intervention reveals the positive outcome of the programme, but not its adoption. Equally Storbeck and Pitman's (2008) pilot programme revealed the advantages of a family-centred intervention, which promotes a holistic approach that values parents' education and support. All five programmes refer to experienced staff members, who were involved in the delivery of the programmes, i.e. social workers, trained facilitators, certified therapist, deaf mentors and accredited interventionist.

Implementation

Reporting on the duration and frequency of the intervention was consistent in all five articles; however, the frequency of the attendance of the participants is not articulated in some of the articles. Information was provided on the number of sessions and the duration of the sessions. The delivery of services by staff and peers was described in all five articles, with Storbeck and Pitman (2008) providing demographic details on the staff and peers, to accommodate the diversity of the participants participating in the intervention. In addition, Storbeck and Pitman (2008) describe the different roles of staff participating in the implementation of the intervention. Feigen and Peled (1998) and Reichmuth *et al.* (2013) provided clear and concise details of the group intervention programme, in terms of its group implementation, as well as the staff, who were to deliver the intended intervention. Conversely, the article by Garcia and Turk (2007), reporting on a video application, made it difficult to discern whether the intervention was implemented with hearing parents, or one hearing parent of the boy on whom the case study was eventually conducted.

High positive participation satisfaction with the interventions was recorded in all the articles, which could suggest that the participants were satisfied with the delivery of the interventions by the staff. This could suggest that the interventions were effectively delivered by staff, who seemed to be well trained in the various interventions (e.g. social workers [Feigen & Peled, 1998]; experienced certified trainers working with hearing parents [Reichmuth *et al.*, 2013]; and deaf mentors and parent advisors, as described in more detail by Storbeck and Pitman [2008]). Two of the articles, Garcia and Turk (2007) and Cassettari *et al.* (2015) mentioned staff as interventionists; however, there is little to suggest what their specific tasks were, especially as these were video recording interventions. The majority of the interventions took place through group work. The aims of the groups, as well as the composition, structure and content of the sessions, were outlined.

Maintenance

This dimension provides an account on the sustainability of the participation in the interventions, and whether specific elements improved or restricted the sustainability of the intervention (Brace *et al.*, 2015; Galio & Glasgow, 2012). Storbeck and Pitman (2008) reported on a pilot project, which eventually led to an evidence-based intervention programme that has since been implemented, in order to effectively address the needs of deaf children's families in South Africa. The articles of Garcia and Turk (2007) and Cassettari *et al.* (2015) did not address the long term effects of the intervention, or report on the indicators used for intervention follow-up. However, their articles do underscore the importance of further comprehensive and widespread research into the effectiveness of early interventions for deaf children.

The article of Reichmuth *et al.* (2013), on the Muester Parental programme, which has been implemented since 2009, with on-going evaluation, ideally, has become a comprehensive intervention programme module for families with deaf children. Of significance is that all the articles made sustainable recommendation for these interventions to become an integral part of future intervention.

DISCUSSION

The aim of the scoping review was to review previous research on parenting interventions that targeted hearing parents and their parenting styles, as well as practices. The review had no specific timeframes attached and the articles were sourced from various databases, as previously mentioned in this study. The RE-AIM framework was explorative in nature, as it explored the effectiveness of the interventions at individual, institutional and community levels (Frantz & Chandeu, 2011).

Despite the varied information provided by these articles, the review has highlighted a number of important challenges and strengths that clarify the significance of intervention programmes for hearing parents, parenting deaf children (Desjardin, 2003). The participation in all the family interventions reviewed, appeared to not only benefit the parents, but also improved the outcomes for the deaf children (Desjardin, 2003; Yoshinaga-Itano, 2003). All the interventions suggested that the parents demonstrated responsive parent behaviours towards their deaf children. Through responsive parenting, the parents were able to expand their interactions with their children, enhancing the parents' own beliefs in their parenting skills and abilities, while, simultaneously, providing them with a sense of empowerment and enjoyment.

Several studies have observed that hearing parents often tended to employ parenting styles with their deaf children, which were intrusive, less flexible and more directive during interaction (Spencer & Meadow-Orlans, 1996; Harrigan & Nikolopoulos, 2002), as well as displaying less reciprocity (Harrigan & Nikolopoulos, 2002; Spencer, 2004). The articles illustrated that raising a deaf child may require parents to adjust, or alter their parenting styles and skills, which would affect the quality of parent-child relationship (Woodgate, Edwards, Ripat, Borton & Rempel, 2015; Sams, 2012; Raya, Ruiz-Olivares, Pino & Herruzo, 2014). According to these authors, when parents are reciprocal to their deaf children's needs, as well as more flexible in their interactions, positive outcomes could be expected for both the parent and the child.

It could be argued that the strength of all these articles rests in the implementation of the group sessions, which appeared to provide positive outcomes for the parents. The group sessions appeared to reinforce existing good parenting skills, and acknowledged the effects that child deafness has on the family, parents and parent-child relationships. Luterman and Ross (1991) observed that support groups play a significant role in increasing parents' social network, and reinforcing their self-confidence, when parenting a deaf child. In addition, the articles reveal that, through these interventions, parents believed they had acquired more strength and coping skills, which helped them to relate to their deaf child as their child, firstly, and secondly, as their child who is deaf, allowing them to act as parents (Feigen & Peled, 1998). A common theme throughout the articles was that the parents valued the contact with other parents, who were experiencing similar challenges, and considered this interface very supportive (Jackson, 2011; Zaidman-Zait, 2007). Evidence from these interventions indicated that there was a shift from merely providing services to families, to actually supporting parents (Macwilliam & Scott, 2001). Consequently, parents were provided with information that reinforced their self-esteem and confidence in their abilities to raise a deaf child (Bemrose, 2003; Young, 2003). These programmes provided parents with the specific knowledge and skills for them to parent their young deaf children (Desjarden, 2003), and, in addition, underscored the importance of supporting parents, as they are the most important carers of the child (Hintermair, 2000; 2006; Jackson, 2011).

Significantly, the study samples included more female participation, than they did males (Feigen & Peled, 1998; Cassettari *et al.*, 2015). This was consistent with literature, as it has been observed that, generally, mothers participated more in intervention programmes, than did fathers. A study, conducted by Zaidman-Zait *et al.* (2017) on mothers' and fathers' involvement in intervention programmes for deaf and hard of hearing children, observed that mothers were notably more involved than fathers were in their children's interventions. Mothers were in regular attendance, displayed a higher interest, than did fathers, and were keener to engage with the professionals assisting in the interventions. Calderon and Greenberg (2003) suggest that specialized interventions, targeting fathers in particular, to promote positive social-emotional outcomes for deaf children, should be developed.

CONCLUSION

This scoping review was intended to understand and identify potential intervention strategies that advanced support and positive outcomes for hearing parents and their deaf children. It advances the argument that intervention programmes for hearing parents are essential, and reinforced the need for more research on parents with disabled children; more specifically on the parenting styles employed by parents of children with hearing loss (Antonopoulou, Hadjikakou, Dagla & Maridaki-Kassotaki, 2015). The positive findings revealed that the effective delivery of programmes with competent staff can be beneficial to the effectiveness and maintenance of these programmes. This scoping review also highlights the limited research and publications in the area of the parenting of deaf children. Therefore, a strong recommendation is made that the implementation of the RE-AIM framework be considered as an effective practice tool, to facilitate consistent and useful information when reporting on interventions.

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Authors' contributions

R.D. conducted the research towards a Ph.D. degree, under the supervision of N.R. and C.S. All of the authors contributed to and finalised the article.

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CHAPTER 5: FINDINGS: QUANTITATIVE INQUIRY.

PARENTING APPROACHES OF HEARING MOTHERS AND FATHERS PARENTING CHILDREN WITH HEARING LOSS/HORENDE MOEDERS EN VADERS SE BENADERING VAN OUERSKAP TOT KINDERS MET GEHOORVERLIES

Davids, R.S., Roman, N.V. Schenck, C. (2020). Horende moeders en vaders se benadering van ouerskap tot kinders met gehoorverlies. The Journal of Humanities/Tydskrif vir Geesteswetenskappe (Accepted).

5.1 Introduction

Chapter 4 presented the results of Phase 1, Stage 1: A scoping review that explored previous literature on interventions targeting parenting styles of hearing parents parenting children with hearing loss. Stage 1 of Phase 1 addressed objective 1 of the research study. Chapter 5 addresses Stage 2 of Phase 1. This stage addressed objectives 2 and 3, namely, to *determine the parenting styles of hearing parents parenting children with hearing loss* and to *determine the challenges that contribute to parenting a child with a hearing loss, including parental self-efficacy*, respectively.

The current chapter presents the results of the internal consistency of reliability of the two scales used for determining the parenting styles of hearing parents and determining the challenges that contribute to parenting a child with a hearing loss, including parental self-efficacy. Descriptive statistics in terms of percentages, means, frequencies, and standard deviations were used to summarise demographic data, type of parenting styles, and challenges contributing to parenting styles, including parental self-efficacy. Mann-Whitney U-test was used to analyse data. The results were presented using the Cronbach alpha for internal consistency. The two instruments were applicable to be used in a South African context.

5.2 Publication Details

This chapter has been accepted for publication by the Tydskrif Vir Geesteswetenskappe Suid Afrika/Journal for Humanities.

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Permission from Journal/editor to use in the PhD thesis	**Correspondence with the editor on the 17th March 2020 and on the 6th of April 2020.** Dear Ronel Congratulations as co-editor for the special editions on vulnerable groups I inform you that the two reviewers were in agreement that your article can be accepted for publication Journal: Tydskrif vir Geesteswetenskappe Article: **Horende moeders en vaders se benadering van ouerskap tot kinders met gehoorverlies**. **Correspondence with the editor on the 17th March 2020 and on the 6th of April 2020.** Hi Ronel Request granted with pleasure, the only requirement being that you cite our journal for the original publication of your article. Full details to be included in the references, in other words. Keep up the good work. I have read all of your contributions with interest, but also with trepidation for the dire circumstances in which so many in our SA community have to survive. Kind regards Ina (Publikasies@akademie.co.za)

5.3 Tydskrif Vir Geesteswetenskappe Suid Afrika/Journal for Humanities

"The *Journal of Humanities/Tydskrif vir Geesteswetenskappe* publishes original research and review articles in the following subject fields: theology, languages, art and culture, social, economic and educational sciences, as well as book reviews, chronicles and poems. It is a quarterly journal with articles in Afrikaans and Dutch only and summaries in English, French and German. The intended audience of this journal is researchers and scholars in the fields of theology, languages, art and culture, social, economic and educational sciences." Retrieved from the website: http://www.scielo.org.za/scielo.php?script=sci_serial&pid=0041-4751&lng=en&nrm=iso. The reason for submitting the article to this journal was because they were going to do a special edition on vulnerable groups.

5.4 Conclusion

In conclusion, the study holds a number of implications and recommendations for future research and practical considerations. It provides for a greater understanding of the gender differences in parenting approaches and parental self-efficacy when parenting a child with hearing loss. Although the findings suggest that fathers scored higher in positive parenting approaches and significantly higher on parental self-efficacy than mothers, generalisation of the study should be cautioned, especially when interpreting the findings of maternal self-efficacy. Methodological limitations of the present study should be noted in terms of the quantitative nature of the study. A mixed methods study, or a qualitative study, might show less consistency, but might also contribute further to the understanding of parents' interpretations of each other's perceptions of parental self-efficacy. This study was based on parents scoring themselves in terms of their own parenting approaches and self-efficacy, and was not based on observations or parents scoring each other. Given the sparsity of research on parenting approaches of children with hearing loss, our study has generated new questions that deserve further research. Further participation in research should be encouraged to facilitate the understanding of paternal effects on children.

Our results call for the development of specific interventions supporting mothers and fathers of children with a hearing loss. The outcomes of the study should be included in the guidelines in the planning of support for hearing parents parenting children with a hearing loss.

This is the final document that was submitted and accepted. It is written in the format and language (Afrikaans) as submitted to the Tydskrif Vir Geesteswetenskappe Suid Afrika/Journal for Humanities.

Horende moeders en vaders se benadering tot ouerskap van kinders met gehoorverlies. Davids, R.S., Roman, N.V. & Schenck, C.J. *Parenting approaches of hearing mothers and fathers parenting children with hearing loss.*

Horende moeders en vaders se benadering tot ouerskap van kinders met gehoorverlies.

Parenting approaches of hearing mothers and fathers parenting children with hearing loss

ABSTRACT

Parenting approaches of hearing mothers and fathers parenting children with hearing loss

It is estimated that there are 32 million children in the world with a hearing loss. Research shows that 90% of children suffering from hearing loss are born to hearing parents who often know nothing or very little about hearing loss. Most research studies on child hearing loss have generally focussed on early intervention, language development and on parents' experiences at the time of diagnosis of child hearing loss. However, the effect of child hearing loss on parents' parenting approaches and on parents' parental self-efficacy in attempting to parent a child with a hearing loss, have received relatively little research attention.

Parenting a child with a hearing loss may necessitate the need for parents to make accommodations for their child by adapting, adjusting, educating themselves about the needs of their child and may modify their parenting approaches, behaviour and attitudes in order to become more engaged in their parenting role. Furthermore, parents parenting a child with this particular disability may lack a sense of parental self-efficacy, and may be unable to put their parenting knowledge into action as they may feel overwhelmed by their extra responsibilities. In many cases, parents of children with a hearing loss are expected to take on new and multiple roles for which they are not prepared. The demands of these roles together with parents' lack of parenting skills (knowledge on hearing loss, communication approaches for example), the need for information resources, social-emotional support leave parents vulnerable. As a result of their vulnerability parents may experience difficulties in developing effective parent child-rearing approaches and may struggle in their parental self-efficacy to parent a child with hearing loss. Research shows that parental self-efficacy is the key to a child's success.

Given the abovementioned challenges, the aim of the present study was to examine and describe the parenting approaches and the contributory factors to parents' parental efficacy when parenting children with a hearing loss. The research involved a sample of 103 hearing parents from the Western Cape, South Africa, whose children were between the ages of 10 and 17. Each parent completed a self-administered questionnaire made up of three sections that included (a) parents' demographic details (b) the adaptation of the Parents as Social Context Questionnaire (PSCQ) and (c) the adaptation of the Parent Self-Efficacy Instrument (PSE). The results of our study show that mothers scored higher on chaotic parenting as well as on structured parenting approaches. Fathers scored higher on autonomy and supportive parenting approaches as well as on parental warmth than mothers. The results also show that there is a significant difference in parental self-efficacy between fathers and mothers, with fathers scoring significantly higher on knowledge, confidence, handling of stress, communication, positive interaction and satisfaction than mothers. The results of the study provide for a greater understanding of mothers' and fathers' differences in parenting approaches as well as the factors influencing their parenting approaches and confidence in parenting a child with a hearing loss.

In summary, children with a hearing loss remain a vulnerable sector in our society just as any other child with a disability. Parents too form part of this vulnerability as they experience a myriad of challenges and a host of relational difficulties when parenting their child thus affected. A clearer awareness and understanding of parents' perspectives of their parenting approaches and the factors contributing to their parental self-efficacy when parenting a child with a hearing loss have important implications for family centred practices. These implications could assist professionals in the development of specific interventions supporting mothers and fathers that will enhance parent child relationships and positive child outcomes. Furthermore, these implications and recommendations made by the current study can be considered for future research in the field of parenting and childhood hearing loss.

KEYWORDS: hearing parents, child with hearing loss, parenting approaches, contributing factors, parental self-efficacy

TREFWOORDE: horende ouers, kind met gehoorverlies, ouerskapbenaderings, bydraende faktore, self-effektiwiteit van ouers

OPSOMMING

Navorsing toon dat 90% van kinders met gehoorverlies vir horende ouers gebore word (Cole & Flexer, 2016; Lederberg, Schick & Spencer 2013). Hierdie ouers kan probleme ondervind om ’n effektiewe benadering tot die grootmaak van kinders te ontwikkel, en hulle kan dit ’n uitdaging vind om ’n kind met gehoorverlies met selfvertroue groot te maak (Calderon, Bargones & Sidman 1998). Studies dui aan dat interaksie tussen gesinslede, familiehulpbronne en ondersteuningsdienste alle areas van die gesinslewe beïnvloed wanneer daar ’n kind met ’n gehoorverlies in die familie is. Boonop ondervind horende ouers nie net uitdagings ten opsigte van hul kind se gehoorverlies nie, maar is daar sprake van verdere uitdagings soos stres, kommunikasie, maatskaplike ondersteuning en toegang tot inligting. Verder beïnvloed gehoorverlies in kinders ouers se vertroue in hulle vermoë om ’n kind met gehoorverlies groot te maak.

In hierdie studie ondersoek ons of daar ’n verskil is tussen moeders en vaders se ouerskapbenadering, en of daar enige bydraende faktore is wat ouers se self-effektiwiteit mag benadeel wanneer hulle ’n kind met gehoorverlies grootmaak.

1. INLEIDING

Om ouerskap te bestudeer kan omstrede wees, want daar is geen voorgeskrewe boeke wat beskryf hoe ’n mens kinders moet grootmaak nie (Roman, Makwakwa & Lacante 2016). Ouerskap is iets persoonliks en hang af van die sosiale omgewing waarin die gesin sig bevind.

Wat byvoorbeeld tot die kompleksiteit van ouerskap bydra, is kindergestremdheid in ’n gesin, wat onvermydelik van ouers ’n ander benadering tot ouerskap vereis.

Deur die jare het navorsers verskillende benaderings tot ouerskap en tot kinders grootmaak bestudeer (Carr & Pike 2012). Dit sluit in die verskeidenheid van ouerskapstyle en die uitwerking wat dit op ’n kind mag hê. Elke ouerskapstyl het verskillende eienskappe en lei tot verskillende reaksies by kinders. Hierdie verskillende eienskappe word uitgebeeld as dimensies (Baumrind 1971), wat gedefinieer word as die beskrywende eienskappe wat gebruik word om die aard van ouerskapstyle te vertolk (Ekim & Ocaksi 2016). Sodanige dimensies sluit in die gedrag of dissiplinêre strategieë wat ouers gebruik om kindergedrag te beïnvloed (Jago, Davison, Thompson, Page, Brockman & Fox 2011).

Die meeste navorsing oor ouerskap is beïnvloed deur die navorsing van Diana Baumrind in die vroeë 1960’s. Hierdie navorsing het die patrone van ouerskapbeheer en kindersosialisering beskryf. Ouerskapstyle word in vier kategorieë beskryf: outoritêr, gesaghebbend, permissief en onbetrokke. Met betrekking tot outoritêre en gesaghebbende ouerskapstyle, lê die verskil tussen die twee style daarin hoe ouers met hulle kinders kommunikeer, en hoe die kinders gestraf word. Outoritêre (“authoritarian”) ouerskap word gekenmerk deur hoë vereistes en min reaksie. Ouers met ’n outoritêre ouerskapstyl het baie hoë verwagtinge van hulle kinders, maar gee baie min terugvoer en aanmoediging. In teenstelling daarmee, is ’n gesaghebbende (“authoritative”) ouerskapstyl een wat hoë vereistes stel én hoë reaksie bied. Gesaghebbende ouers stel hoë standaarde en reageer op die kind se emosionele behoeftes. Hulle stel grense en is baie konsekwent in die afdwing van die grense. Lewis (1981) beweer egter dat dit nie soseer gaan oor gesaghebbende ouers se streng beheer met behulp van reëls wat kinders help om tot onafhanklikheid te ontwikkel nie. Gesaghebbende ouerskap gaan eerder oor gedeelde kommunikasie en die wysiging van ouers se reëls deur middel van gesprek met onafhanklike kinders as uitkoms. Vir ouers wat ’n kind met ’n gestremdheid grootmaak, mag dit anders wees (Woodgate, Edwards, Ripat, Borton & Rempel 2015), en dit mag vir dergelike ouers nodig wees om hulle ouerskapbenadering te heroorweeg. Ouers kan toegewings maak vir ’n kind met ’n gestremdheid deur aanpassings en veranderings te maak, hulleself toe te rus met kennis omtrent die behoeftes van hulle kind, en hul ouerskapgedrag en houding aan te pas sodat hulle meer betrokke raak vir sover dit hulle benadering tot ouerskap aangaan.

Literatuur oor ouerskap-selfeffektiwiteit (“parental self-efficacy”) – ouers se selfvertroue omtrent hulle vermoë om kinders suksesvol te kan grootmaak – toon dat daar ’n direkte verband is tussen ouerskap en ouerskap-effektiwiteit en die gehalte van sorg wat aan kinders voorsien word (Sanders & Woolley 2005). Gehoorverlies word deur die Wêreld Gesondheidsorganisasie (WHO 2015) gedefinieer as stremmend wanneer die verlies aan gehoor meer as 30 desibels is in die oor waarmee die kind die beste hoor. Die implikasies van gehoorverlies kan verreikende gevolge inhou vir die kind se kwaliteit van lewe, vermoë om te kommunikeer en vermoë om ekonomies onafhanklik te word, ongeag van die ouderdom wanneer gehoorverlies ’n aanvang neem. Vir ouers wat kinders met gehoorverlies het, kan ouerskap-effektiwiteit nie net uitdagings ten opsigte van hulle kind se gehoorverlies inhou nie. Ander uitdagings wat ouers met betrekking tot hulle kinders se gehoorverlies mag ervaar, hou verband met stres, kommunikasie, maatskaplike ondersteuning en toegang tot inligting. Hierdie uitdagings kan betekenisvol bydra tot die soort ouerskapbenadering wat horende ouers aanvaar. Dit kan ’n invloed uitoefen op hulle selfvertroue rakende hulle vermoë om die daaglikse uitdagings te hanteer terwyl hulle ’n kind met gehoorverlies grootmaak.

2. PROBLEEMSTELLING

In die konteks van die huidige studie, kan die teenwoordigheid van ’n kind met gehoorverlies die ouerskapbenadering van horende ouers beïnvloed. Sommige ouers beskryf hulle ouerondervinding met so ’n kind as bevredigend, uitputtend en lewensveranderend (Fox 2009). Gehoorverlies in kinders kan gevolge hê wat inhou dat ouers probleme ondervind om ’n effektiewe benadering tot kinderopvoeding te ontwikkel. Hierdie gevolge mag bydra tot ouers se onsekerheid oor die manier waarop hulle hul kind moet grootmaak (Calderon &

Greenberg 2003; Calderon, Bargones & Sidman 1998). Gesinsinteraksie, gesinshulpmiddele, ouerskap en ondersteuningsdienste is alles gebiede van die gesinslewe wat beïnvloed word as ouers ’n kind met gehoorverlies het (Haddad, Steuerwald & Garland 2019).

Baumrind (1971) verwys na die geslagsverskille in ouerskapstyle, en merk op dat moeders meer versorgend en gesaghebbend (“authoritative”) as oorheersend (“authoritarian”) is, in vergelyking met vaders wat meer outoritêr (“authoritarian”) as gesaghebbend (“authoritative”) is. Antonopoulou, Hadjikakou, Stampoltzis en Nicolaou (2015) se studie oor onderskeidende ouerskap- en dissiplinêre voorkeure van moeders met dowe of hardhorende kinders en horende sibbe, het getoon dat die dominante ouerskapstyl van moeders vir albei groepe gesaghebbend is, en dat die toegeeflike en streng ouerskaptipes oor die algemeen die minste voorkom. Ander studies het bevind dat moeders wat oormatig oorbeskermend teenoor hulle kinders is, hulle kinders se sosiale lewe (Gregory 1979) onnodig beperk, wat moederlike indringerigheid tot gevolg het en die selfstandigheid van die kinders beperk (Meadow-Orlans 1990; Vaccari & Marschark 1970).

In teenstelling met Baumrind (1991) se stellings is daar by een van die paar studies wat fokus op vaders wat kinders met gehoorverlies grootmaak, waargeneem dat dergelike vaders oorbeskermend teenoor hulle kinders is, en in vergelyking met vaders van horende kinders, minder demokraties en gedissiplineerd is in hulle benadering (Sahli 2011). Die resultate van ’n studie deur Antonopoulou, Hadjikakou, Dagla en Maridaki-Kassotaki (2015) meld eweneens dat kinders met gehoorverlies hulle vaders as minder outoritêr en streng ervaar as horende adolessente.

Die meeste navorsing oor self-effektiwiteit (“parental self-efficacy”) van ouers neig om Bandura (1997) se teoretiese stellings te volg wat gedefinieer word as ouers se vertroue en bekwaamheid in hulle ouerskapsrol, en in hulle vermoëns om elke taak met selfvertroue uit te voer. Self-effektiwiteit van ouers is geanker in die ouer se persoonlike vertroue en vermoëns om bekwaam en toereikend te funksioneer, en stresvolle eise en uitdagings wat ouers in die gesig staar, te kan hanteer (Coleman & Karraker 2003; Luszczynska, Gutierez-Dona &

Schwarzer 2005). Die literatuur toon dat ouers met ’n hoë ouerskap-effektiwiteitsvertroue neig om ondersteunende ouerskapbenaderinge te gebruik en meer positief teenoor hulle kinders te wees (Mouton, Loop, Stievenart, Roskram 2018). Daarenteen is ouers met min vertroue in hul eie effektiwiteit geneig om in hul ouerskap strenger beheer uit te oefen, wat tot gevolg het dat kinders hoë vlakke van ekstreme gedrag toon (Roskam & Meunier 2012).

Nietemin, om die self-effektiwiteit van ouers beter te verstaan, kan die konsep van algemene effektiwiteit nuttig wees om die breër konteks van ouers wat kinders met gestremdheid grootmaak, te verstaan. Algemene self-effektiwiteit kan vertolk word as die algehele aanpassing en self-bevoegdheid van ouers wat dergelik geaffedteerde kinders grootmaak (Benzies, Trute & Worthington 2013). Ouers van kinders met gehoorverlies kan byvoorbeeld oorweldig voel en onbevoeg vir die taak om so ’n kind groot te maak (Kurtzer-White & Luterman 2003), en dit kan die ouers se vertroue in hulle ouerskapvermoëns beïnvloed. Navorsing oor self-effektiwiteit van ouers van kinders met gehoorverlies is beperk, of meestal gefokus op moeders (Desjardin & Eisenberg 2007). Volgens Luterman (1999) is die selfvertroue van ouers, veral dié van moeders, deurslaggewend vir die kind se sukses. Studies wys daarop dat daar min navorsing gedoen is oor die uitdagings wat ervaar word deur ouers wat kinders met gehoorverlies grootmaak (Movallali & Nemati 2009). Hierdie uitdagings kan betekenisvol bydra tot die soort ouerskapbenadering wat horende ouers aanvaar. Navorsers Movallali en Poorseyed (2015) neem waar dat moeders van kinders met gehoorverlies hoër vlakke van stres aandui, negatiewe ouerskapgedrag sonder warmte en intimiteit toon, en inkonsekwent in hulle dissipline is. Op dieselfde wyse kan kommunikasiebeperkings ook ontwrigting in die interaksie tussen ouers en kind veroorsaak en derhalwe ouerskaprolle en verantwoordelikhede negatief beïnvloed (Tamis-LeMonda, Uzgiris & Bornstein 2002), en daartoe aanleiding gee dat ouers streng optree en strafmaatreëls toepas om kinders te dissiplineer (Sullivan, Brookhouser, Scanlan, Knutson & Schulte 1991). ’n Studie deur Jackson (2011) oor gesinsondersteuning en middele vir ouers van kinders met gehoorverlies het bevind dat daar ’n behoefte is aan insiggewende bronne, maatskaplike bronne, sosiaal-emosionele ondersteuning, en opvoedkundige ondersteuning vir ouers. Hintermiar (2006) en Zaidman-Zait (2007) beklemtoon die belangrikheid van ouerondersteuning, veral om stres te verminder wanneer ouers ’n kind met gehoorverlies grootmaak. Hulle verslag toon dat die deel van ervarings met ander ouers van kinders met gehoorverlies ’n uiters belangrike bron van sosiaal-emosionele ondersteuning vir ouers is.

Hierdie ondersoekterrein, wat op ouerskapbenaderings in gestremdheid fokus, is onbekend in die Suid-Afrikaanse konteks. Navorsing oor ouerskap in Suid-Afrika het hoofsaaklik gefokus op ouers wat nie ’n kind met ’n gestremdheid het nie, selfs al is daar studies wat op beide moeders en vaders fokus. Hierdie studies toon dat daar beduidende verskille is tussen die ouerskapbenaderings van moeders en vaders (Roman, Makwakwa & Lacante 2016, Gamble, Ramakumar, & Diaz 2007), met moeders wat meer gesaghebbend is as vaders in hul benaerings tot ouerskap. Die uitkomste van hierdie studie mag implikasies hê vir praktisyns in Suid-Afrika en bydra tot die navorsing oor insae in die ouerskapbenadering van horende ouers wat kinders met gehoorverlies grootmaak.

Ten einde insig te verkry in die benadering tot ouerskap van horende ouers wat kinders met gehoorverlies grootmaak, beoog die huidige studie om die onderskeie benaderings van moeders en vaders vas te stel en en die self-effektiwiteit van beide moeders en vaders in die opvoeding van ’n kind met gehoorverlies te beskryf.

3. EMPIRIESE ONDERSOEK

3.1 Doel van die navorsing

Die doel van die navorsing was om 1) die ouerskapbenaderings en 2) bydraende faktore tot die self-effektiwiteit van moeders en vaders betreffende die opvoeding van hul kinders met gehoorverlies te ondersoek.

’n Verdere doelwit van die navorsing is om ouerlike intervensies te ontwikkel wat gebaseer is op horende moeders en vaders se ouerskapbenaderings teenoor hul kinders met gehoorverlies.

3.2 Navorsingsoriëntasie

’n Kwantitatiewe navorsingsbenadering is gevolg. Kennis is verkry deur middel van sorgvuldige waarneming en meting, om sin te maak van die wêreld deur middel van ’n wetenskaplike proses wat die kwantitatiewe metodes en statistiek in aanmerking neem (Creswell 2003; Somekh, Burman, Delamont, Meyer, Payne & Thorpe 2005). Ons het die statistiese data wat in die studie ingesamel is, gebruik om ons data op te som, en patrone, verhoudings en konneksies te beskryf (Antonius 2003).

3.3 Navorsingsontwerp en -metode

’n Nie-waarskynlikheidsteekproef (“Non-probability sampling”) is vir die doel van hierdie studie aangewend. Drie skole is genader om met die data-insameling te help. Drie skoolhoofde van skole vir kinders met ’n gehoorverlies is gekontak en om toestemming vir hulle samewerking gevra. Die doel van die studie is aan hulle verduidelik, en nadat toestemming verkry is, het die skoolhoofde die vraelyste uitgedeel as deel van hulle korrespondensie met ouers.

’n Kwantitatiewe navorsingsmetode is in die studie gebruik. Daar is gepoog om by die ouers uit te vind hoe hulle ouerskap met die opvoeding van ’n kind met gehoorverlies benader, en watter bydraende faktore hulle self-effektiwiteit (“self-efficacy”) rakende die opvoeding van sulke kinders kan beïnvloed.

3.4 Deelnemers

Die deelnemers aan die huidige studie was 103 (n=103) horende ouers van die Wes-Kaap, Suid-Afrika. Elke deelnemer het ’n gesin verteenwoordig, wat beteken dat moeders en vaders vir die huidige steekproef uit verskillende gesinne afkomstig was. Die deelnemers het bestaan uit ’n heterogene groep ten opsigte van ouderdom, huishouding, verhoudings, en opvoedkundige en sosio-ekonomiese profiele. Horende ouers was tussen die ouderdomme van 35 en 50 jaar, en hulle kinders, wat gehoorverlies het, tussen 10 en 17 jaar oud. Die meerderheid ouers was vroulik (77/74.8%), en bruin (gemengde ras) (46/44.7%), en die meerderheid het vroulike kinders (62/60.2%). Van die enkelouers was die meerderheid vroulik

(38/77.6%). In die kategorie “verhouding tot kind” word ’n verwysing aan pleegouers gemaak. Pleegouers in hierdie geval, pleegmoeders, word genoem om die samestelling van die ouers wat die vraelys beantwoord het, aan te dui. Hulle is opgeneem in die moedergroep, aangesien al vier pleegouers moeders is.

Die analise van die groepe moeders en vaders is onderneem sonder om te let op die huwelikstatus van die deelnemer. Deelnemers het die reg om nie deel te neem nie, om enige vraag wat hulle ongemaklik laat voel weg te laat, en om te eniger tyd gedurende die ondersoek te onttrek.

Tabel 1. Demografie van ouers

Veranderlikes	n = 103	%
Geslag		
Manlik	26	25.2
Vroulik	77	74.8
Huwelikstatus		
Getroud	54	57.6
Enkellopend	49	52.4
Enkelouerskap		
Manlik	11	22.4
Vroulik	38	77.6
Indiensneming		
Manlik	20	19.4
Vroulik	54	52.4
Werkloosheid		
Manlik	6	5.8
Vroulik	23	22.3

Ras		
Swart	38	36.0
Wit	20	19.4
Bruin	46	43.7
Verhouding tot kind		
Moeder	72	69.9
Vader	27	26.2
Ander (Pleegmoeder)	4	3.9
Huistaal		
Engels	31	30.0
Afrikaans	38	36.8
isiXhosa	32	31.06
Geslag van kind		
Manlik	40	38.8
Vroulik	62	60.2

3.5 Navorsingsinstrument, data-insameling en -analise

Die volgende navorsinginstrumente is by die opstel van die kwantitatiewe vraelys ingesluit: die aangepaste *Parents as Social Context Questionnaire* (PSCQ) (Skinner, Johnson & Snyder 2005) en die aangepaste *Parent Self-Efficacy Instrument* (PSE) (Coleman & Karraker 1998). Die aanpassings van die instrumente is gedoen om die woorde “kind met gehoorverlies” in te sluit, byvoorbeeld van ’n vraag; “Ek weet baie wat met my kind aangaan”. Die verandering was; “ek weet baie wat met my kind met ’n gehoorverlies aangaan”. Daar was geen verandering van die betekenis van die skale nie.

Die aangepaste *Parents Social Context Questionnaire* (PSCQ) is gebruik om vas te stel wat die horende ouers se benadering is om die aard van die ouerskapstyle van moeders en vaders ten opsigte van ouerskapbenaderings tot hul kind met gehoorverlies te verstaan. Hierdie afdeling het uit 29 items bestaan en is verdeel in ses onderafdelings: warmte, verwerping, struktuur, chaos, outonomie/ondersteuning en dwang. Ons het die ses onderafdelings vir hierdie ontleding gebruik omdat dit die meer algemene aspekte van ouerskapbenadering behels in die konteks van ouerskap van kinders met gehoorverlies. Elkeen van die ses onderafdelings bevat vyf items, met die uitsondering van outonomie/ondersteunende ouerskapdimensie ("parenting dimension") wat vier items bevat. Die deelnemers is gevra om elke vraag te beantwoord wat betrekking het op 'n dimensie op 'n 4 punt-Likertskaal, wat wissel van "glad nie waar nie", "nie heeltemal waar nie", "min of meer waar" tot "heeltemal waar".

Die aangepaste *Parent Self-Efficacy Instrument* (PSE) (Bandura, Adams, Hardy & Howells 1980) is effens gewysig om ouers se vertroue in hulle vermoë om die rol van ouerskap suksesvol te verrig, te beskryf. Die PSE sluit tien items in wat spesifiek kyk na die eksterne veranderlikes wat op die self-effektiwiteit ("self-efficacy") van moeder- en vaderouerskap inwerk wanneer hulle 'n kind met gehoorverlies grootmaak. Hierdie veranderlikes weerspieël algemene ouerskaptake sowel as spesifieke take wat betrekking het op ouerlike benaderings tot dergelike kinders en verskaf 'n taakgerigte meting ("task-specific measure") van ouers se selfvertroue. Elkeen van die 10 items is op 'n 6 punt-skaal gemeet, wat ouers se reaksies van 0=laag tot 6=hoog meet.

Beide skale is suksevol geïmplementeer in studies met ouerskapbenadering van horende ouers wat kinders met gehoorverlies grootmaak (Ekim & Ocakci 2016) en met betrekking tot ouers se selfeffektiwiteit betreffende volwassenes met gehoorverlies (Adi-Bensaid, Michael, Most & Gali-Cinamon 2012).

Die vraelys het dus uit drie afdelings bestaan: (a) ouers se demografiese besonderhede, (b) die aangepaste *Parents as Social Context Questionnaire* (PSCQ) en (c) die aangepaste *Parent Self-Efficacy Instrument* (PSE).

Die Engelse vraelys is ook in twee ander tale, isiXhosa en Afrikaans vertaal, wat saam die drie dominante tale in die Wes-Kaap, Suid-Afrika is. Die vertaling van die vraelyste is gedoen met die doel om die geldigheid en betroubaarheid van die antwoorde van die deelnemers te verhoog, selfs al is daar geen navorsing bekend wat aandui dat hierdie instrumente voorheen in Suid-Afrika gebruik is nie.

Die vraelyste is in weergawe 25 van die *Statistical Package for Social Sciences* (SPSS) opgeneem. Die data is gekodeer, opgeruim en nagegaan vir foute. Sowel beskrywende (gemiddeldes en standaardafwykings) as inferensiële statistiek (onafhanklike steekproewe, nie-parametriese toets – Mann-Whitney U-toets) is in die analise gebruik.

3.6 Betroubaarheidsaspekte

Joppe (2000:1) definieer betroubaarheid as volg: “the extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability, and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable.” Om die betroubaarheid van die instrument vas te stel, is Cronbach se Alpha (’n statistiese wyse vir die vasstelling van betroubaarheid) bepaal met die tellings wat deur PSCQ en PSE verkry is. Die resultate van die analise toon dat die items die tevredenheidsvlak van konstrukgeldigheid en interne konsekwentheid (“internal consistency”) van hierdie aangepaste vraelys (Taber 2018) aandui. Cronbach se alpha vir PSCQ is 0.95 en PSE is 0.90 en dus kan hierdie assessering as betroubaar beskou word, aangesien dit goeie interne konsekwentheid reflekteer.

3.7 Etiese aspekte

Tydens die studie is die volgende stappe geneem om aan die etiese voorwaardes van navorsing te voldoen:

- Etiese goedkeuring om die huidige studie uit te voer is verkry van die Universiteit van Wes-Kaapland, Suid-Afrika.
- Toestemming is ook van die Wes-Kaap Onderwysdepartement verkry.
- Die skoolhoofde van die skole vir dowes is genader om met die studie te help. Die doel van die studie is verduidelik en met die skoolhoofde se toestemming is vraelyste versprei as deel van hulle korrespondensie met ouers.
- ’n Brief waarin die etiese oorwegings van die studie in detail uiteengesit is, vertroulikheid en anonimiteit deur die gebuik van skuilname gewaarborg is, en deelnemers van enige leed gevrywaar word, is by die brief ingesluit.

4. RESULTATE

4.1 Ouerlike dimensies deur vaders en moeders

Tabel 2 toon die heersende benaderinge tot ouerskap tussen moeders en vaders. Die bevindings toon dat moeders hoër presteer in chaotiese ouerskap (M = 2.52, SD = 0.62) sowel as in gestruktureerde ouerskap (M = 3.31, SD = 0.79) as vaders (M = 2.48, SD = 0.67; M = 3.18, SD = 0.89). Vaders presteer hoër in outonomie en ondersteunende ouerskapbenaderinge (M – 3.02, SD = 0.43), sowel as ouerlike warmte (M = 3.26, SD = 0.68), as moeders 9M = 3.00, SD = 0.68; M = 3.25, SD = 0.70). Daar was ’n effense verskil in die beoordeling van prestasie in ouerskapverwerping, waarin vaders hulleself hoër aangeslaan het (M = 2.68, SD = 0.72) as moeders (M = 2.61. SD = 0.71). SD = 0.27). Hierdie verskille was nie betekenisvol nie.

Tabel 2. Ouerlike dimensies deur vaders en moeders (warmte, verwerping, struktuur, chaos, ondersteuning, dwang)

Veranderlike		**N**	***G***	***S***	***T-Waarde***	***P-Waarde***
Ouerlike warmte	Vader	25	3.26	0.68	0.055	0.957
	Moeder	76	3.25	0.70		
Ouerlike verwerping	Vader	24	2.68	0.72	0.418	0.677
	Moeder	74	2.61	0.71		
Ouerlike struktuur	Vader	26	3.18	0.89	0.714	0.477
	Moeder	77	3.31	0.79		
Ouerlike chaos	Vader	25	2.48	0.67	0.292	0.771
	Moeder	75	2.52	0.62		
Ouerlike ondersteuning	Vader	21	3.02	0.43	0.109	0.913
	Moeder	67	3.00	0.68		
Ouerlike dwang	Vader	24	2.30	0.88	0.704	0.483
	Moeder	75	2.44	0.82		

4.2 Eksterne faktore wat moeders en vaders se self-effektiwiteit beïnvloed

Tabel 3 bied gemiddelde resultate ("mean scores") en standaardafwykings van moeders en vaders se reaksie op die PSE om ouers se vertroue in hulle vermoë om die rol van ouerskap suksesvol te verrig, te bepaal.

Vaders beoordeel hulleself hoër wat betref hul kennis van hoe hulle kind groei en ontwikkel (M = 5.36) in vergelyking met moeders wat hulself laer beoordeel (M = 4.73). Vaders presteer ook hoër (M = 5.40) wat betref die hoeveelheid kommunikasie en probleemoplossing met hulle metgeselle omtrent kwessies wat met hulle kind verband hou in vergelyking met moeders (M = 4.18). Daarby beoordeel vaders hulleself hoër wat betref die aantal positiewe of behulpsame interaksies wat hulle met ander ouers het (M= 4.84) as moeders wat hulleself laer aanslaan (M = 4.18). Vaders presteer weer eens hoër in hul beoordeling van hulle vermoë om hulle kind te help leer (M = 4.83). Eweneens beoordeel vaders hulle selfvertroue en vermoë om die daaglikse uitdagings van kinders met gehoorverlies groot te maak (M = 5.54) hoër as moeders se beoordeling van hul selfvertroue en vermoëns (M = 4. 97). Vaders takseer hulleself ook hoër vir hulle vermoë om die stres in hulle lewe te hanteer (M = 5.24) in vergelyking met moeders (M = 4.68).

Tabel 3. Die self-effektiwiteit van moeders en vaders

Veranderlikes		***N***	***M***	***SD***
U kennis van hoe u kind groei en ontwikkel	Vader	25	5.36	.995
	Moeder	73	4.73	1.16
U vertroue dat u weet wat reg is vir u kind	Vader	24	5.50	.722
	Moeder	75	4.96	1.12
U vertroue in u vermoë om die daaglikse uitdagings van ouerskap in die gesig te staar	Vader	24	5.54	.78
	Moeder	76	4.97	1.05
U vermoë om u kind te help leer	Vader	24	5.42	1.07
	Moeder	76	4.83	1.16
U vermoë om die spanning in u lewe die hoof te bied	Vader	25	5.24	1.01
	Moeder	75	4.68	1.21
Die hoeveelheid positiewe interaksies wat u met ander ouers het	Vader	25	4.84	1.31
	Moeder	66	4.18	1.26
U bewustheid van gemeenskapsinligting en bronne vir ouers	Vader	24	4.46	1.47
	Moeder	66	4.18	1.26
Die hoeveelheid nuttige inligting vir ouers en ondersteuning wat u van ander kry	Vader	25	4.92	1.35
	Moeder	62	4.65	1.26

Die hoeveelheid kommunikasie en probleemoplossing met die ander ouers oor kwessies in verband met u kind	Vader	25	5.40	.91
	Moeder	58	4.76	1.25
U tevredenheid met u ervaring as ouer	Vader	25	5.16	1.25
	Moeder	75	4.93	1.16

4.3. Algehele ouerskapeffektiwiteit van moeders en vaders – onafhanklike t-toets

In Tabel 4 is ’n onafhanklike steekproef t-toets onderneem om te bepaal of moeders en vaders beduidend verskil ten opsigte van ouerskap-selfeffektiwiteit. A Mann-Whitney U-toets het getoon dat daar ’n beduidende verskil is (U= 346.500, p =.002) in ouerskap-selfeffektiwiteit waar vaders (M = 5.21, SD = 0.61) ’n hoër telling behaal as moeders (M = 4.46, SD = 0.98). Vaders het ’n hoër telling behaal in kennis, selfvertroue, streshantering, kommunikasie, positiewe interaksie en tevredenheid as moeders.

Tabel 4. Algehele ouerskapeffektiwiteit van moeders en vaders – onafhanklike t-toets

Veranderlike		**N**	*M*	*SD*	***T***	***U***	***p***
Self-effektiwiteit van ouers	Vader	26	5.21	0.61	4.06	346.500	0.002
	Moeder	77	4.46	0.98			

5. BESPREKING

Die doel van die studie was om die onderskeie benaderings tot ouerskap van moeders en vaders te bepaal en die self-effektiwiteit van sowel moeders as vaders in hul opvoeding van ’n kind met gehoorverlies voorts te beskryf. Dit was sover bekend die eerste Suid-Afrikaanse studie in hierdie veld. Die resultate van die studie dra by tot die navorsing oor geslagsverskille betreffende die ouerskap van horende ouers in hul opvoeding van ’n kind met gehoorverlies.

Ons resultate het getoon dat moeders hoër presteer in chaotiese en onder dwang-ouerskapbenadering, én ook hoër in hulle gestruktureerde ouerskapbenadering. Moeders presteer laer in al die veranderlikes wat met self-effektiwiteit verband hou. Twee van die laer tellings sluit in moeders se selfvertroue rakende hulle vermoë om die daaglikse uitdagings wat ouerskap van kinders met gehoorverlies vereis, te hanteer, en hulle tevredenheid met hulle ondervindings as ouer van ’n kind met gehoorverlies. Die versorging van ’n kind met ’n sodanige gestremdheid affekteer die rol van beide ouers, maar veral die daaglikse lewens van moeders, omdat hulle gewoonlik die kind se primêre sorggewers is (Singogo, Mweshi & Rhoda 2015). Hierdie teenstrydighede in die resultate kan gebaseer wees op moeders se ondervinding van hulle daaglikse verantwoordelikhede as ouer as die primêre versorger van hulle kind (Zaidman-Zait, Most, Tarrasch, Haddad-Eid & Brand 2015). Om as ouer minder tevrede te voel, kan beteken dat moeders emosionele uitputting en verminderde gevoelens van ouerskapprestasie en effektiwiteit (Roskam, Raes & Mikolajczak 2017) ondervind wanneer hulle ’n kind met gehoorverlies grootmaak. ’n Verdere moontlike verduideliking vir hierdie resultate kan verband hou met die feit dat die meerderheid van die moeders enkelouers is (77.6), of dat hulle werk (72.9%) en maklik dubbele rolle in hulle gesinne vertolk. Hierdie groter verantwoordelikhede kan tot gevolg hê dat moeders hulle ouerskapverantwoordelikhede so moet struktureer dat hulle al die verantwoordelikhede vir die rehabilitasie (opvoedkundig, medies, bywoning van kommunikasie-afsprake) van hulle kind aanvaar, maar nog steeds werk en dus die verantwoordelikheid vir die kinderopvoeding met hul werk moet kombineer. Dit kan veral uitdagend en uitputtend vir ’n enkelouer wees wat alleen verantwoordelik is vir die daaglikse eise van ouerskap van ’n kind met gehoorverlies.

Hierdie bevindings kan verder daarop dui dat verantwoordelikhede vir kinderopvoeding groter word terwyl ouers hulle pad baan deur die ontwikkelingstadium waarin die kind hom of haar bevind. Die grootste groep ouers wat aan hierdie studie deelgeneem het, se kinders is tussen die ouderdomme van 10 en 17 jaar. Een manier om hierdie bevindings te verstaan, is dat hierdie ouderdomsgroep dikwels ’n moeilike oorgangstadium verteenwoordig, vir ouers sowel as die kinders. Dit kan (i) fisieke en emosionele uitputting, (ii) emosionele afstand van ’n mens se kinders, en (iii) ’n gevoel van onbevoegdheid in ’n mens se ouerskaprol veroorsaak (Mikolajczak 2018), wat die rigiditeit en teenstrydigheid in moeders se ouerskapbenadering kan verklaar.

Daarby presteer moeders laer betreffende die stresveranderlikes in vergelyking met vaders. Ouerskapstres by ouers van kinders met gehoorverlies word geassosieer met negatiewe uitkomste vir ouers sowel as kinders, wat insluit swak gehegtheid aan (“attachment”), minder positiewe ouer-kind-interaksie, sowel as ongelukkigheid in die huwelik (Asberg, Vogel & Bowers 2008). Een manier om hierdie bevindings te verstaan, hou verband met ouderdom (adolessente) en kindergeslag. Die resultate kan beteken dat hoe ouer die kinders is, hoe meer stres kan die moeders ondervind. Hierdie ouderdomsgroep is gekoppel aan adolessente-uitdagings soos liggaamsveranderinge, emosionele veranderinge en probleme, gedragsveranderinge en psigologiese probleme (Blakemore & Mills 2014). Pipp-Siegel, Sedey, Yoshinaga-Itano (2002) het in hulle studie oor voorspellers van ouerskapstres in moeders van jong kinders met gehoorverlies bevind dat moeders van ouer kinders meer stres gerapporteer het as moeders van jonger kinders as gevolg van hulle persepsie dat hulle kinders moeiliker as jonger kinders is. Maar hulle studie en ons studie kan nie vergelyk word nie omdat daar verskillende steekproewe (“samples”) betrokke was.

Ten opsigte van kommunikasie en ouerskapeffektiwiteit, dui die bevindings in die huidige studie op verskille in prestasie tussen moeders en vaders. Kommunikasieprobleme is geïdentifiseer as die hoofstressor vir ouers van kinders met gehoorverlies (Zaidman-Zait & Most 2005), veral wanneer die visuele behoeftes van ’n kind met gehoorverlies in aanmerking geneem word (Davids, Roman & Schenck 2018). Aanpassing om aan die kommunikasiebehoeftes van die kind te voldoen, kan ontwrigting veroorsaak in die interaksie tussen ouer en kind en ouerskaprolle en -verantwoordelikhede negatief affekteer (Tamis-LeMonda, Uzgiris & Bornstein 2002), veral as kinders tussen die ouderdomme van 10 en 17 is. ’n Redelike verduideliking vir die bevinding kan ook wees dat moeders dikwels die kommunikasieverantwoordelikhede in die huis aanvaar sodat daar gespreksinteraksie in gesinne kan wees om misverstande te vermy. Moeders word dikwels die effektiewe kommunikeerders in die gesin, maar moeders kan ook moeg word deurdat hulle voortdurend met hierdie verantwoordelikheid belas word (Luterman & Ross 1991).

Terselfdertyd word maatskaplike ondersteuning vir ouers en gemeenskapsinligting en hulpbronne geassosieer met ’n laer self-effektiwiteittelling by moeders as by vaders. Hierdie resultate sal aandui dat moeders dalk beperkte interaksies met ander ouers het, minder bewus is van inligting en hulpbronne, en baie min, indien enige, sosiale ondersteuning het. Studies toon dat moeders van kinders met gehoorverlies sosiale isolasie, eensaamheid en verlaagde vlakke van sosiale en intieme verhoudings ondervind (Lederberg & Golbach 2002; Jackson, Wegner & Turnbull 2010). Alhoewel daar gemeld is dat sosiale ondersteuning vir moeders belangrik is omdat dit betekenisvol bydra tot positiewe moeder-en-kind-interaksies (MacTurk, Meadow-Orlans, Koester & Spencer 1993), moet moeders se belewenis in aanmerking geneem word. Hierdie belewenisse kan onder andere insluit: voltydse werk, versorging van ander kinders, enkelouerskap en finansiële koste. Addisionele navorsing word aanbeveel om ’n beter begrip te kry veral rondom moeders en enkelouerskap van kinders met gehoorverlies.

’n Verdere verduideliking vir hierdie bevindinge kan gekoppel word aan die wyd verspreide armoede en ongelykheid wat ons nog steeds in Suid-Afrika ondervind (David, Guilbert, Hamaguchi, Higashi, Hino, Leibbrandt & Shifa 2018). Ongelukkig woon baie ouers in Suid-Afrika buite die geografiese areas van skole vir kinders met gehoorverlies, en buite geografiese areas van diensverskaffers. Dit maak dit vir moeders moeilik om op hul eie maatskaplike ondersteuning te kry. Twee of drie wyses van vervoer is gewoonlik nodig vir ouers om toegang tot diensverskaffers te verkry, terwyl die veiligheid van vroue ’n bykomende bekommernis is. Gebrek aan vervoer en groot afstande om te reis kan geloofwaardige verduidelikings wees vir moeders se gevoel van isolasie van ander ouers, min inligting of hulpmiddele en nie-deelneming aan maatskaplike ondersteuningsdienste. Moeders se lae prestasie in hierdie veranderlikes kan ’n aanduiding van hulle ondervindings wees.

Bykomende faktore wat kan bydra tot moederlike stres in hierdie huidige studie, is moeders se persepsie van die hoeveelheid ondersteuning wat hulle van lewensmaats of vaders van hulle kinders ontvang, en moet verder ondersoek word (Pipp-Siegel *et al*. 2002).

In teenstelling hiermee, het die studie van Zaidman-Zait, Most, Tarrasch, Haddad-Eid en Brand (2015) die verband ondersoek tussen middele om by te hou en ouerskapstres tussen moeders en vaders van kinders met gehoorverlies. Ten opsigte van verskille tussen moeders en vaders se sin vir self-effektiwiteit, het moeders hoër vlakke van ouerskapeffektiwiteit gerapporteer. Die outeurs dui aan dat die primêre betrokkenheid van moeders in die daaglikse sorg van hulle kinders, asook hulle deelname aan intervensieprogramme een aanvaarbare rede vir die bevindinge van hoër vlakke van self-effektiwiteit onder moeders is. Die studie was ook in staat om aan te dui dat vaders minder selfvertroue het as moeders wat betref hulpverlening aan hulle kind met gehoorverlies, wat strydig is met die huidige studie waarin vaders meer vertroue het in hulle vermoë om die daaglikse uitdagings van hulle kind met gehoorverlies te hanteer, vergeleke met moeders.

Gevolglik kan al die bogenoemde bevindings ’n mate van verduideliking bied vir die rigiditeit (“rigidity”) en teenstrydige stellings van dwang- en gestruktureerde ouerskapbenadering by moeders. Addisionele navorsing word aanbeveel om ’n beter begrip te kry van ouerskapuitputting met die grootmaak van adolessente met gehoorverlies.

Die bevindings het ook aan die lig gebring dat vaders hoër presteer in hul warmte en ondersteunende ouerskapbenadering as moeders. Net so toon die bevindings dat vaders betekenisvol hoër presteer in al die veranderlikes in verband met self-effektiwitet. Studies toon dat vaderbetrokkenheid by sorg, ontwikkeling, herkenning van en reaksie op die kind, en hantering van probleme sedert 1965 bykans verdriedubbel het (Teti & Gelfand 1991; Ingber & Most 2012; Zaidman-Zait, Most, Tarrasch & Haddad 2017). ’n Studie, uitgevoer deur Antonopoulou, Hadjikakou, Dagla, Maridaki-Kassotaki (2015), waarin die skakel tussen persepsies van ouerskaptipologie ondersoek word, het getoon dat adolessente met gehoorverlies hulle vaders as minder outoritêr en streng ervaar in vergelyking met adolessente wat kan hoor. Een aanvaarbare verduideliking vir hierdie bevindings in die huidige studie is dat vaders se interaksie met hulle kind met gehoorverlies van moeders s’n kan verskil. Die aard van interaksie kan verband hou met byvoorbeeld die hoeveelheid tyd wat vaders, in vergelyking met moeders, met hulle kind deurbring. Verdere duidelikheid oor hierdie bevindings kan verband hou met vaders se eie persepsie van hulle ouerskapbenadering en ouerskap-selfeffektiwiteit, en nie volgens hoe moeders vaders se ouerskapbenadering en self-effektiwiteit sien nie. Verdere navorsing is nodig om te verstaan wat die verskil is in die aard van interaksie van moeders en vaders wanneer hulle kinders met gehoorverlies grootmaak. Verdere navorsing is ook nodig om vaderbetrokkenheid in gesinne van kinders met ’n gehoorverlies te verstaan.

Ten slotte: kinders met ’n gehoorverlies bly ’n kwesbare groep in ons samelewing. Ouers vorm ook deel van hierdie kwesbare groep omdat hulle talle uitdagings ervaar en ’n hele aantal verhoudingsprobleme ondervind wanneer hulle hul kind met ’n gehoorverlies opvoed. Hierdie uitdagings sluit in ekstra emosionele eise op ouers en gesinne. Ouers en hul gesin kan byvoorbeeld meer sosiaal geïsoleer voel, wat die vermindering van hulle ondersteuningsnetwerke veroorsaak. Terselfdertyd ervaar ouers probleme met die tekort aan hulpbronne en ondersteuning wat dus gesinstresvlakke negatief kan beïnvloed.

Gevolglik bevat die studie ’n hele aantal implikasies en aanbevelings vir toekomstige navorsing en praktiese oorwegings. Dit maak voorsiening vir beter begrip van die genderverskille in ouerskapbenadering en ouerskap-selfeffektiwiteit in die grootmaak van kinders met gehoorverlies. Hoewel die bevindings aandui dat vaders hoër presteer in positiewe ouerskapbenadering en betekenisvol hoër as moeders in ouerskap-selfeffektiwiteit, moet daar gewaak word teen veralgemening van die studie, veral by die interpretasie van moeders se ouerskap-selfeffektiwiteit. Daar moet gelet word op die metodologiese beperkings van die huidige studie, spesifiek ten opsigte van die kwantitatiewe aard daarvan. ’n Gemengde metodologiestudie of ’n kwalitatiewe studie kan minder konsekwentheid toon, en kan verder bydra tot die begrip van ouers se interpretasie van mekaar se persepsies van ouerskap-selfeffektiwiteit. Hierdie studie is gebaseer op ouers wat hulleself beoordeel het ten opsigte van hulle eie ouerskapbenadering en self-effektiwiteit, en is nie gebaseer op observasies of ouers wat mekaar beoordeel nie, wat ’n sekere vlak van vooroordeel kan skep. Hoewel die steekproef en die lokaliteit van die steekproef beperk was tot skole in die Wes-Kaap en as ’n beperking van die studie beskou kan word, is daar min navorsing oor ouerskapbenadering teenoor kinders met gehoorverlies onderneem. Ons studie bied ’n begrip aan van die horende moeders en vaders se ouerskapsbenadering teenoor hul kinders met gehoorverlies en beklemtoon die noodsaak van ’n omvattende benadering om die kompleksiteite van hierdie ouers te beoordeel.

Hierdie benadering stel die ontwikkeling van ouerlike intervensies voor wat die uiteenlopende behoeftes van horende ouers aanspreek. Dergelike ouerlike intervensies sluit maatskaplike dienste in wat spreek tot spesifieke kennis en vaardighede betreffende gehoorverlies, veral in kinders. Maatskaplike dienste sluit in emosionele en sosiale ondersteuning en die fasilitering van ouer-groepsessies waar ouers die geleentheid kry om met ander ouers kontak te maak en hul ervarings met ouerskapbenadering te deel.

6. SAMEVATTING

Samevattend word gekonstateer dat hierdie studie bydra tot die literatuur oor ouerskap van kinders met gehoorverlies. Ons resultate ondersteun die ontwikkeling van spesifieke intervensies vir moeders en vaders van kinders met ’n gehoorverlies. Die resultate van hierdie studie kan ingesluit word by die riglyne vir die beplanning van ondersteuning vir horende ouers van kinders met ’n gehoorverlies en kan as ’n effektiewe instrument vir verandering gebruik word.

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CHAPTER 6: FINDINGS: QUALITATIVE INQUIRY

CHALLENGES OF HEARING PARENTS WHEN PARENTING A CHILD WITH HEARING LOSS

Davids, R.S., Roman, N.V. & Schenck, C.J. (2020). The challenges experienced by parents when parenting a child with hearing loss. Journal of Family and Social Work (Accepted)

6.1 Introduction

Chapter 5 comprises Stage 3 of the last stage of Phase 1. It presents objective 4 of the study which was to *explore the challenges and social needs of hearing parents parenting children with a hearing loss*. A qualitative exploratory-descriptive study was conducted with the hearing parents recruited using the purposive sampling method. Four themes emerged from the study, namely, 1) communication is difficult, hard, limiting and frustrating, leading to feelings of guilt and shame; 2) lack of information about hearing loss makes it difficult to parent; 3) lack of support for parents makes it difficult to parent a child with hearing loss, and 4) support as described by parents for parents. The findings of the study contributed to the recommendations for the development of guidelines for hearing parents parenting children with hearing loss.

6.2 Publication details

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Status	Accepted
Permission from Journal/editor to use in the PhD thesis	**Correspondence with the editor on the 17th March 2020 and on the 6th of April 2020.** Hi Ronel, Yes, you can use this publication for your work, as long as it is an academic exercise and not available as a publication in a published book or another journal. You also need to provide a note on the title page that this paper was published in.... and provide the correct information. Hope that helps, Judy Judith Siegel, Ph.D., L.C.S.W. Professor Editor-in-Chief, Journal of Family Social Work Coordinator Post Masters Certificate Program in Child & Family Therapy Coordinator Post Masters Online Certificate in Advanced Assessment and Diagnosis (212) 998-5949 (914) 381-0407

6.3 Journal of Family Social Work

Aim and scope of the Journal obtained from the Journal website.

"The Journal of Family Social Work contains peer-reviewed research articles, conceptual and practice articles devoted to innovative family theory and practice subjects. In celebrating social workers' tradition of working with couples and families in their life context, the Journal of Family Social Work features articles which advance the capacity of practitioners to integrate research, theory building, and practice wisdom into their services to families. It is a journal of policy, clinical practice, and research directed to the needs of social workers and other mental health and family practitioners who work with couples and families. The Journal of Family Social Work makes a unique attempt at balancing clinical relevance and academic exactitude. By uniting clinicians and researchers from social work, family enrichment, family therapy, family studies, family psychology and sociology, health and mental health, and child welfare, it stresses a blending of sociocultural contexts, the uniqueness of the family, and the person of the clinician. As an interdisciplinary forum, it provides a creative mixing of clinical innovation, practice wisdom, theory, and academic excellence". Retrieved from the website: https://www.tandfonline.com/toc/wfsw20/current.

6.4 Conclusion

The Editor-in-Chief and reviewers believed that there was considerable merit in the research study. Overall, the findings highlight the challenges that contribute to the experiences of hearing parents parenting children with a hearing loss. They provide an understanding of the complexities of these challenges and emphasise the need for parent-child and family interventions. They underscore the importance of the multidimensionality of support for parents and contribute to the development of interventions that address the diverse needs of parents. This research is an extension of previous research conducted on challenges experiences by parents, and draws upon some of the principles relating to the "Best Practice in Family–Centred Early Intervention for Children who are Deaf or Hard of Hearing" which sets out to promote the implementation of endorsed evidenced-based principles for family-centred intervention with families and children with hearing loss (Moeller, Carr, Seaver, Stredler-Brown, & Holzinger; 2013).

This is the final document that was submitted and accepted. It is written in the format and language as submitted to the Journal of Family Social Work:

Title: The challenges experienced by parents when parenting a child with hearing loss

ABSTRACT

The purpose of the current study is to explore the communication, information and support challenges experience by hearing parents, parenting a child with hearing loss. Using a qualitative purpose sampling design, interviews were conducted with 13 parents (9 mothers, 4 fathers), residing in Cape Town, South Africa. Four salient themes emerged, namely:

1) communication is difficult, hard, limiting and frustrating, leading to feelings of guilt and shame
2) lack of information about hearing loss makes it difficult to parent;
3) lack of support for parents makes it difficult to parent a child with hearing loss
4) support as described by parents, for parents.

The findings of the study have important implications for the collaboration and partnerships between parents, health and family practitioners, for the design and development of supportive interventions for parents, and children with hearing loss.

Keywords: hearing parents, a child with a hearing loss, challenges, experiences

Introduction

90% of all children, with a hearing loss, are said to be found in the developing world, with an estimated total of 32 million children; with the greatest prevalence (70 %) in South Asia, Asia Pacific, and Sub-Saharan Africa (World Health Organisation (WHO), 2012). In South Africa, there is a lack of data on the prevalence of hearing loss (Ramma & Sebothoma, 2016). The prevalence of hearing loss among children is four to six, in every 1000 infants, in the public health care sector (Swanepoel et al., 2009). More recently, studies specifically related to prevalence of hearing loss in the Cape Town Metropolitan area, the geographical location of this study, found that 11.4% of 174 children aged 0–3 years and 4.3% of 430 children aged 4–9 years, presented with hearing loss (Ramma & Sebothoma, 2016). While research suggests that the majority of children with hearing loss are born to hearing parents, who often know very little about child hearing loss (The Galluadet Research Institute (GRI), 2012), there are few reported interventions targeting parents of children with hearing loss in South Africa (Chan, 2018). The lack of data on the prevalence of child hearing loss and in the absence of national consensus on the statistics in relation to how many hearing parents have children with hearing loss in South Africa, makes it difficult to plan adequately for interventions and services aimed at parents.

To date, we have found only two reported intervention and support programmes for parents in South Africa. These support programmes for parents are offered and facilitated by an organisation known as “Thrive”. Thrive is a parent support and advocacy group who provides family, and early intervention for parents of children, with hearing loss, in South Africa. One of their main programmes is the parent mentorship programme. This programme is offered by parents who have accepted their parenting journey, who have an unbiased approach and can walk alongside other parents on their journey, of parenting a child with hearing loss.

A further intervention programme known as “HI HOPES” (an acronym which stands for Home Intervention Hearing and Language Opportunities Parent Education Services) - the first South African home-based early intervention project—was launched in August 2006, offers parents and families weekly homebased support that is both child-centred and family-directed. This programme was offered due to the lack of support for the family of infants, with hearing loss, in South Africa. However, these programmes are only offered in parts of the country, and therefore the need for similar programmes throughout other parts of South Africa have become apparent.

Therefore, given the importance of the parent-child relationship within the family, a better understanding of the challenges experienced by parents, parenting children with a hearing loss, is needed. Exploring some of the challenges that shape these parents’ parenting experiences, is a valuable step in the process of providing support and gaining knowledge. Such insight can provide much needed support for parents and families, with the intention of growing knowledge, and providing intervention in the emerging field of social work and disability.

Parenting a child with hearing loss presents unique challenges for hearing parents. For these parents, the extra demands of raising a child with hearing loss, can affect the overall development of the child, and can seriously influence the quality of parent-child relationships, family acclimatisation to the child’s hearing loss, and how the family copes (Calderon, 2000). Increased time demands, uncertainties about parenting and limited access to supportive services have previously shown, to influence, how families cope with a child with hearing loss (Jackson et al., 2008). A number of studies have indicated parents’ need for: 1) support and participation in parent-to-parent networks (Jackson et al., 2008), 2) unbiased assistance with communication options; and 3) multifarious information (Jamieson et al., 2011; Most & Zaidman-Zait, 2001).

Challenges:

Firstly, research shows that strong social support can act as a protective mechanism against parental stress, provide emotional support (that is, encouragement, praise and understanding) and may contribute positively to the coping and well-being of hearing parents of children with hearing loss (Asberg et al., 2008; Zaidman-Zait, 2007; Lederberg & Golbach, 2002). These studies suggest that strong social support from family members and close friends, have assisted parents to mitigate the negative effects of parenting a child with hearing loss. Parents with strong social support are able to manage challenges more effectively, compared to families with few social support (Dunst & Trivette, 1994). The findings of Asberg et al's. (2008) study showed that support can provide parents with significant life satisfaction, as well as lower levels of stress, when parenting a child with hearing loss.

Over the years there has been a growing body of evidence showing that parents have expressed a need for additional support to connect, and have discussions with other parents, who are also parenting children with a hearing loss (Jackson 2011). Some research has shown for example, parent-to-parent support provides positive assistance in managing the needs of parents (Mathiesen et al., 2012; McHugh et al., 2013; Olin et al., 2014; Wright & Wooden, 2013). Further results of a study conducted by Jackson et al. (2010) examined parents' perceptions of parents' quality of life after their child was identified with hearing loss, found that only one third of their participants, reported participating in any kind of parent support. The results showed that there was a need for additional support among the parents. Further results from studies conducted by Jackson (2011), Jackson et al., (2008) and Friedman Narr and Kemmery (2015), show that parents frequently have a need to talk to someone, someone with whom they can identify with regarding their experiences. Likewise, to connect with parents who can act as parental mentors, who are able to better meet the parents' needs, both personally and emotionally when empathising and conversing about their own experiences through the mentoring relationship.

Secondly, parents have identified and described communication difficulties as one of the main challenges contributing to the experiences of parenting a child with hearing loss (Zaidman-Zait & Most, 2005). A study conducted by Magnusson, (2000) shows that the majority of children with a hearing loss are born to hearing parents, and that a shared communication mode between parent and child, is often non-existent. Humphries et al.'s (2018) study on support for parents, have identified common questions regarding communication challenges posed by parents. These questions included, for example, whether parents must teach their child sign language, or whether parents must learn sign language. Although the answers to these questions were intended to assist professionals as they advise and counsel parents, these questions serve as an important source of information for parents, who have similar questions.

However, regardless of the mode of communication parents adopt, a child with a hearing loss presents unique communication challenges for hearing parents (West, 2012), as replacing learned communication practices, with new approaches, can be challenging. Learning a new language as an adult can be time-consuming, likewise challenging a parent's sense of competence (McKee, 2006). For these reasons, parents have often described communication as frustrating, difficult and demanding, causing ineffective communication and a strain on interactions (Freeman et al., 2002). Disruption in the interaction between parents and children affects parenting roles and responsibilities negatively if there is difficulty in adopting new approaches, to meeting the communication needs of a child (Tamis-LeMonda et al., 2002). In addition, parents who struggle to adjust to the communication needs of their child, from an early age, may find it difficult to communicate with the child as he/she grows older, as they realise that their expectations of the child's capabilities are different to the child's actual abilities (Quittner et al., 2010). Blose and Joseph (2017) observed the nature of communication across typical daily contexts of a child born into a hearing family in South Africa, with no prior experience of sign language. The case study design, which included quantitative and qualitative components, showed that there was a gap in the communication mode at home, and described communication interaction between parent and child as limited, poor, mainly oral and with constant breakdowns.

On the other hand, studies describing the perceptions of the communication experiences of deaf adults growing up in hearing families, found that deaf adults reported to having limited access to contextual learning opportunities in families, while growing up. These contextual learning opportunities were non-existent for deaf children in conversations at family mealtimes and family outings, for example, as parents were unable to communicate with their children in sign language (Hall et al., 2018). A further study conducted in Cyprus by Hadjikakou and Nikolaraizi (2008) showed similar results. The authors conducted interviews with 24 deaf adults, between the ages of 19 to 54 years, with different family and school backgrounds. Their study found that from an early age, deaf adults experienced negative communication at home and could not communicate orally, or in sign language, with their parents. The study recommended that, regardless of the modality of communication between parent and child, early and mutual modes of communication between the family and the child be encouraged, thus ensuring amiable family communication interchanges, and experiences. Personal accounts provided by deaf adults, who have experience of communication struggles when growing up in a hearing family, can assist with understanding, and offer useful information for both parents and families, and can assist health and family practitioners to develop valid intervention.

Thirdly, the provision of information with regards to parenting a child with hearing loss, has contributed to parents feeling more confident and sensitive in their parenting practices towards their child's needs, as some hearing parents may feel inadequate and may see themselves as ineffective in their parenting role (DesJardin, 2003). The provision of information can build parents' confidence in their ability to raise and parent a child with hearing loss (Bemrose, 2003), thereby transforming their own parent identity (Young, 2003). Reliable and accurate information, strengthens parents to provide the necessary support for their whole family to function. It can contribute to parents' ability to cope, and can assist in the decision-making process, so that parents can become active in their role in child management (Zaidman-Zait & Jamieson, 2004 and Young, et al., 2005). Besides, information can assist parents to answer issues such as, "How do I parent a child with a hearing loss?", and "If only I was provided with the correct information.", which would then facilitate better understanding, and enhance parent-child relationships.

A study conducted by Zaidman-Zait and Jamieson (2004) states that there has been little documented about the need for information and guidance for parents of children with hearing loss. The findings of their study pointed to four areas of concern for parents, namely; parents' need for various types of information, including the need to know how their child develops; parents' need for a family-centred approach to service provision; parents' apprehension about education and future opportunities of their child; and worrying about parenting children with hearing loss, who have additional needs. Furthermore, a study conducted by Young (2003), on investigating parenting of deaf children, observed that parents found it difficult to access information, which impacted considerably on their experiences of parenting. They recommend that parents be provided with information on parenting a child with hearing loss during the early stages of their life, so that by the time the child reaches adolescence, parents may be viewed as experts who then, in turn, could provide parental information, and support, to other parents, in a similar situation. Likewise, Henderson's (2015:38) study, provides evidence of 29 research studies, indicating that parents would benefit from information that is "accurate, well-balanced, comprehensive, and conveyed in an unbiased manner". However, their study also showed that parents had received inadequate, out-dated, biased and incomplete information from their child's specialists.

Research also shows that families are turning to the internet to access information about hearing loss. The internet allows parents to find information quickly, easily, and conveniently in the privacy of their home, and can assist parents in making informed decisions (Porter & Edirippulige, 2007). A study conducted in Australia by Porter and Edirippulige (2007) on parents seeking hearing- loss related information on the internet, confirmed that parents continue to search for information on the internet throughout the lifespan of their child, and are likely to participate in online support groups.

Therefore, the purpose of the current study is to explore the challenges of communication, information and social support experience by hearing parents, when parenting a child with hearing loss.

Method

Study setting

The research study was conducted in Cape Town South Africa.

Study design and participants

A qualitative research methodology was implemented to gain insight into the challenges hearing parents experience, when parenting their children, with hearing loss. The challenges experienced by parents were viewed as the central phenomenon requiring exploration and understanding, as qualitative research aims to provide an in-depth understanding of the social world of the participants, by learning about their experiences and perspectives (Ritchie & Lewis, 2003:16). Therefore, our study provides an understanding of how hearing parents experience and interpret these challenges, when parenting a child with hearing loss.

Purposive sampling was used to select the participants for the study. Participants were recruited using two techniques: (1) approaching three local organisations of the deaf to assist with providing names of parents who attended their parenting programmes; (2) participant referral snowballing technique, whereby participants knew of other parents who may be interested in participating in the research study, and had a similar experience to theirs (Babbie, 2010).

The population for the study was hearing parents of children with a hearing loss. A total of 13 parents, between the ages of 35-55 years, participated in the research. Participants consisted of nine hearing mothers, and four hearing fathers, of a child, with hearing loss between the ages 10 and 16. Originally 15 parents agreed to participate in the research study, however during the course of the research study, two fathers declined participation citing work commitments. None of the participants who participated in the research study were related.

The following table reflects the demographic profile of the hearing parents, regarding their parental experiences, when parenting a child with hearing loss.

Table 1 Demographic details of the participants

Pseudo name	Parent Gender:	Marital/ Status	Race	Employed	Age of Child	Gender of Child	Position of deaf child in family	Type of hearing loss	Cause of hearing loss
A	Female	Divorced Age 55	Mix race	Yes	16	Female	Eldest	H/H	Meningitis
G	Female	Married Age 40	Mix race	Yes	13	Male	Eldest	Profoundly Deaf	Unknown
T	Male	Married Age 42	Mix race	Yes	14	Male	Eldest	Profoundly Deaf	Unknown
M	Male	Married Age 38	White	Yes	13	Female	Eldest	H/H	Ear infection
C	Female	Married Age 40	Mix race	Yes	13	Female	Eldest	H/H	Ear infection
A	Female	Single Age 40	Black	No	16	Female	Only child	H/H	TB treatment
N	Female	Single Age 44	Black	Yes	14	Male	Eldest	H/H	Unknown
L	Female	Married Age 46	Mix race	Yes	13	Female	Youngest	Profoundly Deaf	Meningitis
F	Female	Married	Mix race	No	12	Female			Unknown

		Age 51					2nd youngest of 5 children	Profoundly Deaf	
D	Male	Divorced Age 38	White	Yes	14	Male	Eldest	H/H	Unknown
B	Male	Divorced Age 43	Mix race	Yes	14	Female	2nd daughter of three children	H/H	Unknown
J	Female	Married Age 43	White	Yes	11	Female	Youngest of 3 children	Profoundly Deaf	Unknown
K	Female	Married Age 44	White	Yes	10	Male	Youngest of 2 children	Profoundly Deaf	Unknown

Data collection

Data were collected via semi-structured interviews with the aim of understanding the challenges and social needs from the perspectives of the parents. Interviews were conducted at the homes of parents, and ranged in length between 45 to 60 minutes. Written informed consent was obtained from all participants included in the study. Participation was voluntary. The following interview questions were asked, which focused on parents' challenges and social needs: (1) tell me about your experience of parenting a child with hearing loss; (2) tell me about the communication, information and social support challenges you experience when parenting your child with a hearing loss; (3) tell me how these challenges affect your experience as a parent of a child with hearing loss; and (4) what kind of support do you think parents need to assist them in their parenting role, when parenting a child with a hearing loss?

Ethical clearance was obtained from the University of the Western Cape's Senate Research Committee, before the research commenced. All ethical considerations were adhered to, including confidentiality and anonymity of participants.

Data analysis

Thematic data analysis which identified themes, relationships and dynamics within the findings (Carey, 2012) was applied. Participant's names were removed and replaced with pseudonyms. The analysis of data was conducted by an independent coder, who was not involved, or familiar with the study. Further credibility of the data analysis was done by the two study supervisors.

Results

Four major themes emerged from the data analysis: (1) communication is difficult, hard, limiting and frustrating, leading to feelings of shame and guilt (2) the lack of information about hearing loss makes it difficult to parent, (3) the lack of support for parents makes it difficult to parent a child with hearing loss; and 4) support as described by parents, for parents.

Theme 1: Communication is difficult, hard, limiting and frustrating, leading to feelings of guilt and shame

Parents cited communication as the main challenge between themselves and their child with a hearing loss. Parents described how communication challenges affected their parenting abilities as; difficult, hard, and frustrating. They found their communication skills in sign language limiting, which made them feel ashamed and guilty. These are evident is the following comments made by parents. The following five quotes from parents illustrate their communication difficulties: "It is so difficult to communicate with her…. Communication is really hard….The communication is a big problem with us…..It is hard to explain it to her in her language. I do not always know how to communicate with her….". One parent reported how she and her child were living pass each other, as they experience difficulty in communicating with each other: "Communication is difficult, we live so past each other…

The following quotes demonstrates parents' limited ability to converse with their children in sign language causing difficulty and frustration in disciplining their children, affecting their parenting roles and responsibilities negatively: "I don't know sign language and I don't know how to explain things to him/her". "Often the conversations were limited to yes" or no responses…, *"*It is also about the day-to-day communication, the signs that we don't know…… I cannot explain things to her….All she says is yes or no, and it has no relevance to the conversation". "It's all about communication, it makes disciplining her very frustrating and difficult."

Four parents felt guilty and ashamed, as they experienced communication difficulties in sharing their family ideologies' such as family culture and family religion' with their children, evident in the following quotes; "How do I explain our culture to her, I feel ashamed that I can't communicate it to her……He doesn't know our way of life, the school he goes is different to our faith...I feel so guilty, how do I communicate this (our way of life) to him?"

Theme 2: Lack of information about hearing loss makes it difficult to parent

Participants reported lacking information and understanding about their child's hearing loss in general. They explained that they had very little knowledge and specific information pertaining to their child's hearing loss, which made parenting difficult: four examples of these descriptions are as follows:" Understanding her deafness is the major issue … Not knowing anything about it… Not knowing about deafness and her own deafness…..Basically, I know nothing about deafness and this makes parenting difficult*"*. One parent felt that parents should be provided with information from an early stage to assist them on their parenting journey, which could contribute to better understanding, resulting in easier parenting: “If we are told or given information from the start what this journey will be all about, then maybe it would make parenting easier*... ”*. Most parents did not know the cause of the child’s hearing loss, or did not have any information on the aetiology of their child’s hearing loss, often stating during our interviews that: “No one in the family is deaf”. One parent commented that they wanted deaf specific information on how their child became deaf, which could have eased their parenting experiences and helped them with their parenting experience:” All of this information on how she became deaf is important, it will help to be better parents*... ”*. Two fathers in particular experienced difficulty in attending any support programmes, due to their working hours, and sited that accessing information about hearing loss on the internet, was easier for them. They felt the need for new online applications to assist parents in obtaining information: *“*I go online sometimes for information to learn about my child’s hearing loss as I don’t have time for these meetings due to work commitments. They need to develop new google apps for parents, so we can access information, for example, on communication as I don’t really have time”.

Theme 3: The lack of support for parents makes it difficult to parent a child with hearing loss

Some parents reported feeling isolated by family members because of nasty comments and negative attitudes towards their child’s hearing loss. They felt secluded and lonely. Three parents commented on the negative attitudes and comments made by their family members, and by parents who openly denied their child with a hearing loss, because hearing loss was never experienced in their family:” Family members are nasty and don’t accept him because he can’t hear. “In my family, my mother chased me away and she said that the child can’t be using hearing aids because that has never happened in the family.*”* Another mother described how her son’s father did not accept him, based on his belief that deafness is not a heredity in his family:” He (father) said it’s not his child as he said in the family we don’t have things (hearing loss) like this…”

Seven of the nine mothers stated that they felt alone and isolated, with very little support from friends, the community, family members or even professionals, making parenting a child with a hearing loss more difficult, as evident from their following quotes:” I feel isolated as a parent…. I was alone for years I had to walk this road alone …There was no support, it is difficult …Sometimes I feel alone in doing all of this. …The thing is we as parents don’t have much support…There is no community support, no family support, no one to assist each other… There is no help from professionals who knows about deafness….”

Theme 4: Support as described by parents, for parents.

A fourth theme was identified where parents made recommendations for support, to minimise their adverse experience, in relation to parenting a child with hearing loss. Parents suggested that a support group would minimise feelings of isolation, provide parents with opportunities to share and learn from each other’s experiences, as evident in the quotes by a few parents:” …. Support…then parents don’t need to experience everything alone… As parents we need support groups…., We can learn from each other and talk about our experiences… Parents can come together to share. *”* All four fathers stated that there should be support groups specifically for mothers including social media groups for mothers accommodating those who live far: ”A mother support group, …..This will be good for the mothers then they don’t need to experience everything alone… supportive group on WhatsApp…. What about a WhatsApp group for mothers to support mothers if they live far.... *”*. Another father suggested a social media (WhatsApp) support group for mothers with a social worker as well “What about a WhatsApp group for mother with a social worker”. Parent too suggested the need for counselling for parents and for their child with a hearing loss, while another stated they needed support with communicating with their child, as they felt isolated from their child with a hearing loss "……. there is no counselling for deaf children and us, we need it….we need support with communicating with our children as we feel isolated from them…"

Discussion

The aim of the current study was to explore the challenges experienced by hearing parents when parenting a child with hearing loss. The analysis of the responses provided by the parents generated four themes in relation to the challenges parents' experience. These themes describe the practicalities of parents' communication challenges, their lack of information and support, and provides a description of what kind of support parents would like to receive, when parenting a child with hearing loss.

Firstly, the findings in the current study are consistent with previous research conducted by Freeman et al. (2002) and Hintermair (2000), who reported that daily interaction, involving communication between parents and a child with hearing loss, leads to frustrations, communication difficulties and negative relations. The findings show that parents experience difficulty in meeting the communication needs of their child, affecting both parenting roles and responsibilities negatively (Tamis-LeMonda et al., 2002). The findings are also consistent with those reported by Petersen (2001) and Marschark (2007), as they show parents experiencing difficulties in learning sign language to improve communication and interaction with their child with a hearing loss, which could lessen feelings of guilt and shame, experienced by parents. The study shows parents' limited abilities to communicate with their children, which left parents feeling guilty and ashamed. Feelings of guilt and shame may lead parents to feeling insecure about their lack of skill in communicating effectively with their child, which may have far reaching implications for effective parenting (Mason & Mason, 2007). Examples of these communication difficulties are found in the current study where parents described their desire to communicate and share their family ideologies, such as family religious practices and family culture, with their child, who has a hearing loss. These ideologies are normally passed down from generation to generation, and may exclude a deaf child, due to communication difficulties. These ideology speaks to a family’s cultural identity, as described by Young (2002: 6) specifically, referring to a family’s “preferred language, value systems, religious affiliations, class background, and socio-economic status”. Often children with hearing loss adopt a new language and culture that is outside the context of family norms, especially when they are attending, and boarding, at schools for the deaf. The findings would suggest that the separation of the two worlds are further widened as communication difficulties make it harder for these two worlds to be understood (Munoz-Baell & Ruiz, 2000).

Secondly, the need for diverse information about hearing loss, as part of making good decisions on behalf of their children and to parent effectively, was also singled out as a challenge for parents. Although literature indicates that there is a great amount of information available for parents and professionals, to make effective choices for their child with a hearing loss (DesJardin, 2016), the findings of the current study show parents’ lack of information, their lack of knowledge and understanding about their child’s hearing loss, making their parenting experience challenging and difficult. Our study is therefore consistent with the findings of Henderson’s (2015) study indicating that parents would benefit from information that is comprehensive and accurate; and that information can help parents to be more pragmatic in their expectations of themselves and their children, and in so doing, are more likely to act in developmentally appropriate ways with their children (Bornstein et al., 2003).

Further research on support indicates that families who receive strong social support, are better placed to handle challenges more effectively (Dunst & Trivette, 1994). Our study shows that parenting a child with hearing loss can be a lonely experience, especially when it is done by a single parent, or with no support from family. Our findings are consistent with studies conducted by Lederberg and Golbach (2002) and Jackson et al. (2010) that have shown that parents experience social isolation and loneliness when parenting a child with hearing loss. Some family members, or even one parent, may distance themselves in reaction to their fears about the disability, leaving one parent or family member alone with the caregiving responsibility. Some families may struggle to accept a child's hearing loss, based on their own beliefs about disability (Marshak & Seligman, 1993). A parent's view of disability may see them experiencing a personal conflict between their beliefs about a disability, and having a child with a disability. Stigmatisation and stereotyping still exist today, adding to exclusion and isolation of parents, children with disabilities, and even families. Our study found that mothers in particular experienced isolation, stigmatisation and blame from family members, diminishing their sense of communion and community (McDaniel & Pisani, 2012).

Thirdly, the finding also highlighted recommendations made by parents for social support groups to meet other parents, who experience the same challenges as them. Connecting with other parents with similar experiences can empower parents and build their confidence. Knowing that you are not alone is a huge step towards parent empowerment. (Sexton, 2017). Creating and supporting opportunities, to bring parents together, help them create their own support communities. These findings are similar to the findings of Henderson (2015), Jackson (2011), Jackson et al. (2008) and Friedman Narr and Kemmery (2015), which advocate for the needs of parents to be met via programmes, such as parent- to- parent support, or parent mentoring programmes.

Findings from our study would suggest, like Decker et al. (2012) and Porter and Edirippulige (2007) that parents are looking at alternative ways of providing and obtaining professional support, via the social media (internet and WhatsApp) platform. This area of support for parents needs further exploration, especially in terms of seeking the correct information, which may be parent, child and family specific. These findings proposes further exploration of the effective use of such formal and informal support for parents, and with professionals, which includes the exploration of ethical boundaries for professionals.

In summary, a strength of the study includes the diversity of parents who participated in the study, as participants were parents of children who attended different schooling systems (oral and signed), and used different amplification (hearing aids and cochlear implants). However, the sample size is a limitation and therefore generalization of the findings should be avoided, as the findings of the study cannot assume to be representative of all parents' experiences; when parenting a child with hearing loss.

Implications for practice

The overall findings reinforced the importance of formal and informal support for parents. Formal and informal support include professional and social support, which speaks to specific knowledge and skills in the field of hearing loss and parenting. Implications for practice would suggest that there should be a collaborative approach to the rendering of these services by professionals, encouraging family centred interventions that address the challenges parents and families face, when parenting a child with a hearing loss. It is important that practitioners, for example, social workers working within the field of deafness, to understand the challenges experienced by parents, and work to promote multi-disciplinary practices and collaboration. Multi-disciplinary practices and collaboration are usually drawn from fields of social work, audiologists, deaf professionals, intervention programme leaders, parent mentors and researchers who should be trained, and involved in local communities of the deaf. Part of these collaborative services provided to parents should include parent social and emotional support, where parents are connected to support systems, so that they can receive the necessary information, knowledge and understanding that can enable them to function effectively as parents, as well and promote the well-being of parents and family (Moeller et al., 2013). For example, part of social work services may include a parent support group intervention model, which would assist parents in managing their difficulties of parenting a child with hearing loss. The group activities may include focusing on parents' individual experiences, and providing parents with an opportunity to speak about difficulties. A parent-to-parent support group creates an environment of shared information, where parents can learn about communication options, best practice, new research, technological advancements and amplification options (Henderson, 2015). Based on this research study, deaf mentor programmes can be offered to parents. These mentor programmes can assist parents and families in understanding their child's journey, and introduce mentors, who act as role models to parents, and who have walked, or are walking, the same journey.

Moreover, the influence of information, particular from health and family practitioners, has been acknowledged (Eleweke & Rodda, 2000). Practitioners can assist parents to gain the necessary information and knowledge, whereby parents can make informed decisions that are beneficial for them and the family (Moeller et al., 2013). Information provided by health and family practitioners can allay hearing parents' feelings of fear and guilt; and assist them in accepting their child with a hearing loss. Practitioners can provide parents and families with the aetiology for example of their child's hearing loss, which can assist them to change from a "fix what is wrong" to "build what is strong", perspective (Duckworth et al., 2005:3).

Similarly, computer and internet technology can be beneficial to parents, in order for them to access on-line information and support. This would include building a network of formal and informal parent support, via the social media (Facebook, WhatsApp). Formal support allows parents to connect and communicate with professional in the field of deafness, who can provide parents with unbiased information. Social media allows parents also to connect with other parents, re-enforcing mutual support among each other.

Further, this study holds scholarly significance for those within the larger disability field, and within the field of social work. Having explored the challenges and support needs experiences by hearing parents, these findings may stimulate additional explorations of deaf adults' experiences of being parented by hearing parents, or explore how families from diverse cultures process their journey raising a child with hearing loss, thus adding to the suggestions for training, and documenting support provided to parents.

There is also potential for this study to influence policy issues in South Africa pertaining to the crucial need for parental support. Supporting parents' makes a difference, but only where policies and programmes are responsive to parents' needs, especially when parenting a child with a disability. If research (Henderson, 2015, Jackson, 2011, Jackson, et al., (2008) and Friedman Narr & Kemmery, 2015), shows there is a need for parenting support for parents parenting children with a hearing loss, then it is inevitable that government should design and facilitate these programmes If this study shows parents' desire to communicate with their children, their need for diverse information and need for support, then, in essence, the study has shown the need for interventions for parents parenting children with hearing loss. The study too has shown that strong interventions require collaboration and partnerships with parents and organisations. These partnerships can assist parents with the provision of parenting skills and linking parents with relevant services, parenting programmes and where necessary, for expert intervention.

Conclusion

Overall, our findings highlight the challenges and social need of hearing parents parenting children with a hearing loss. They provide an understanding of the complexities of these challenges and emphasize the need for parent and family interventions. This research is an extension of previous research conducted on challenges experiences by parents, and draws upon some of the principles relating to the "Best Practice in Family –Centred Early Intervention for Children who are Deaf or Hard of Hearing", which sets out to promote the implementation of endorsed evidenced-based principles for family-centred intervention, with families and children with hearing loss (Moeller et al.; 2013).

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CHAPTER 7: SECTION A: A CONSENSUS WORKSHOP

THE DEVELOPMENT OF GUIDELINES FOR HEARING PARENTS PARENTING CHILDREN WITH HEARING LOSS: A CONSENSUS WORKSHOP

7.A1 Introduction

Chapters 4, 5 and 6 presented the research that was conducted in Phase 1, comprising the three stages of the study. In this chapter, a consensus workshop was conducted, completing objective 5 of the study, which was *to develop and design guidelines for hearing parents parenting children with a hearing loss*. The consensus workshop was conducted from the findings of the previous chapters – Chapters 1, 2, and 3. Prior to the consensus workshop, the research drafted the first set of proposed guidelines emanating from the findings of the three previous chapters. In Round 1, a pilot study was conducted with a panel of experts to reach consensus on the recommended guidelines drafted by the researcher and to make any further recommendations. In Round 2, a consensus workshop was held with stakeholders, also to reach consensus on the first draft of guidelines emanating from the findings of the previous chapters and pilot study conducted with the panel of experts. Once consensus was reached, the researcher drafted the final guidelines into a framework of guidelines for hearing parents parenting children with a hearing loss.

Section A has been submitted for publication to the African Journal on Disabilities and was therefore written in article form according to the aim, scope, and format of the Journal.

7.A2 Publication details

Title	The recommendations for the development for guidelines for hearing parents parenting children with a hearing loss
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7.A3 African Journal on Disabilities

The articles in the African Journal on Disabilities "yield new insight into established human development practices, evaluate new educational techniques and disability research, examine current cultural and social discrimination, and bring serious critical analysis to bear on problems shared across the African continent". Retrieved from the website: https://ajod.org/index.php/ajod/pages/view/journal-information

7.A4 Conclusion

The aim of the study was successfully realised by employing a consensus workshop to achieve agreement on four broad recommendations (4 themes and 16 sub-themes) on specific themes to complement the research on: The development of a framework for guidelines for hearing parents parenting children with hearing loss: A consensus workshop.

These recommendations have the potential for partner collaboration between parents, professionals, and organisations. An ideal environment is where parents, professionals, and organisations of the Deaf work together to enhance parent capacity, support parent skills, and take appropriate action to enhance the opportunities and outcomes of children with a hearing loss in a hearing world.

TITLE: DEVELOPING A FRAMEWORK FOR GUIDELINES FOR HEARING PARENTS PARENTING CHILDREN WITH HEARING LOSS USING A CONSENSUS WORKSHOP

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Title: Developing a framework for guidelines for hearing parents parenting children with hearing loss using a consensus workshop

Background: For many hearing parents, parenting children with a hearing loss can be challenging. The individual needs of parents vary greatly. In this regard, many studies have highlighted parents' multifaceted need for support and unbiased information. Solutions to address these needs can be developed in participation and collaboration with parents and professionals in the field of hearing loss. With the aforementioned in mind, the aim of this study was to develop a framework for guidelines for hearing parents parenting children with a hearing loss using a consensus workshop design.

Objective: The objective of the study was to engage with panellists of experts and stakeholders to achieve consensus on a set of recommended guidelines by identifying, deleting, and adding themes, receiving clarity on terminology, and language usage resulting in a framework for guidelines.

Method: A two-round consensus workshop design was implemented. Experts working in the field of child, family, and disability studies who have relevant expertise at the research, clinical and policy level, were invited to participate in round 1. Stakeholders within the field of hearing loss were invited to participate in round 2. After each round, the responses from the two panellists were collated, interpreted, and developed into a framework for guidelines.

Results: Consensus was reached on the final 4 themes and 16 subthemes to be included in the framework for guidelines.

Conclusions: The framework for guidelines holds important programme implications and the need for practical implementation together with multidisciplinary collaborations to support parents when parenting children with a hearing loss.

Keywords

Guidelines, Consensus Workshop, parents, children with a hearing loss

Introduction

The framework for guidelines is intended as a type of support for parents parenting children with a hearing loss. It does not replace any ongoing services provided to parents but compliments and contributes to the existing professional services offered to parents. The framework for guidelines helps to identify 1) what has already been done 2) to build and strengthen partnerships with parents and between parents and professionals, and 3) provide services that are effective, family centred, and strengths-based (Hamilton, 2017).

The World Health Organization (WHO, 2014) defines guidelines as any document covering recommendations for clinical practice. These in turn inform the user of the guideline(s) – what he or she can or should do in a given situation – to attain the best possible health outcomes. The view espoused in this article is that the guidelines should be considered a resource for parents parenting children with a hearing loss. The benefit of having written guidelines is that they serve as a source of information informing parents of the topic at hand. Moreover, they allow parents to question and make inquiries that best suit their child’s needs and assist them to take an active role in the responses and management of parenting their child (Goodall & Vorhaus, 2011).

For parents parenting children with a hearing loss, information in the form of guidelines are a frame of reference as they begin their parenting journey of searching, inquiring, learning and making informed decisions that are most appropriate and applicable for them as parents, their family, and child. Research shows that to date there has been little documented about the need to support, guide and provide parents of children with hearing loss with hearing-loss related information (Zaidman-Zait & Jamieson, 2004). Parents often have to weigh up information about communication options, habitation, and education choices (DesGeorges, 2016). Unbiased information on these topics may assist parents to make well-informed choices and aid them in managing their child’s hearing loss. More recently, there has been an increased awareness of the importance of unbiased professional guidelines in the field of family centred intervention for parents and children with a hearing loss (Moeller, Carr, Seaver, Stredler-Brown & Holzinger, 2013). More often than not, guidance and support provided by professionals is ideologically and methodologically driven (Potter, & Edirippulige, 2007), causing parents great stress. In reality, professionals need to understand how to balance and marry their own professional expertise and judgment with patient or client preferences (Wang, Norris & Bero, 2018). Of the recently published guidelines by an international panel of experts who came together with the purpose of reaching consensus on 10 guiding principles to implement a family centred intervention, five of the principles (2, 3, 4, 6 and 7) placed an emphasis on neutral and unbiased information (Moeller et al., 2013). In addition, each of the published principles include objectives that inform and provide service with practical guidance on how to improve services to families and parents of children with a hearing loss.

As already touched on above, the advantage of written guidelines is that it allows parents to take information home and refer back to it when they are less stressed. This gives parents the opportunity to view information and consider their options in the privacy of their own homes, and leisurely jot down questions to ask later for clarity and understanding. In this way, parents feel empowered and in control with information that aids them in the decision-making process. By gaining knowledge, parents typically become less dependent on professionals and take a more active lead in the decision-making process.

However, the development of a framework for guidelines cannot be the sole responsibility of professionals in care giving settings. Expert and stakeholder participation can lead to tailored guidelines that reflect the processes of engagement and collaboration, contributing to the development of a framework for guidelines. Therefore, the development of a framework for guidelines for hearing parents parenting children with a hearing loss is solutions-centred as it is developed in participation and collaboration with parents and professionals in the field of hearing loss.

Background

Prior to the implementation of the current study, the researcher conducted a mixed-methods approach with a sequential explanatory design using a two-phased approach. Phase 1 of the study sought to 1) identify and explore existing research on parenting styles and practices of hearing parents parenting children with hearing loss through a scoping review; 2) administer a questionnaire to a larger group of hearing parents to determine the parenting styles and challenges parents experience when parenting a child with hearing loss; and 3) conduct unstructured interviews to explore the challenges and social needs of hearing parents parenting their child with hearing loss. Based on the findings of Phase 1, 22 draft recommendations were compiled by the researcher (Table 1). These in turn formed the basis for the consensus workshop that was undertaken with the panel of experts and with the panel of stakeholders.

Table 1. Key findings of Phase 1: Scoping review and mixed-methods research approach with a sequential explanatory design

Phase 1	**Findings and recommendations included in the framework for guidelines**
Stage 1: Scoping review	**Interventions** 1. Information sharing on hearing loss 2. Professional support 3. Provide with knowledge and skills on child's hearing loss 4. Resources 5. Increase network with other parents 6. Socio-emotional support 7. Father support programmes
Stage 2: Quantitative inquiry	**Challenges** 8. Socio-emotional support 9. Understanding the aetiology of hearing loss 10. Information and resources on hearing loss 11. Parent support and intervention programmes 12. Father programmes 13. Understanding parenting a child with hearing loss 14. Communication challenges

Stage 3: Qualitative inquiry	**Support** 15. Support groups and guidance 16. Support for parents in terms of resources 17. Support groups for a child with hearing loss 18. Support for siblings of children with hearing loss 19. Professional and empathetic and unbiased support 20. Parents’ challenges when parenting a child with hearing loss 21. Need guidance, information on hearing loss, information and support 22. Communication challenges and needs and unbiased support for communication choices

This article reports on Phase 2 of the study – a consensus workshop. The aim of the consensus workshop was to develop a framework for guidelines for hearing parents parenting children with hearing loss. The consensus workshop was conducted in two stages: Stage 1 – comprised the pilot design of the consensus workshop with experts (academics) in the field of child, family and disability studies; this was followed by Stage 2 – a second consensus workshop with stakeholders in the field of hearing loss, including parents, to test the feasibility of the recommendations.

Methodology

A workshop was used as the research methodology. Recent literature on workshops as a research methodological frame (Ørngreen & Levinsen, 2017) states that a workshop is reliable in producing valid data as it aims to achieve participants’ expectancies to realising something associated with their own interest. Based on literature conducted by Ørngreen and Levinsen (2017), they found a variety of basic shared features when using a workshop methodology, namely: 1) the workshop was arranged and conducted with participants with a common interest and done within a limited timeframe; 2) it was carried out with experienced people familiar with the research topic; 3) active participation among all attendees was encouraged; and 4) participants expected an outcome at the end of the workshop.

Furthermore, the development of this framework used the principles of action research. Action research includes an action researcher and community members who are in search of improving their situation (McDonald, 2012). Therefore, this research study was concerned with including the participation of experts and stakeholders by expressing the belief of combining and sharing knowledge to define and understand a problem in order to find solutions (Greenwood & Levin, 1998)

Design

A consensus workshop design was conducted to develop a framework for guidelines for hearing parents parenting children with a hearing loss. The objective of the consensus workshop was to present the key findings of Phase 1 and engage with panel of experts and stakeholders, and work towards reaching a consensus (Colquhoun et al., 2014). The consensus workshop was best suited for consensus building and was based on the assumption that group judgments are more convincing than individual judgments (Miller, 2006). During each round, once group consensus was reached, the process was stopped.

This study received ethical approval from the Research Ethics Committee at the University of the Western Cape (ethical clearance number HS16/6/12).

Stage 1: Expert input

Participants

Round 1: To ensure a broad perspective on the themes, 10 experts from the University of the Western Cape working in the field of child, family and disability who have relevant knowledge and expertise at the research, clinical and policy level, were invited via email to participate in round 1 (Akins, Tolson & Cole, 2005). On the day of the workshop, six of the panel of experts attended the workshop.

Data Collection

Round 1:

A panel of experts (academics) participated in round 1 to identify the unclear or ambiguous recommendations indicated in Table 1 of Phase 1 of the research study.

The goals of round 1 were to share with the panel of experts: 1) the aim and objectives of the current study; 2) the outcomes of each stage in Phase 1 of the research process, which resulted in the 22 recommendations; and based on these, 3) identify themes and sub-themes resonating with the findings. The panel of experts were asked to respond to a set of questions corresponding with the recommendations made, namely: 1) what is your opinion regarding the content of the draft recommendations made in the context of formulating guidelines?; 2) what are the themes that resonate with the findings of the research study as well as on its usefulness for implementation?; 3) comment on your language use in the research study, particularly disability-friendly language?; and 4) do you have any additional recommendations that you feel were not addressed by the guidelines?

Consensus reached in round 1

Based on the 22 guidelines recommended in Phase 1, the three themes and their corresponding sub-themes that were identified in Phase 1 were agreed upon by the panel of experts. However, the panel strongly argued for the inclusion of two more guidelines, namely:

Early intervention programmes

The first guideline to be included was on early intervention programmes for children with hearing loss especially at the time of the child's diagnosis. This theme, they felt, could address issues of early screening and diagnosis and the need for counselling parents as sub-themes under early intervention.

Information and resources

The second recommendation made by the panel of experts was to include a "resource list" under the theme of "information and resources" for parents. The discussion around the theme centred on parents' need for some form of "documentation" or an "information list" that they can refer back to at any time. The common sentiment among the panellists was that the resource list could be shared with extended family members to address their needs and concerns related to the child's hearing loss, thereby serving as a resource and referral list. After a brief discussion, the panellists reached consensus on including the resource list as it was agreed that it would disseminate comprehensive, unbiased, meaningful information to help parents make informed decisions (Moeller et al., 2016).

Furthermore, the panellists recommended consistency in language use, for example, "do not use deaf or hearing loss interchangeably". One expert had a preference for the word "Deaf" and not "hearing loss" to be used in the study. Conversely, others perceived the words "hearing loss" as all-encompassing to include different types and degrees of hearing loss; therefore, consensus was reached to use the words "hearing loss" in the study. When the experts advised that a recommendation be merged, changed, deleted, or replaced by another recommendation, the changes were made immediately by the researcher.

Results

The panel of experts eventually reached consensus on four themes and 13 sub-themes. These are listed in Table 2 below. Theme 1 deals with early intervention and screening programmes for parents and children who have been diagnosed with hearing loss. The sub-themes focused on the content of offering parent support in hearing screening in the framework of informed choices (Moeller et al., 2013). Theme 2 addressed the needs of parents in terms of parents' social and emotional support. The content of this sub-theme focused on professional support (counselling), support groups for children with hearing loss, support groups for parents (mother and fathers), support groups for siblings, the need for increased social networks with other parents, and the need for professional and empathetic support. Theme 3 identified and focussed on resources required by parents. The sub-themes and their content areas looked at issues of guidance, knowledge on hearing loss, information and support, the provision of knowledge and skills on child hearing loss, and an understanding of the aetiology of hearing loss. Theme 4 focussed on communication intervention. The sub-themes included content on issues of the communication challenges and needs of parents.

Table 2: First round of guidelines with comments from experts

Themes	**Sub-themes**	**Comments made by a panel of experts**
1. Early intervention programmes	1. Early screening and diagnosis and counselling for parents	"This must be included in the guidelines as it will inform parents that early diagnosis is important" "This is also an important recommendation for the drafting and implementation of the policy" "Yes, this recommendation I support"
2. Parent social and emotional support	1. Professional counselling 2. Support groups for a child with hearing loss/siblings/mothers/fathers 3. Support groups for parents (to improve parent self-efficacy) 4. Support groups for father 5. Support groups for a sibling	"Agree" "No additions need to be made" "Nothing at this point as it is clear"

	6. Increase social network with other parents 7. Professional and empathetic and unbiased support 8. Parenting challenges	“I see that the recommendations do include the child with the hearing loss, I am glad about this”
3. Information and resource support	9. Need guidance, information on hearing loss, information and support 10. Provide with knowledge and skills on child’s hearing loss 11. Understanding the aetiology of hearing loss (type/degree) 12. Resource list for parents	“Agree” “I think we need to add a resource list for parents as they will need to be provided with the information where to get support” “Yes agree, the information in the resource list must also be unbiased and present parents with choices” “The resource list can be read anytime and can be shared with other family members”
4.Communication intervention	13. Communication challenges and needs and unbiased support for communication choices	“Yes, we agree that communication is very important for parents”

Stage 2: Stakeholder input

Participants

Round 2: The panel of stakeholders that participated in round 2 consisted of expert stakeholders in the field of hearing loss. Invitations were sent via email to 17 stakeholders to participate in this round of consensus. Among the stakeholders were: two (2) social workers working at local organisations for the Deaf, one (1) provincial director of an organisation for the Deaf (Deaf), two (2) audiologists (one (1) from a public hospital and one (1) in private practice), two (2) school social workers, five (5) parents of children with hearing loss, two (2) volunteers from organisations for the Deaf (long service in the Deaf community), and three (3) deaf mentors.

Data collection

Round 2

One of the goals of round 2 was to generate further stakeholder opinion and feedback on the guidelines resulting from round 1. Additional goals were to: 1) share with the panel of stakeholders the aim and objectives of the current study as well as the outcomes of each stage of the research process, which included the 22 recommendations emanating from Phase 1; and 2) based on the draft recommendations in Phase 1 and the recommendations made in round 1 with the panel of experts, to identify further themes and sub-themes that resonate with the findings. The panel of stakeholders was asked to respond to a set of questions corresponding with the recommendations made. These included: 1) what are the themes that resonate with the recommendation made in the research study? 2) how important is the recommendation made in the context of the research study – priority of topics? 3) comment on your language use in the research study, particularly disability-friendly language 4) Do you have any additional recommendations to add?

Consensus reached in round 2

All of the recommendations made in Phase 1 of the research study and in round 1 by the panel of experts were agreed upon, with the suggestion of two additional guidelines by the panel of stakeholders, namely: "parenting styles" and "deaf mentors". Consensus was reached that these guidelines be included under Theme 2: "Parent social and emotional support", including parenting styles as a sub-theme. It was further established that this recommendation would encompass the content on different parenting styles (involved parenting, avoidance parenting, and protective parenting) and independent living. Agreement was then reached that the recommendation for deaf mentors be included under Theme 3: "Resource support" as an additional sub-theme. The content area of deaf mentors looks at issues of guidance, information to promote knowledge on hearing loss, information and support where deaf role models who are powerful influences can provide parents and professionals with an understanding of their day-to-day real-life experiences living in a hearing world (Hintermair, 2000).

Results

The panel of stakeholders reached unanimity on 4 themes and 15 sub-themes as reflected in Table 3. The additions made in Theme 2, which addressed the needs of parents in terms of parents' social and emotional support, included a sub-theme on parenting styles. A further guideline recommendation was made in Theme 3 which identified and focussed on resources required by parents. The sub-theme and its content area included the recommendation made to incorporate deaf mentors.

Table 3: Second round of guidelines with stakeholder comments

Theme	Additional recommendations for sub-themes	Comments made by a panel of stakeholders
1.Early intervention support	1. Early screening and diagnosis and counselling for parents	"Agree with the theme as well as the recommendation made by the panellist in round 1" All in agreement/consensus reached
2. Parent social and emotional support	1. Professional support (counselling) 2. Support groups for a child with hearing loss/siblings/mothers/fathers 3. Support groups for parents 4. Support groups for fathers 5. Support groups for siblings 6. Increase social network with other parents 7. Professional and empathetic & unbiased support 8. Parenting challenges 9. Parenting styles	"Agree with this theme; however, we need to look at parenting approaches, especially the different styles by parents" "Yes, what about styles, like involved parenting, overprotective parenting, and so on" Agreed by the rest of the panel/consensus reached
3. Resources support	10. Need guidance, information on hearing loss, information and support 11. Provide with knowledge and skills on child's hearing loss 12. Understanding the aetiology of hearing loss – including audiogram 13. List of resources for parents 14. Deaf mentors	"Agree to the themes; however, can you add Deaf mentors as they have an important role to play" "Parents and children with a hearing loss can see that there are deaf youth that have gone through the same challenges and have succeeded" "A deaf mentor shows parents that there is hope" "Deaf mentors can teach deaf culture to parents"
4. Supporting means of communication intervention	15. Communication challenges, needs, and unbiased support for communication choices	"I agree that parents must be provided with unbiased information regarding communication choices for their children" "Guidelines must include how to communicate with our child as communication includes the visual language"

		"Parents need to understand the child's way of life, including [that] communication is influenced by their hearing loss" "Parents must be provided with unbiased communication choices"

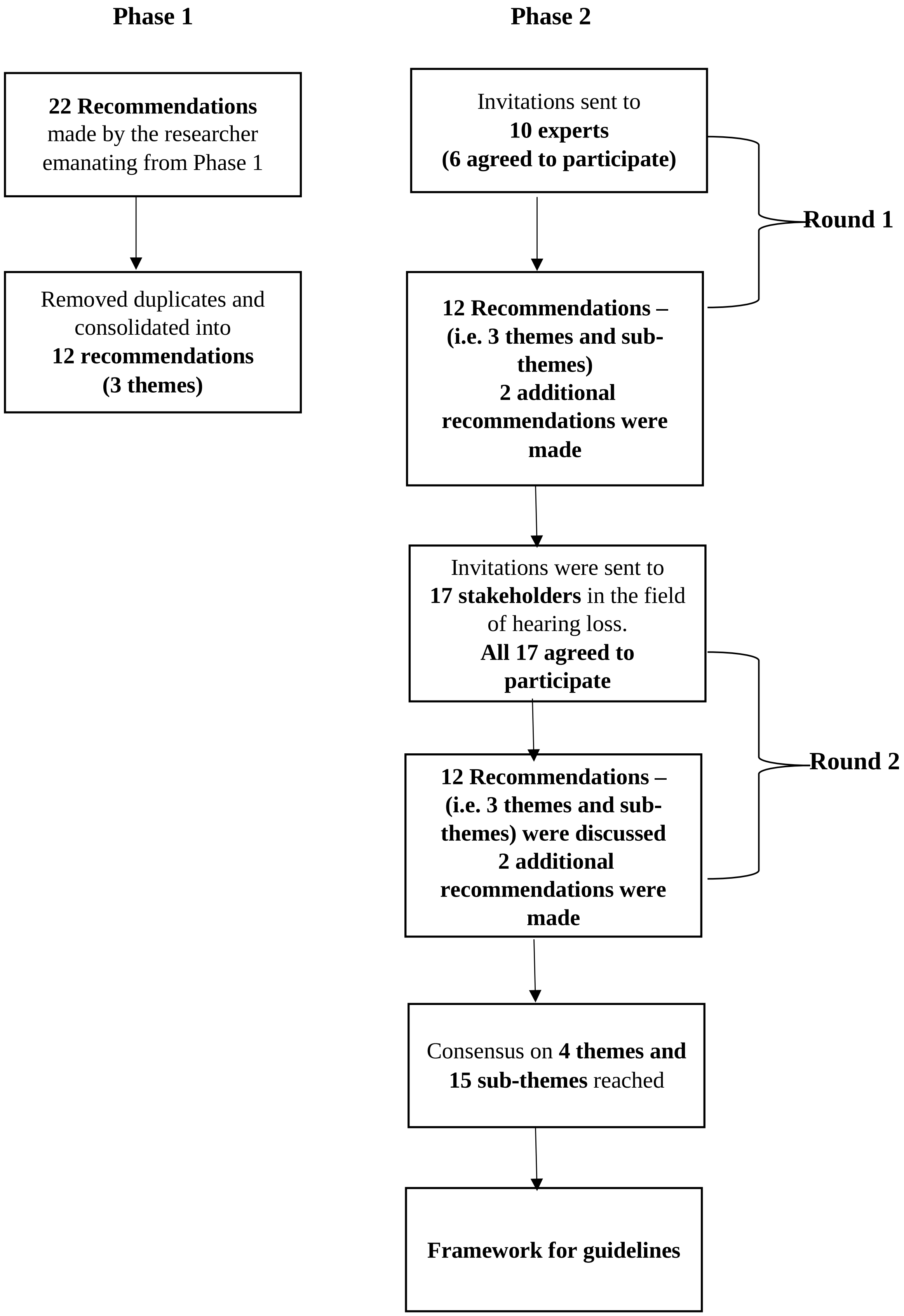

Figure 1: Illustration of the consensus process

Data analysis

Data were analysed through thematic analysis in response to the specific questions. Four themes were identified. The 4 themes were: 1) early intervention programmes, 2) parent support, 3) resource support, and 4) communication support. These themes and sub-themes are discussed and motivated with verbatim comments made by both panels for inclusion in the proposed guidelines.

Theme 1: Early intervention support

Early screening and diagnose and counselling for parents

The panel of experts recommended an additional theme to be added to the list, resulting in the emergence of 4 sub-themes (Table 3). This recommendation was made on the bases that early intervention and screening support and programmes for parents of children with a hearing loss are important and offer parents support with regards to early hearing screening in terms of informed choices (Moeller et al., 2013). Comments from the panel of experts included:

> *"This must be included in the guidelines as it will inform parents that early diagnosis is important."*

> *"This is also an important recommendation for the drafting and implementation of the policy."*

> *"Yes, this recommendation I support."*

The panel of stakeholders in round 2 supported and agreed with the above recommendations, as is evident in the comment made below:

> *"Agree with the theme as well as the recommendation made by the panellist in round 1."*

Therefore, no additional comments or recommendations were made and therefore consensus was reached.

Theme 2: Parent social and emotional support

In terms of Theme 2, eight recommendations were initially proposed. A consensus was reached on all these recommendations. However, the panel of stakeholders in round 2 made a further recommendation to include “parenting styles”, confirmed in the following comments made by parents on the panel:

> *“Agree with this theme; however, we need to look at parenting styles, especially the different approaches by parents.”*
>
> *“Yes, what about styles (types), like involved parenting, overprotective parenting, and so on.”*

The motivation for these additional recommendations made by the panel of stakeholders was made by deaf mentors and social workers, and is supported by literature that states that the presence of a child with a hearing loss may affect, amongst others, parenting approaches of hearing parents, which may result in them being overprotective and experiencing difficulties in developing effective parental child-rearing approaches, causing parents to be unsure of how to raise their child with a hearing loss (Calderon & Greenberg, 1999; Calderon, Bagones & Sidman, 1998; Jackson & Turnbull, 2004), Koester & Meadow-Orlans, 1999). Very often, overprotective parenting can cause children to become fearful, resulting in them not coping with the world independently (Luterman, 2004). In addition to finding it difficult to make friends, they become aggressive, selfish, and boastful (Kumar & Lalitha, 2013).

Consensus was reached on the inclusion of this theme.

Theme 3: Resource support

Initially, three sub-themes were recommended for Theme 3. However, the panel of experts recommended one more sub-theme to be included, namely, a list of resources. In this regard, the following comments were made:

> *"I think we need to add a resource list for parents as they will need to be provided with the information where to get support."*

> *"Yes, agree, the information in the resource list must also be unbiased and present parents with choices."*

This recommendation was made to promote the gaining of the necessary information to make fully informed decisions (Moeller et al., 2013) and to link parents with resources that support their decisions.

Likewise, the panel of stakeholders recommended the inclusion of one more sub-theme – "Deaf mentors". They felt that deaf mentors play an important role as they are powerful influences that can provide parents and professionals with an understanding of the day-to-day real-life experiences of children with hearing loss (Hintermair, 2000). The following comments were made by four deaf panellists:

> "*Can you add deaf mentors as they have an important role to play?"*

> *"Parents and children with a hearing loss can see that there are deaf youth that have gone through the same challenges and have succeeded,"*

> *"A deaf mentor shows parents that there is hope."*

> *"Deaf mentors can teach deaf culture to parents."*

Literature shows that parents who have contact with adults who also have a hearing loss show a strong sense of parental competency concerning the upbringing of their child (Hintermair, 2000).

Theme 4: Supporting means of communication intervention

Both panels reached consensus and agreed on the recommendations made in this theme, affirmed in the comment below:

> *"Yes, we agree that communication is very important for parents."*

The following comments made by the panel of stakeholders included comments from one social worker, two of the deaf mentors, and one audiologist:

> *"I agree, parents must be provided with unbiased information regarding communication choices for their children"* (social worker)

> *"Guidelines must include how to communicate with our child as communication includes the visual language"* (deaf mentor)

> *"Parents need to understand* [that] *the child's way of life is influenced by their hearing loss"* (Audiologist)

> *"Parents must be provided with unbiased communication choices"* (deaf mentor)

Service providers should work together and collaboratively on programmes for parents and their children with hearing loss, offering parent's different communication options (Moeller et al., 2013).

It is noted that panellists in round 1 and round 2 were asked to add any other recommendations when comments were received. Therefore, it is assumed that the remaining experts agreed with the recommendations that were formulated.

As per the consensus workshop, the final recommendations were drafted, including the rationale for their inclusion, as outlined in Table 3. The rationale for these recommendations is based on the study's findings and suggestions made by all the participants.

Summary of findings

Responses to the 22 recommendations made in Phase 1 of the study, and in response to the set of questions corresponding with these recommendations, further suggestions were received from the 6-member panel of experts in the first round. Due to similar and overlapping themes, the panel of experts agreed to the merging of several of the recommendations proposed in Phase 1, which resulted in 3 themes and 12 sub-themes. Furthermore, based on evidence from Phase 1, consensus was reached to include two additional recommendations, namely: 1) early intervention programmes, which encompass issues concerning early screening and diagnosis, and counselling for parents; and 2) a resource list under the overarching theme of resource support. In essence, there was unanimous agreement by all the experts concerning these recommendations. Additional comments from the panel of experts included a request for clarification on the term "Deaf" and "hearing loss", eventually leading to the term "hearing loss" being used in the study and edited for consistency in the report. The researcher combined the feedback on the recommendations made and included it in the report.

The second round elicited a further 2 recommendations from the 17 member panel of stakeholders. The addition of the 2 recommendations was based on the evidence of the research undertaken in phase 1. For example, based on the findings in the scoping review (phase 1 of the study), the panel of stakeholders felt that the matter of parenting styles should be addressed under theme 2: parental social and emotional support. They felt that parents should be made aware of different parenting styles and how these different parenting styles may contribute to their parenting experiences. Another recommendation is based on the findings found in the qualitative stage of the research study, phase 1. The panel of stakeholders strongly recommended and supported the inclusion of adult deaf mentors. This recommendation, after a brief discussion and with the consensus being researched, was included under the "resource" theme. Tables 2 and 3 illustrates the progress and recommendations made through the 2-round Consensus Workshop process leading to the final framework for guidelines, Table 4.

Table 4: Framework for guidelines

Framework for the guidelines	
Theme 1: Early intervention support	**Sub-themes** ● Early screening and diagnosis and counselling for parents
Theme 2: Parent social and emotional support	**Sub-themes** ● Professional support/interventions ● Professional and empathetic & unbiased support ● Parenting styles ● Parenting challenges ● Support groups for a child with hearing loss ● Support groups for parents ● Support groups for fathers ● Support groups for siblings ● Increase social network with other parents
Theme 3: Resource support	**Sub-themes** ● Need guidance, information on hearing loss, information and support ● Provide with knowledge and skills on child's hearing loss ● Understanding the aetiology of hearing loss – including audiogram ● List of resources for parents ● Deaf mentors
Theme 4: Supporting means of communication intervention	**Sub-themes** ● Communication challenges, needs, and unbiased support for communication choices

Discussion

The purpose of the consensus workshop was to develop a framework for guidelines for hearing parents parenting children with a hearing loss and for professionals in the field of hearing loss.

This was successfully done through a workshop methodological approach using principles of action research. Action research offers an alternative to knowledge development. It offers marginalised groups the opportunity to improve their own situation (Koch, Selim & Kralik, 2002). Through the participation and collaboration of a 6–member panel of experts and a 17–member panel of stakeholders, the emerged framework can be viewed as the first port of initial support for parents.

In meeting the aim of the research study, consensus was reached that the following agreed upon guidelines: 1) early intervention, 2) parental support, 3) resources, and 4) communication options be integrated into a framework for guidelines for parents parenting children with a hearing loss. The findings of the consensus workshop conform to previous research, including an international consensus on family-centred early intervention with children who are deaf and hard of hearing and their families (Moeller et al., 2013). Some of our findings have specific bearings on Moeller et al.,'s (2013) research, such as how it relates to 1) early intervention, 2) family social and emotional support, 3) informed choices, 4) supporting different options of communication modes, and 5) collaboration between parents and professionals.

Firstly, assent was reached on early intervention. The motivation for this inclusion as agreed upon by all panellists was that parents should be provided with guidance, information and counselling by professionals on early identification and screening programmes that offer parents support with regards to early hearing screening in the framework of informed choices. Furthermore, panel 1 also indicated that this guideline has the potential to influence policy outcomes. For example, newborn babies should be referred for early hearing detection and families should be referred timeously for confirmation and counselling when the child is diagnosed with a hearing loss. These guidelines collaborate with the findings of Yoshinaga-Itano (2014) who put forward 12 best practice guidelines for early identification, which includes timely referrals to early intervention services, and infusing parent–professional partnership in the best interest of the child with a hearing loss.

Secondly, consensus was reached on Theme 2 on parent social and emotional support. All the panellists agreed that parents should be provided with unbiased support. These findings concur with Meibos (2018) that healthcare professionals should be more empathetic, sensitive, and have a greater understanding of the emotional impact of the diagnosis on the family, considering the feelings of the family and the child with hearing loss. Our findings show that parents should receive unbiased professional social support, which includes counselling, connecting parents to support groups that can increase parents, siblings, and children with hearing loss' social network and at the same time reinforce parent self-confidence. Guidelines offering information on support groups serve as a strong healing and educational tool, providing parents with the opportunities to share their feelings and concerns on issues that they are experiencing when parenting a child with a hearing loss (Henderson, 2015). These recommended guidelines to be included in the framework concur with the findings of Asberg, Vogel, and Bowers (2008) who found a strong correlation between social support and parental stress and life satisfaction, with lower levels of stress being experienced by parents parenting a child with hearing loss. Further recommendation to include professional support targeting and involving hearing siblings and children with a hearing loss should be offered the opportunity to share their experiences with parents and families. Previous studies have found that parents' behaviour and feelings towards their child with a hearing loss does influence a hearing sibling's behaviour and feelings towards their sibling with a hearing loss (Bat-Chava & Martin, 2002). The inclusion of this recommendation in the framework of guidelines will go a long way in contributing to the psychological development of siblings of a child with a hearing loss and promote supportive sibling relationships.

In addition, panel 2 further recognised the need in the guidelines for parents to understand their own parenting styles when parenting their child with a hearing loss. Several studies have suggested that raising a child with a hearing loss may require parents to adapt their parenting styles and skills, which would affect the quality of the parent-child relationship (Woodgate, Edwards, Ripat, Borton & Rempel, 2015; Sams, 2012; Raya, Ruiz-Olivares, Pino & Herruzo, 2014). Parents who were part of the stakeholder panel admitted to being overprotective of their child with a hearing loss due to their own uncertainties. Our findings collaborate with the findings of Calderon and Greenberg (1999), and Calderon et al., (1998) who suggest that parents may experience difficulties in developing effective parental child-rearing styles causing parents to be unsure of the manner in which they raise their child with a hearing loss. Further research by Raya et al., 2014) and Jackson and Turnbull (2004) indicated overprotective parenting styles. Our framework for guidelines, therefore, has the potential to introduce parents to different parenting styles, and thereby assist them in their role of parenting their child with a hearing loss.

Thirdly, panel 1 reached consensus to include a resource list to the framework for guidelines. This list encompasses information that is comprehensive, unbiased, accurate, and well-balanced (Hendersen, 2015). Such information allows parents to make informed choices and enables them to play an active role in their child's development. In addition, a resource list can include information on the aetiology of child hearing loss (Duckworth, Steen & Seligman, 2005:3) and provide a detailed explanation of the child's audiogram each time hearing tests are performed. A resource list allows for collaboration and partnerships between professionals and parents. The panel of experts felt that parents should be seen as partners and not mere receivers of information. The recommendation made by the panel steered away from parents receiving information that is influenced by professionals who appear biased, opinionated, limited in scope, and conflicting (Bruin & Nevøy, 2014; Jackson, 2011; Eleweke & Rodda, 2000). Written unbiased information with simple diagrams should be available to parents to facilitate a better understanding of parents, siblings, and children with a hearing loss. Furthermore, consensus was reached around deaf mentors being a resource for hearing parents. Evidently, there is a dearth of studies about deaf mentors, with limited research conducted on the invaluable assistance they can provide to parents and families of children with a hearing loss (Hamilton, 2017). Linking parents to deaf mentors helps parents to understand the personal insight and personal experience of growing up in hearing families and overcoming obstacles.

Fourthly, our findings suggest that parents receive guidance and support for communication intervention. Hence, the consensus among the panel of participants highlighted the view that parents should be provided with objective information on a full range of communication options as early as possible. Our findings are broadly consistent with previous literature on communication challenges between parents and their child with a hearing loss (Ching et al., 2018)

To reiterate for emphasis, the development of a framework for guidelines is not intended to replace existing professional support offered to parents. Rather, the implications of the emerged framework is simply to suggest implementable, practical, content to assist parents in assuming the role of an expert in the management of their child. The framework is based on the daily experiences of hearing parents parenting a child with hearing loss. It is envisaged that this study will provide parents and professionals in the field of hearing loss with clear guidelines to be integrated into programme delivery and policy development. Furthermore, the study can be viewed as an extension of an international consensus document on best practice for family

centred intervention for families and children with hearing loss (Moeller et al., 2013). Family centred interventions clearly need to take into consideration the perspectives of parents as their perceptions have the potential to inform programme design and programme implementation.
In this study, attempts were made to select expert and stakeholder panellists who represented disciplines and constituencies relevant to family and parenting children with hearing loss. Parents who participated in the current study (round 2) also participated in Phase 1 of the study. Likewise, the findings of the current consensus workshop highlighted experts' and stakeholders' participation and collaboration to reach consensus on a set of guidelines to enhance family centred interventions. The participation of experts and stakeholders in the design of the research study underscores the rigour undertaken in reaching consensus in the development of a framework for guidelines.

Advancing intervention in the field of disability, this study holds invaluable significance for those working within the field of social work and the emerging field of public health enquiry. Having reached consensus on a framework for guidelines, these findings may stimulate practical social work implementation, thus leading to programme and training applications. These applications include the need for counselling for parents, or the facilitation of parent to parent support groups, specific programmes engaging fathers, connecting parents with deaf mentors or programmes within the domain of parenting and parenting styles. With an understanding of the diverse needs of parents in mind, these are but a few insightful recommendations made to facilitate social work intervention when providing support services to parents parenting a child with a hearing loss.

Conclusion

The research study was successfully implemented by employing a consensus workshop to achieve agreement on four broad recommendations (4 themes and 15 sub-themes) on specific themes to complement the research on: *The development of a framework for guidelines for hearing parents parenting children with hearing loss using a consensus workshop.* The study highlighted the processes followed in reaching consensus.

Furthermore, the framework may help to promote a better understanding of the diverse needs of parents and practices related to meeting the needs of parents parenting a child with hearing loss. The framework, therefore, builds on what has already been done, strengthens partnerships with parents and between parents and professionals, and provides services that are effective, family-centred, and strengths-based (Hamilton, 2017).

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CHAPTER 7: SECTION B

GUIDELINES FOR PARENTS PARENTING CHILDREN WITH A HEARING LOSS

7. B1 Introduction

In Section 7A, the process of developing a framework for guidelines for hearing parents parenting children with a hearing loss was discussed. A consensus workshop with a two-phased approach was used to develop the framework. The two-phased approach involved the participation of (1) a panel of experts, and (2) a panel of stakeholders within the Deaf community, to assist in reaching consensus on the guidelines to be included in the framework. The overall study – through the processes of data collection and data analysis – revealed the parents' need for support when parenting a child with a hearing loss. These needs, which were identified and discussed in the finding's chapters, were shared with the participants in the consensus workshop. Through the consensus workshop, the findings were discussed, refined, and drafted into a framework for guidelines. This framework informed the formulation of the guidelines used to enlighten parents and professionals to understand parenting a child with a hearing loss. Therefore, the current section – Section B – presents the formulated guidelines in the domain of parenting children with a hearing loss. These guidelines are aimed at hearing parents to assist them in their parenting roles and to provide support when parenting children with a hearing loss.

7. B2 Guidelines from a Family Systems Approach

As discussed in Chapter 2, this research is grounded in the family systems theory. From a family systems theorist's perspective, an attempt is made to understand the importance of seeing a family as a whole in order to maintain and find solutions to presenting problems

(Winek, 2010). An important notion of a family-centred approach is that children (in the case of this study, children with a hearing loss) cannot be viewed apart from their families. In South Africa, the White Paper on Families (DSD, 2013) views the family as more than its component parts. The family is viewed as a social system because its members are interdependent and any change in the behaviour of one member will affect the behaviour of others (Baker, 2001). Therefore, a child with a hearing loss is part of the family system, and the hearing loss belongs not only to the child but to the whole family (Henderson & Hendershott, 1991). Providing services to parents with children with a hearing loss has shifted over the last few years in recognising the critical role of families (and parents) in the provision of services. There has been an acknowledgement of the importance of strengthening and building the capacity of family members and existing family support systems within the family system (Jackson, 2011). A family-centred approach weighs up family needs with the best interest of its members in mind. It also encourages family input on the kind of care it needs, where each family member is treated as unique, instead of being seen as rigid to a specific group (Burns et al., 2009). Therefore, any intervention should include the whole family (Thorpe, 2013). In terms of the bigger picture, the advancement of family life and the strengthening of the family is vital to the general stability and overall well-being of the nation (DSD, 2013).

Furthermore, assistance offered to parents from a family-centred perspective provides support for the well-being of the family, which is likely to have a positive impact on the child with the hearing loss (Calderon & Greenberg, 2003). Such services take into account parents' and families' abilities to positively adapt to the challenges and demands associated with early diagnosis of child hearing loss and the capacity of the family system, including the family structure, family functioning, as well as their interpersonal, social, and economic resources. Professionals working with parents should at the onset of child hearing loss identify the tension within a family system and employ appropriate family-centred approaches in early intervention, since the focus of the intervention is the family system rather than the individual child with the hearing loss. Child hearing loss may threaten the equilibrium of a family system, but the professional response would be to support the positive stabilisation of the whole family system. When families are understood as systems (sub-systems), intervention services can be designed to enhance the quality of life of the family and parents and improve the developmental outcomes of the child with the hearing loss.

Other theoretical perspectives that may be suitable alongside these guidelines include: 1) the strengths-base perspective, which is closely aligned to empowerment. A strengths-base perspective seeks to identify, build, use, and reinforce strengths and capabilities that people already have. It is based on a collaborative process that promotes change, empowerment, and liberation (Cowger, 1994) and 2). The social developmental approach recognises that there are certain families in need of additional supportive services in order for them to solve problems related to parenting, communication, substance abuse, family violence arising from life changes and events, to mention a few examples (Patel, 2005).

This study therefore applied the family systems theory as a theoretical perspective to frame the guidelines outlined in this section of the study.

7. B3 The purpose, objective and outcomes of the guidelines

Purpose

As indicated in Section A, the framework for the guidelines was intended to reflect a kind of support for parents parenting children with a hearing loss. It does not replace any ongoing services provided to parents, but rather contributes and complements the existing services offered to parents. The guidelines attempt to provide basic information to assist parents and family members to understand hearing loss and to learn about the support and services that are available to them. It attempts to answer many of the questions that parents may have concerning their child’s hearing loss in order to bring about understanding and improve parent-child relationships. Therefore, the guidelines were developed to strengthen parenting and build parents’ confidence in their adaptation and ability to raise and parent a child with hearing loss (Bemrose, 2003).

***Objective*:**

- *To provide hearing parents with information and support so that they play a meaningful role in parenting their child with a hearing loss.*

Outcomes

The outcomes of the guidelines are to:

- Build and strengthen parents when parenting a child with hearing loss.
- Offer support and information that is effective, family-centred, and strength-based to improve parents’ parental self-efficacy when parenting a child with hearing loss.
- Facilitate partnerships between parents and practitioners to improve parent-child relationships.

Herewith follows the key findings of participants who participated in this study across the three phases of the study, which included the quantitative and qualitative phases, and the consensus workshop that was conducted.

7. B4 Guidelines for parents and practitioners

As stated in Section 7A, the WHO (2014) defines ‘guidelines’ as any document covering recommendations for clinical practice. It is usually presented in the form of a pamphlet or a booklet, and synthesises current evidence on how to most effectively organise and deliver services (Gagliardi, Marshall, Huckson, James & Moore, 2015:19).

In the current study, guidelines were developed to provide parents with invaluable information, recommendations, and support to strengthen parents in their parenting role when parenting a child with a hearing loss. These will serve as an intervention strategy that can be integrated into service delivery to clients (parents parenting children with a hearing loss). Furthermore, these guidelines will provide hearing parents with the opportunity to gain and develop their knowledge about parenting a child with a hearing loss, and thereby improve their own parental self-efficacy which was identified as a challenge in the findings in Chapter 5. In this way, parents who lack a sense of self-efficacy may be able to adapt and put their parenting knowledge into action and take greater control of factors that impact their family life and family well-being.

The following guidelines were developed for parents and practitioners on: 1) early intervention support, 2) parents socio and emotional support, 3) information and resources, and 4) communication options, as identified in the framework for guidelines for parents parenting children with a hearing loss in Section 7A. These are outlined and discussed below.

7. B4.1 Early intervention support

Guidelines for parents

What parents need to know about early intervention support is that hearing the news that one's child cannot hear may leave parents feeling devastated, confused, and in disbelief. Consequently, they may have many unanswered questions. Questions asked by parents frequently include: "What is hearing loss?"; "What do you mean by hard of hearing or profoundly deafness?"; "How can he/she be deaf, no one in the family is deaf?" What parents need to know is that 90%–95% of children with a hearing loss are born to hearing parents who often know very little or nothing about the matter. The involvement of parents and family in the child's early years of intervention is pivotal. Therefore:

- Parental involvement in the child’s early years of intervention makes a positive difference in the life of the child, enhancing family and communication interaction (Moeller, 2001). During early intervention, parents should be provided with unbiased information. The concept of “informed choice” is fundamental, as parents need comprehensive, meaningful, and evidence-based information to make the appropriate choices when it comes to their child (Young et. al., 2005).
- Equally important at the time of the child’s hearing loss diagnosis is the need for parental counselling. Parents and families of children with a hearing loss must realise that they also face a great amount of emotional stress. One disadvantage of early intervention is that parents have often not yet developed a relationship with their child before they have to deal with all the information and decision-making concerning their child’s diagnosis It is therefore important to understand parents’ concerns – opportunity must be given for them to share their concerns, feelings, and emotions. Parents often say they don’t have time to enjoy being parents as early intervention usually starts immediately. Although this is done in the best interest of the child – parents, especially moms – struggle emotionally, and are put at an emotional risk when they are not emotionally, physically, interpersonally, or financially adequately prepared for the journey ahead.
- Through the provision of counselling, parents can be provided with opportunities to tell their stories and explain their feelings. Throughout the counselling process, parents are given the opportunity to move through the cycle of grief, which includes shock, denial, anger, and eventually acceptance.
- To assist with the grieving process, parents should become involved in the diagnostic process or test protocols, as this will help with increasing acceptance of their child’s hearing loss and decrease parents’ denial. For example, some audiologists opine that parents should participate in the tests they administer so that parents have a better understanding of these;

look and interpret the results together; and plan for the child’s future together. In this way, parents feel empowered as partners in the testing process which is also therapeutic for them. Similarly, parents can attend newly diagnosed parent groups or topic-based groups. Some parents may not seek support for themselves but may attend information sessions to help them parent their child as well as meet with other families (Madell, 2015).

Practitioners’ support to parents

- Practitioners who have specialised knowledge and skills of working with families and children with a hearing loss must realise that parents also face a great amount of emotional stress.
- Practitioners must involve parents in the decision-making processes.
- Practitioners must help parents understand the tests and terminology linked to early intervention.
- Practitioners must make appropriate referrals for counselling to support the whole family.
- Practitioners and families must work collaboratively to identify family concerns, hopes, priorities, and goals, and together plan how goals and positive family outcomes can be achieved.
- Practitioners must provide unbiased support by recognising family diversity within various cultural groups, especially within the South African context, which comprises diverse cultures, beliefs, family structuring, and family functioning.

7. B4.2 Social and emotional support for parents

Guidelines for parents

Parents often express feeling socially isolated and lonely when parenting a child with hearing loss. Frequently, some family members, or even one parent, may distance themselves from family and friends, as they feel embarrassed or fear the reaction of others. Unfortunately, stigmatisation and stereotyping still exists today, adding to the exclusion and isolation of parents and children with a hearing loss. Strong social support can function as a buffer, act as protection, and provide parents with emotional support (that is, encouragement, praise, and understanding), which in turn lessens the stress experienced by these parents.

- Parents often express the need to connect with other parents and talk to someone – someone they can identify with regarding their experiences. Parents are therefore encouraged to join a **parent to parent support group(s)** as it plays a significant role in increasing parents' social network and reinforcing their self-confidence. It also serves as a strong healing and educational tool for parents, as well as provides parents with the opportunity to share their feelings and concerns about issues they are currently experiencing. Sharing with other parents who also have children with hearing loss is a vital source of social emotional support for parents. Parents should inquire if there are any support groups for parents in their area. If there are none, they should consider starting one.
- Some parents can consider starting a **parent mentorship programme** where parents act as mentors for other parents who are struggling on their parenting journey. These parent mentors are better able to meet parents' needs, both personally and emotionally when empathising and conversing about their own experiences through the mentoring relationship. The parent mentorship programme is offered by parents who have accepted their parenting journey, who have an unbiased approach, and who can walk alongside other parents on their journey of parenting a child with hearing loss.
- Likewise, support and programmes targeting hearing **siblings** is important. Hearing siblings often feel detached from their families, unimportant, and overlooked. This is because all their parents' attention is focused on the sibling with a hearing loss. Parents' behaviour towards their child with a hearing loss can indicate that they are different, thus leading to strong feelings of sibling rivalry as hearing siblings may perceive themselves as

less loved and as getting less attention from their parents. Proper information about hearing loss and the causes of hearing loss should be provided to the **hearing sibling** so as to avoid misunderstanding and unnecessary anxiety.

- In addition, children with a hearing loss should be encouraged to attend supportive programmes so that they can improve their own self-confidence, especially in communication competencies and speech skills. These programmes encourage children with a hearing loss to share their experiences with their parents and families. They should also to be included in counselling services and provided with an opportunity to speak about their own experiences growing up in a hearing family.
- **Support and role of fathers** are also important as there is much written about the role of mothers in the development of children with a hearing loss, their relationship with their child, and their involvement with support services. Fathers have been identified by researchers in this field as “hard to reach” (McConkey, 1994), “the invisible parent” (Ballard, 1994), and the “peripheral parent” (Herbert & Carpenter, 1994). There is an assumption that fathers are not as involved as mothers in the development of young children with a hearing loss.
- Furthermore, it is important for parents to understand how to develop effective **parental child-rearing styles** causing parents to be more assured of the manner in which they raise their child with a hearing loss. The presence of a child with a hearing loss may affect, among others, the parenting styles of hearing parents, as parenting a child with a hearing loss may require hearing parents to modify their parenting behaviour, learn new communication methods, and become more engaged in their parenting style towards their child with hearing loss. For example, parents may have to adopt a more authoritative parenting style. This may require of parents to be responsive to the child’s emotional needs while having high standards, setting limits, and being consistent in enforcing boundaries.

Responsive parenting involves accepting a child's hearing loss. Responsive parents are able to adapt their parenting style so that it is responsive to their child's hearing loss needs and limitations. These parents are open to learning about their child's hearing loss and not to limit their parenting abilities. They are willing to learn from their child, become involved in the activities of their children, ask questions, and be informed, and become the experts of their children's hearing loss.

Practitioners' support to parents

- Professional support should ensure that support is individualised to the unique needs of families (Moeller et al., 2013). This requires professionals to understand families in terms of their backgrounds, experiences, personal economic situation, and access to social support.
- Understanding parents and family members personal beliefs, for example, on disability and their view of their children's abilities, will go a long way in providing support to parents and families. This kind of professional support is family-centred, which is sensitive to the diverse needs and context of families (Poon & Zaidman-Zait, 2013).
- Targeted support for fathers is crucial – this includes acknowledging the unique role fathers play in their deaf children's lives – tailoring services to them, and providing opportunities to engage firsthand with appropriate support networks.
- Fathers need to be offered increased access to support, to be provided with opportunities to network with other fathers, and to have their need for information and emotional support within the family addressed.
- Individual and family counselling provided to fathers can help them express their grief and become more involved and confident in their family and parenting role.

7. B4.3 Guidelines on resource support for parents

Guidelines for parents

It is important that parents are provided with information in relation to parenting a child with hearing loss. This will in turn assist parents to be more confident and sensitive in their parenting practices towards their child's needs. Information will assist parents to cope and enable them to make more informed decisions and choices, and thereby become active in their parenting role in child management. Parents should be proactive and ask questions, as information can assist parents to become self-reliant, leading to parent confidence and exercising of own judgement in line with informed (parenting) choices.

- Parents must be informed and become the expert on their child's hearing loss. They should not readily accept or rely on professionals to make decisions on their behalf. Instead, they should search the Internet, connect and ask other parents, and not allow professionals to rush them to make decisions without providing alternatives. In becoming the experts of their children's hearing loss, parents should elicit professional support that is empathetic and unbiased**.** Often parents become strongly influenced by the information they receive from professionals.
- Furthermore, parents should inquire and gain an understanding of their child's hearing loss. They must be aware and have an understanding of the **type and degree of hearing loss** the child has been diagnosed with as this will assist them to make informed decisions about communication and education options for their child. Almost all parents are interested in knowing more about the function of the ear and where the hearing loss occurs, these explanations can be facilitated through diagrams or simple videos.
- Parents should ask for a careful explanation of the **audiogram** each time the child's hearing is assessed to facilitate their understanding. The audiogram should also be explained to other family members, including grandparents, caregivers, siblings, and the child with a

hearing loss. Explanations and clarification of questions will enhance their understanding and improve family relationships. Parents should be encouraged to keep a record (in a file) of all the hearing tests done with the child.

- It is vital that parents explain the hearing loss to the child so that they too have an understanding of their own hearing loss – they need to accept their hearing loss and should be able to explain with confidence what they can and cannot hear. This enhances their self-acceptance and confidence.
- Parents should be open to meeting **Deaf mentors.** Deaf mentors can be a vital resource for parents and families in understanding their child's journey. They can also become role models for young children with a hearing loss, especially when these Deaf mentors have become successfully integrated into society. In addition, they understand the parents' journey, as they too have walked, or are walking, the same journey with their own parents. Parents can learn from the experiences and perceptions of Deaf people.

Practitioners' support to parents

- In providing resource support to parents from a family-centred approach, practitioners should actively support the decisions made by parents which lends itself to self-determination.
- In order to support and strengthen parents and families, practitioners are encouraged to form family-professional partnerships that both nurtures and enhances family well-being. The family-professional relationship is vital as it facilitates shared decision-making where parents and families together with the child with a hearing loss participate and share in all the decisions related to intervention.
- Collaboration and partnerships between practitioners should view parents as partners and not mere receivers of information. This in turn will build parents' confidence in their ability to raise and parent a child with hearing loss, and thereby transform their own parenting.

- Practitioners should provide parents with a list of different resources on where to source support. This list should include the following information: website addresses; contact information of various professionals, and a brief description of the services they offer; organisations and agencies related to children with a hearing loss and their families.
- Practitioners must acknowledge that the decision-making process belongs to each individual family and not to them.
- A **list of resources** for parents with clearly written unbiased information should be available to parents with simple diagrams to facilitate the understanding of both parents and children. Parents should consult a variety of sources that are comprehensive, meaningful, and unbiased to help them make informed decisions (Moeller et al., 2013).

7. B4.4 Guidelines on communication options

Guidelines for parents

"How will I communicate with my child?" is often one of the first questions parents ask after they discover their child has a hearing loss. While this is a question only each individual family can answer for themselves, it is often the most challenging issue because parents usually know very little about communication options available to them. The key to learning and language development is using two-way communication. This is done through the family interacting with the child and encouraging the child to interact with the family.

- The choice of communication should be in the best interest of the child and the family, and not only in the best interest of the family or parents. This means that the family should consider whether the communication choice enhances the child's relationship with family members, peers, the community, and enhances his/her own developmental outcomes.
- Parents should use and develop their own parent-child communication ques in order to understand and form a bond and relationship with their child. This helps lessen the feelings

of guilt and shame experienced by parents. Communication options should be explored further.

- Parents should be open and flexible to hear about the personal accounts of deaf adults/mentors who have a personal experience of growing up in a hearing family. Their stories of their communication struggles and challenges can provide clarity and useful information on communication for both parents and families, and can assist health care professionals on which to base a valid intervention.
- Parents and family members should take the time to learn how to communicate with the child. The responsibility of communication with the child rests on all family members and not only on the primary parent/caregiver.
- The whole family must understand the commitment of choice of communication for the child and be willing to accommodate the child's communication, including barriers to communication.
- Ask questions and talk to other families with children who have hearing loss. Parents should take their time in making communication options, discuss options with professionals, read, and obtain as much information as they can about communication options.

Practitioners' support to parents

- Practitioners should provide parents with objective unbiased information on a full range of communication options as early as possible.
- Regardless of the modality of communication chosen, practitioners should actively support the communication option chosen by parents.
- Adopt an open and flexible attitude that reflects a non-judgemental approach to parents' decisions on the communication options for their children.

- Make appropriate referrals that will assist families and children with the communication options made, regardless of their socio-economic status, income, or geographic location.

7. B5 Conclusion of the guidelines for parents and practitioners

These guidelines have been designed for hearing parents parenting children with a hearing loss. Their purpose is to foster parents' and practitioners' understanding of the challenges and needs of parents when parenting a child with a hearing loss. The guidelines highlighted four specific areas of support for parents, namely: early intervention support, social and emotional support, resource support for parents, and communication needs. It is hoped that these guidelines and their four specific focus areas will provide parents with support strategies related to family-centred approaches. These family-centred approaches include support during assessment and the planning phases of intervention when working with parents and families whose child has a hearing loss. Furthermore, it includes parents and practitioners working collaboratively in the best interest of the child, which promotes a better understanding of the diverse needs of parents and their children with a hearing loss. It allows professionals to develop an awareness of the parenting practices of parenting a child with hearing loss and to build upon individual family strengths to meet family needs. Therefore, the development of these guidelines could potentially assist with the empowering and competencies of parents parenting a child with a hearing loss.

7. B6 References

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CHAPTER 8

DISCUSSION, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

8.1 Introduction

Parenting a child with a hearing loss presents unique challenges for parents and families (Zaidman-Zait, Most, Tarrasch, Haddad-eid & Brand, 2016). The findings of this study contributed to the development of guidelines for hearing parents parenting children with a hearing loss with the aim to strengthen parenting and build parents' confidence in their adaptation and ability to raise and parent a child with hearing loss (Bemrose, 2003). The development of guidelines was deemed necessary by parents, practitioners, researchers, academics, and community stakeholders within the Deaf community: 1) to provide hearing parents with support so that they play a meaningful role in parenting their child with a hearing loss; 2) to improve parents parental self-efficacy when parenting a child with a hearing loss; 3) to form partnerships between parents and practitioners to improve parent-child relationships. Family systems theory (Bowen, 1976) views the family as a system (a unit) with each family member playing an important part. This theory implies that when something happens to one member of the family, the whole family system is affected (Seligman & Darling, 2009). It is therefore assumed that disability, and in this case, child hearing loss, places extra demands or challenges on the family system, affecting relationships and roles of each one in the family (Aksoy & Yildirim, 2008). The assumption is that when a child with a hearing loss is born into a hearing family, family structure and family functioning is disrupted (West, 2012). For this reason, emphasis was placed on understanding the challenges parents and families experience when parenting a child with a hearing loss by exploring and determining what these challenges are and their influence on parenting and families.

The aim of the current study was to develop guidelines for hearing parents parenting children with a hearing loss. The objectives of the study were to:

1. Explore previous literature on interventions targeting parenting styles of hearing parents parenting children with hearing loss (Chapter 4).
2. Determine the parenting styles of hearing parents parenting children with hearing loss (Chapter 5).
3. Determine the challenges that contribute to parenting a child with a hearing loss, including parental self-efficacy (Chapter 5).
4. Explore the challenges and social needs of hearing parents parenting children with hearing loss (Chapter 6).
5. Develop guidelines on parenting for hearing parents to parent children with a hearing loss (Chapter 7).

These objectives have been achieved and were discussed in the finding's chapters (Chapters 4–7). This chapter provides an overall discussion of the findings, followed by recommendations for practice and future research along with the limitations that were encountered. The Chapter concludes with some final remarks.

8.2 Discussion of the overall findings

The findings in Phase 1 and Phase 2 resulted in the development of guidelines for hearing parents parenting children with a hearing loss. Phase 1 with its three stages focused on identifying the problem by conducting 1) a scoping review, 2) a quantitative inquiry, and 3) a qualitative inquiry by exploring the challenges and social needs of parents, eventually leading to the development of the guidelines.

Stage 1, the scoping review, addressed the interventions of parenting styles and practices of hearing parents when parenting a child with a hearing loss. It sought to determine what research has already been published on the topic. By synthesising and analysing an extensive body of research to provide a better understanding and clarity about existing interventions for hearing parents parenting children with a hearing loss, the findings of the review did not specifically address parenting styles. However, the review highlighted a number of important challenges and strengths that clarify the significance of intervention programmes for hearing parents of children with a hearing loss (DesJardin, 2003). Importantly, what the review revealed was that there is only one parent intervention programme for hearing parents parenting children with a hearing loss in South Africa. Consequently, another parent intervention programme was established by parents for parents of children with a hearing loss. This study highlighted the urgent need for more parenting support for hearing parents parenting children with hearing loss, especially in the South African context. The results of the review advanced the argument that support programmes for hearing parents parenting children with a hearing loss are essential and has the potential to promote support and positive outcomes for both parent and child. Therefore, the question posed, *What are the interventions, programmes, best practices or approaches targeting parenting styles of hearing parents parenting children with hearing loss?* (as discussed in chapter 4), was satisfied through the scoping review.

In Stage 2, a quantitative inquiry, determined the parenting styles of hearing parents and the challenges that contribute to their parenting style, and how these in turn influenced parents' parental self-efficacy. The findings of the quantitative inquiry showed the differences in mothers' and fathers' parenting styles, and in addition, parents' insights into their own challenges that contributed to their parenting styles as well as to their parental self-efficacy.

Stage 3, a qualitative inquiry, explored the challenges and social needs of hearing parents when parenting a child with a hearing loss. The findings revealed the challenges the parents experienced and the support they considered important and necessary to assist them in parenting a child with a hearing loss. This study described the challenges and support needs of parents and how these can be addressed within the development of guidelines for parents.

Therefore, Phase 1, through its three stages of inquiry, revealed that guidelines were indeed necessary and that the following points concerning support need to be addressed when developing guidelines for parents: a) programme support for parents providing a clearer understanding of parents' perspectives of their parenting approaches and the factors contributing to their parental self-efficacy when parenting a child with a hearing loss; b) support on early intervention and counselling for parents; c) assistance in the form of information on social and emotional support for parents, which included support networks to minimise isolation, and support in terms of counselling for parents, siblings, and the child with the hearing loss; d) referrals to resources and the need for multifaceted information on the child hearing loss in order for parents to make informed choices concerning their child, with an emphasis on collaborative partnerships between family and practitioners; and e) unbiased support and information on communication needs and options. Phase 1, therefore, provided some valuable insights and awareness into the kind of guidelines needed to be developed to assist parents in their parenting role when parenting a child with a hearing loss, and that support for parents must be to improve parent child relationships, parenting satisfaction, adaptation of parenting styles, parental self-efficacy, knowledge, and parental adjustments (Ruane & Carr, 2018).

Phase 2 of the study focused on the development of the guidelines by conducting a consensus workshop with a two-stage approach. The objective of the consensus workshop was to present the key findings of Phase 1 and engage with a panel of experts and a panel of stakeholders, and work towards reaching consensus. Collaboration was noted as vital in both workshop rounds for the successful development of the guidelines. Round 1 of the consensus workshop was presented to university academics who are knowledgeable and have significant experience in the field of child, family, and disability studies, and who have expertise at the research, clinical, and policy level. The panel of experts eventually reached consensus on four themes and 13 sub-themes. Round 2 of the consensus workshop was presented to stakeholders in the in the field of hearing loss. All of the recommendations made in Phase 1 of the research study and in Round 1 by the panel of experts were agreed upon, with the suggestion of two additional guidelines by the panel of stakeholders. The consensus workshop provided an opportunity to engage in knowledge transfer and arrive at a deeper understanding of what was to be included in the guidelines. Phase 2 was therefore applied towards advancing the development of guidelines for hearing parents parenting children with hearing loss.

Due to the lack of studies focusing on guidelines for hearing parents in South Africa, it is difficult to compare and contrast the current findings. However, this study could assist in the provision of support for parents in South Africa through parent support programmes. Parent support programmes that provide support for well-being are likely to see a positive effect on the overall development of the child (Calderon & Greenberg, 2003). In addition, these guidelines can be a valuable source for policy makers due to their unique nature and recommendations for programme support for families and parents of children with a hearing loss. Policies on families draw strongly from a family systems approach in which family and governmental factors are considered in addressing the needs and support for families. These guidelines further allow for support to families and parents, regardless of the family's socio-economic status, income, or geographic location. In addition, they are also culturally sensitive and adaptive to the family context, which includes the family's spirituality, views of disability, child-rearing practices, and family structure (Moeller, et al, 2013). A move to develop guidelines that link to cultural diversity and that is tailored towards the needs of the individual as well as that of the family, especially within the South African context, echoes an authentic family-centred approach to delivering support to families. The research therefore has local relevance.

In terms of international practices, it appears that the way the current guidelines were developed is in line with an international study conducted by Moeller et al., (2013). These authors developed ten international guidelines for families with deaf children by identifying family-centred practice guidelines that were specific to partnering with families. The goal of these ten guidelines was to enhance family support for families, parents, and children with a hearing loss. It was envisaged that similar guidelines would be developed by countries to support families and children with hearing loss. It is evident that the content of the current guidelines is aligned to this international study. The findings in this study followed a scientific process (community engagement) towards local and international relevance to understanding and supporting healthcare practitioners and hearing parents parenting children with a hearing loss. The study itself was explorative in that it sought to research a relatively new problem about which little is known. It attempted to provide a solution based on collaborations in the form of guidelines, and therefore lends itself to local relevance to influence policy issues in South Africa pertaining to the crucial need for parental support as government should design and facilitate programmes to strengthen families (Department of Social Development, 2013). Its international relevance forms part of an international call for action for adapted Global Coalition of Parents of Children who are Deaf or Hard of Hearing (GPOD) which calls for a research agenda through collaboration of practices in various countries (Moeller et al., 2013).

Using family systems theory as a conceptual framework, the development of the guidelines is theoretically grounded to support family and parents when parenting a child with a hearing loss. A family systems approach theorises that the family system is the primary and most powerful system to which a person belongs. As mentioned earlier, family systems theory posits that if anything happens to one member of the family, the member as well as the whole family system is affected (Hendersen & Hendershott, 1991; Lutherman & Ross, 1991; Seligman & Darling, 2009). These authors point out that a child with a hearing loss is part of the family system, and therefore, the hearing loss belongs not only to the child but to the whole family. Therefore, the development of these guidelines enhances parent self-efficacy, family well-being, parent-child relationships, and the overall functioning of the whole family.

While the guidelines are aimed at supporting hearing parents in parenting a child with a hearing loss, it includes guidelines for health care practitioners on how to support families, parents in parenting, and children with hearing loss. As highlighted in the preceding chapters, particularly in the consensus workshop, partnerships between the family and practitioner are imperative. In that, creating a collaborative environment allows for best strategies to be sought. Most importantly, healthcare professionals must be aware of the dynamics of the family itself, especially when families are offered comprehensive family support during assessments and planning phases of social service in which the family identifies concerns. Service delivery that includes family concerns shows respect, recognises and supports family diversity within family formation (beliefs, culture, values, and family dynamics), and implements participatory help whereby the focus is on family involvement in achieving family goals and outcomes. The acknowledgement of families' and parents' experiences and challenges when parenting a child with a hearing loss provides essential information necessary for valid assessments and appropriate planning (Kemp, Marcenko, Hoagwood & Vesneski, 2009). Likewise, through a family-centred approach, there is a partnership taking place between family and healthcare practitioners that facilitates and sustains positive change (Kokorelias, Gignac, Naglie & Cameron, 2019). The consensus workshop created a collaborative environment that facilitated and actively supported parents in the process of participation and reaching consensus with experts and stakeholders in the field of hearing loss. This in itself points to parent leadership and ownership of intervention services, and more importantly, strategic developments for parents parenting children with a hearing loss. Interdisciplinary collaborations among healthcare practitioners when rendering services to a family and parents parenting children with a hearing loss are also important. This approach includes, but is not limited to, collaborations between parents, social workers, psychologists, audiologists, Deaf mentors, service providers/organisations of the deaf, and family and support networks. These are professionals who have the necessary skills to match the specific needs/concerns of family and parents and are comfortable with role release to make referrals in the best interest of the family. Professionals should guard against self-interest, which includes providing information and opinions that are biased, but should promote self-assessment and self-reflection when rendering services to families and parents.

It is envisaged that the carefully crafted and specifically formulated guidelines developed in this study will inform future practice and the work of professionals particularly in the field of child hearing loss, including social workers, family practitioners, audiologists and community workers. Next, a set of recommendations are made, targeted at three groups: (1) future practice, (2) practitioners in the field, and (3) future research in the area. The first two points are combined under the first heading below.

8.3 Recommendations from the study findings

This research study was positioned within the pragmatic worldview that necessitates the identification of a problem. It attempted to find a solution that may be used to bring about change in the field of social work and other related fields working with families and children with hearing loss. A holistic approach is necessary because children co-exist within families. This research identified the scarcity of guidelines for parents and the lack of research focusing on support in the South African context. This highlights the need for research on parents parenting children with a hearing loss in South Africa, with a specific focus on support for these parents and their families. It is envisaged that these guidelines will be used as a guide in the rendering of support services to families and parents in parenting a child with a hearing loss.

8.3 1 Recommendations for practice/practitioners

It is recommended that:

- Social work practice build on the insights generated herein and incorporate these guidelines in their practices, focusing on specific areas relevant to parenting a child with a hearing loss. For instance: 1) assisting parents to adapt their parenting approaches to parenting a child with a hearing loss; 2) emphasising and focusing on the challenges parents are confronted with when parenting a child with a hearing loss; and 3) creating awareness of how the child’s hearing loss affects parents’ self-efficacy.
- Professionals (social workers, family practitioners, audiologists, and community workers) working in this context obtain a deeper understanding of the unique experiences and needs of these families and thereby provide services that are culturally sensitive, family specific, and intervention specific.
- Social workers obtain the prerequisite skills to provide family-centred social work intervention.
- Continued training and curriculum development take place in the field of social work, with specialised knowledge and skills in hearing loss for early intervention with parents, families, and children with a hearing loss.

- Family-centred support be linked to macrosystemic support, such as communities and the services they provide to families.

- The Department of Social Development and the Department of Health use the insights generated herein as a framework or foundation to design and develop relevant and suitable programmes to meet the needs of families and parents parenting a child with a hearing loss. If these programmes cannot be facilitated by government, there should be a concerted effort made by government to fund such programmes offered by organisations of the deaf or parent support programmes. Such funding can ensure that parents have access to a range of resources and formal support that can specifically assist them in adapting their parenting approaches to parenting a child with a hearing loss.

8.3.2 Recommendations for future research

It is further recommended that future research be conducted on:

- The challenges and needs of hearing parents parenting a child with a hearing loss.
- Parenting programmes targeting hearing parents parenting children with a hearing loss (as there are currently only two reported programmes that address this need in the country).
- The role of the father in parenting a child with hearing loss, as they offer valuable and unique perspectives and insights.
- The experiences of deaf adults. Insight into their lives and growing up in a hearing family is an important resource for parents and children with a hearing loss.
- Deaf parents raising deaf children. Comparative studies comparing the experiences of deaf parents with those of hearing parents maybe provide invaluable research and insights.
- The topic in different geographical areas in South Africa, to identify trends as well as compare parents’ challenges, experiences, perceptions, and needs.
- The topic through collaborative research at university level, among organisations of the Deaf, not only in South Africa, but across the African continent.

8.4 Study limitations

The following limitations were encountered in this study:

- Paternal participation in the study was a challenge.
- The study was conducted in Cape Town, one region of South Africa. The findings may therefore not be generalisable to other regions of the country.
- Literature on interventions on parenting approaches in South Africa, Africa, and across the globe are limited, and many of the existing sources are outdated.

8.5 Conclusion

The purpose of this study was to develop guidelines for hearing parents parenting children with a hearing loss. This was done using a mixed methods approach with a sequential explanatory design using a two-phased approach. The research study included four studies, comprising a scoping review, quantitative and qualitative studies, and a consensus workshop.

Regarding the theoretical implications of this research, the findings support that the family systems theory is of critical importance and has a strong influence on family and children. The study’s approach and design assisted in 1) understanding the parenting style framework, which lends itself to the different, modified, or adjustable parenting approaches parents employ when parenting a child with a hearing loss; 2) determining and exploring parents’ challenges and experiences, which ultimately led to the design of guidelines for parents parenting a child with a hearing loss.

This research study holds promising results in terms of implementation from a family-centred approach. The research study gives rise to broadening our knowledge into the challenges and experiences and social support needs of hearing parents parenting a child with a hearing loss and how collaboration between healthcare practitioners and parents is key in delivering effective services to parents and families.

8.6 References

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Appendices

Appendix 1: Ethical Clearance

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 4111/2948
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07 August 2018

Mrs R Davids
Social Work
Faculty of Community and Health Science

Ethics Reference Number: HS16/6/12

Project Title: To develop guidelines for hearing parenting deaf children.

Approval Period: 14 June 2018 – 14 June 2019

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER - 130416-049

FROM HOPE TO ACTION THROUGH KNOWLEDGE

Appendix 2: Permission from the WCED

Western Cape
Government
Education

Directorate: Research

Audrey.wyngaard@westerncape.gov.za
tel: +27 021 467 9272
Fax: 0865902282
Private Bag x9114, Cape Town, 8000
wced.wcape.gov.za

REFERENCE: 20171101–6405
ENQUIRIES: Dr A T Wyngaard

Mrs Ronel Davids
Faculty of Community and Health Sciences UWC
Private Bag X17
Bellville
7535

Dear Mrs Ronel Davids

RESEARCH PROPOSAL: GUIDELINES FOR HEARING PARENTS PARENTING DEAF CHILDREN

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **23 January 2018 till 30 April 2018**
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).

Should you wish to extend the period of your survey, please contact Dr A.T Wyngaard at the contact numbers above quoting the reference number?

7. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
8. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
9. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
10. The Department receives a copy of the completed report/dissertation/thesis addressed to:

The Director: Research Services
Western Cape Education Department
Private Bag X9114
CAPE TOWN
8000

We wish you success in your research.

Kind regards.
Signed: Dr Audrey T Wyngaard
Directorate: Research

Appendix 3: Information Sheet

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2012 Fax: 27 21-959 4028
E-mail: rsdavids@uwc.ac.za

INFORMATION SHEET

Project Title: To develop guidelines for hearing parents parenting children with a hearing loss

What is the study about?

This is a research study conducted by student, Ronel Davids from the University of the Western Cape. You are invited to voluntarily participate in this research project because we would like to understand how hearing parents parent a deaf child. The purpose of this research is to document the narratives the hearing parenting styles and practices when parenting a deaf child.

What will I be asked to do if I agree to participate?

The first part of the study will require you as participant to complete a questionnaire. The questions will probe; parenting practices, styles and parenting factors.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect you confidentiality, the information you provide will be totally private; no names will be used so there is no way that you can be identified as a participant in this study. The information will be treated with anonymity and confidentiality.

What are the risks of the study?

There are no known risks in participating in the study. However all human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study.

What are the benefits of this research?

The research will provide an opportunity for hearing parents to share their narratives of raising a deaf child to be documented. It will also provide an opportunity for guidelines to be written to enhance parents-child relationships.

Describe the anticipated benefits to science or society expected from the research, if any?

The research findings will contribute to the broader information and understanding on hearing parents parenting a deaf child.

Do I have to be in this research and may I stop participating at any time?

If you decide to participate in the study, and at any time during the interview process change your mind, and decide to end the interview you will not be penalized in any way.

Is any assistance available if I am negatively affected by participating in this study?

Every effort has been taken to protect you from any harm in this study. If however you may feel affected you can be referred to your nearest community resource for assistance.

What if I have questions?

Should you have any questions regarding this study or wish to report any problems you have experienced related to this study, please contact my research supervisors:

Professor C. Schenck	Or	Prof. N. Roman
Telephone: 021-959 2012		Email: nroman@uwc.ac.za
Email: cschenck@uwc.ac.za		
University of the Western Cape		
Private Bag X17		
Bellville, 7535		

Thank you for your participation!

Appendix 4: Consent form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2911, Fax: 27 21-959 2911

CONSENT FORM

Title of Research Project: ***The development of guidelines for hearing parents parenting children with a hearing loss***

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name………………………..
Participant's signature…………………
Date………………………

Researcher's details

For any further enquiries, the following persons may be contacted in relation to the study:

Supervisors:

Prof. Rinie Schenck (Schenckc@gmail.com), and

Prof N. Roman (nroman@uwc.ac.za)

Contactable at: 021 9593960

Research student:

Ms Ronel Davids (rsdavids@uwc.ac.za)

Appendix 5: Research Confidentiality Form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2012 Fax: 27 21-959 4028

E-mail: rsdavids@uwc.ac.za

CONFIDENTIALITY FORM

Title of Research Project: To develop guideline for hearing parents parenting children with a hearing loss

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits

Participant's name…………………………………………………………………………………

Participant's signature……………………………………………………………………………..

Date………………………………………………………………………………………………..

Appendix 6: Quantitative Questionnaire

Quantitative Questionnaire: To determine the parenting styles when parenting a deaf child and to determine the challenges that contribute to parenting a child with a hearing loss including parental self-efficacy

Instructions: This questionnaire is confidential. No names are included. Please answer as truthfully as possible as your answers can lend to a better understanding for hearing parents parenting **deaf children.**

Section A: Please complete the following by marking an X in the appropriate space

Biographical Information		
Gender	Male	Female / Ibhinqa
Age of parent		
Race	Black	White
	Coloured	Indian
Relation to child	Mother	Father
Home Language		
Age of your deaf child		
Gender of Deaf child	Male / Manlik / Yindoda	Female / Vroulik / Bhinqa

Section B: **Social Context Questionnaire**

The following section is about attitudes and behaviours towards your child. Please indicate with a cross (x) the attitude or behaviour you show towards your child by answering the following questions.

Warmth	Not at all true /	Not very true	Sort of true	Very true
1. I know a lot what goes on with my child				
2. I really know how my child feels about things				
3. I do special things with my child				
4. I set aside time to talk to my child about what is important to him/her				
5. I let my child know that I love him/her				
Rejection	Not at all true	Not very true	Sort of true	Very true

6. I don’t understand my child very well				
7. Sometimes my child is hard to like				
8. At times, the demands that my child makes feel like a burden				
9. My child needs more than I have time to give him/her				
10. Sometimes I feel like I can’t be there for my child when he/she needs me				
Structure	Not at all true	Not very true	Sort of true	Very true
11. I make it clear to what will happen if my child does not follow the rules				
12. I make it clear to my child what I expect from him/her				
13. I expect my child to follow our family rules				
14. When I tell my child I’ll do something, I do it.				
15. If my child has a problem, I help him/her to figure it out what to do about it.				
Chaos	Not at all true	Not very true	Sort of true	Very true
16. I let my child get away with things I really shouldn’t allow				
17. When my child gets in trouble, my reaction is not very predicable				
18. My child doesn’t seem to know what I expect from him/her				

19. I change the rules a lot at home				
20. I can get mad at my child with no warning				
Autonomy Support / Inkxaso yokuzimela	Not at all	Not very true	Sort of true	Very true
21. I encourage my child to express his/her feelings even when it is too hard to her				
22. I encourage my child to express his/her opinion even if I don't agree with them				
23. I trust my child				
24. I encourage my child to be true to him/herself				
Coercion	Not at all true	Not very true	Sort of true	Very true
25. My child fights with me at every turn				
26. To get my child to do something, I have to yell at him/her				
27. I can't afford to let my child decide too many things on his/her own				
28. I sometimes feel that I have to push my child to do thing.				
29. I find getting into power struggles with my child.				
Section C: Emotion-Related Parenting Styles Scales Instructions: Please answer the following questions by indicating with an (x), what your response is to your child				
Parental acceptance		Always	Sometimes	Never /

30. I want my child to experience sadness			
31. I want my child to experience anger			
32. I think it is good for kids to feel angry sometimes			
33. A child's anger is important			
34. Children have a right to feel angry			
Parental rejection / Ukulahlwa kwabazali			
35. Children acting sad are usually just trying to get adults to feel sorry for them.			
36. Children often act sad to get their way			
37. I don't mind dealing with a child's sadness, so long it doesn't last too long			
38. When my child gets sad, I warn him or her about not developing a bad character			
39. When my child gets angry, my goal is for him/her to stop			
Emotion Coaching			
40. When my deaf child is sad, we sit down and talk about the sadness			
41. When my deaf child is sad, I try to help my child to figure out why the feeling is there.			
42. When my deaf child is sad, I try to help my child to explore what is making him/her sad			
43. When my child is angry, it's time to solve a problem.			

44. When my child is sad, I try to help him or her figure out why the feeling is there.			
Uncertain/Ineffective			
45. When my child is sad, I'm not quite sure what he or she wants me to do			
46. When my child is angry, I'm not quite sure what my child wants me to do			
47. When my child gets angry with me, I think " I don't want to hear this"			
48. When my child gets angry, I think, " if only he/she could just roll with the punches"			
49. When my child gets angry, I think, "Why can't her/she accept things as they are".			

Section D: ***Parental self-efficacy.*** The Parenting Ladder

INSTRUCTIONS: For the following questions, think about parenting as a ladder that you climb from the lowest rung to the highest rung. This ladder has 6 levels from 0 = Low to 6 = High. For each question, **circle the number that best describes where you see yourself on the ladder.**

1. Your knowledge of how your child grow and develop	**0 2 3 4 5 6**
2. Your confidence that you know what is right for your child	**0 2 3 4 5 6**
3. Your confidence in your ability to handle the day-to-day challenges of raising your child	**0 2 3 4 5 6**
4. Your ability to help your child learn	**0 2 3 4 5 6**
5. Your ability to cope with the stress in your life (self-care/stress management)	**0 2 3 4 5 6**

6. The amount of positive or helpful interactions you have with other parents	**0 2 3 4 5 6**
7. Your awareness of community information and resources for parents	**0 2 3 4 5 6**
8. The amount of helpful parenting information and support you get from others	**0 2 3 4 5 6**
9. The amount of communication and problem solving with your partner about issues related to your child (*leave blank if you do not have a partner*)	**0 2 3 4 5 6**
10. Your satisfaction with your experience as a parent	**0 2 3 4 5 6**

Email to Ronel Davids on rsdavids@uwc.ac.za Your assistance is greatly appreciated.

Appendix 7: Qualitative Questionnaire

Qualitative Questionnaire: to explore the challenges and social needs of hearing parents parenting children with a hearing loss.

Instructions: This questionnaire is confidential. No names are included. Please answer as truthfully as possible as your answers can lend to a better understanding for hearing parents parenting **deaf children.**

Section A: Please complete the following by marking an X in the appropriate space

Biographical Information		
Gender	Male	Female / Ibhinqa
Age of parent		
Race	Black	White
	Coloured	Indian
Relation to child	Mother	Father
Home Language		
Age of your deaf child		
Gender of Deaf child	Male / Manlik / Yindoda	Female / Vroulik / Bhinqa

The following interview questions were asked, which focused on parents' challenges and social needs:

5. Tell me about your experience of parenting a child with hearing loss;
6. Tell me about the communication, information and social support challenges you experience when parenting your child with a hearing loss;
7. Tell me how these challenges affect your experience as a parent of a child with hearing loss; and
8. What kind of support do you think parents need to assist them in their parenting role, when parenting a child with a hearing loss?

Appendix 8: Afrikaans article translated into English

Title: Parenting approaches of hearing mothers and fathers parenting children with hearing loss

SUMMARY

Research shows that 90% of children with a hearing loss are born to hearing parents (Cole & Flexer, 2016; Lederberg, Schick & Spencer, 2013). These parents may experience difficulties in developing effective parent child-rearing approaches and may struggle in their confidence to parent a child with hearing loss (Calderon, Bargones & Sidman, 1998). Studies has shown that family interactions, family resources, parenting, and support services are all areas of family life that are affected by having a child with a hearing loss. In addition, hearing parents don't just experience challenges in relation to their child's hearing loss but their experiences are further intensified by navigating through other challenges such as stress, communication, social support and access to information. Moreover parents confidence in their ability to parent a child's with a hearing loss may be affected.

In this study we examine whether mothers and fathers parent differently and whether external factors may determine their parental confidence when parenting a child with hearing loss.

INTRODUCTION

Studying parenting can be controversial because there are no prescriptive books describing how children should be raised (Roman, Makwakwa, & Lacante, 2016). Parenting is personal, and depending on the social milieu the family finds itself in, some parents may describe their experiences as rewarding, exhausting, and life-changing (Fox, 2009). Added to the complexity of parenting for example, is child disability within a family, which may inevitably call for different parenting approaches from parents.

Over the years, researchers have studied different approaches to parenting in raising children (Carr & Pike, 2012) and have examined a variety of parenting styles and the effects these may have on child outcomes. Each parenting style carries different characteristics and brings about different reactions in children. These different characteristics are portrayed as dimensions (Baumrind, 1971) which are described as the descriptive characteristic used to capture the nature of parenting styles (Ekim & Ocaksi, 2016) as well as behaviours or disciplinary strategies parents use to influence child behaviour (Jago, Davison, Thompson, Page, Brockman & Fox, 2011).

Most research on parenting has been influenced by the research of Diana Baumrind in the early 1960s to describe patterns of parental control and child socialization. These parenting styles are presented in four parenting styles - , authoritarian, authoritative, permissive and uninvolved parenting styles. In terms of authoritarian and authoritative parenting styles, the differences between the two parenting styles lie in how parents communicate with their children and how the children are punished. Authoritarian parenting is characterized by high demands and low responsiveness. Parents with an authoritarian style have very high expectations of their children, yet provide very little in the way of feedback and nurturance. In contrast, authoritative parenting is a parenting style characterized by high responsiveness and high demands. Authoritative parents are responsive to the child's emotional needs while having high standards. They set limits and are very consistent in enforcing boundaries. Lewis (1981) purports however, that it is not about high control of authoritative parents with rules that helps children to develop independence but authoritative parenting is rather about shared communication, the modification of parental rules through argumentation that allows for the outcome of independent children.

Although much has been written in theory about parenting styles, there is still limited research on the circumstances under which parents' parent and how these circumstances affect parenting styles and differently affect children outcomes (Raya, Ruiz-Olivares, Pino & Herruzo, 2014). Raising a child with a disability for example, may be different (Woodgate, Edwards, Ripat, Borton & Rempel, 2015) and may necessitate the need for parents to rethink their parenting approaches. Parents may make accommodations, for a child with a disability, by adapting, adjusting, educating themselves about the needs of their child and may modify their parenting behaviour and attitudes in order to become more engaged in their parenting approaches.

1. PROBLEM STATEMENT

In the context of the current study, the presence of a child with a hearing loss may affect the parenting approaches of hearing parents, which may result in parents experiencing difficulties in developing effective parent child-rearing approaches, resulting in parents being unsure of the manner in which they should raise their child (Calderon & Greenberg, 2003; Calderon, Bargones, Sidman, 1998). Family interactions, family resources, parenting, and support services are all areas of family life that are affected by having a child with a hearing loss (Haddad, Steuerwald,, Garland, 2019).

Baumrind (1971) alludes to the gender differences in parenting styles and observes that mothers are more nurturing (authoritative) than controlling (authoritarian) compared to fathers who are more demanding (authoritarian) than responsive (authoritative). Jennings and Dietz (2010) suggest that parents of children with hearing loss are more likely to be authoritarian in their parenting styles and tend to be less involved in their children's lives. Parents may for example become overprotective (Jackson, Turnbull, 2004; Koester & Meadow-Orlans, 1999), controlling (Movallali & Poorseyed, 2015) and may extend the boundary lines (Raya, Ruiz-Olivares, Pino & Herruzo, 2014; Austen & Jeffery, 2006) when parenting a child with hearing loss.

Movallali and Poorseved (2015) study on attachment styles and perceived parenting styles, reported no significant difference between perceived authoritarian and authoritative parenting styles of parents of children with and without hearing loss. However they observe that there is a difference in parenting styles in these parents especially when faced with distress and anxiety. Furthermore, it is suggested that mothers show more negative parenting behaviour and inconsistent discipline towards children with a hearing loss.

Antonopoulou, Hadjikakou, Stampoltzis, and Nicolaou (2015) study on differentiating parenting and disciplinary preferences of mothers with deaf or hard of hearing children and hearing siblings, were able to show that the dominant parenting style of mothers for both groups were authoritative and the least prevalent parental types were permissive and strict. Other studies have found mothers unreasonably overprotective of their children and unnecessary restricting their children social life (Gregory 1979) resulting in maternal intrusiveness and restricted child autonomy (Meadow-Orlans, 1990; Vaccari & Marschark, 1997). Contrary to Baumrind's (1991) assertions, one of the few studies focusing on fathers parenting children with hearing loss, observed that fathers of children with hearing loss are overprotective of their children and less democratic and disciplined in their approach, compared to fathers of hearing children (Sahli, 2011). Likewise the results of a study conducted by Antonopoulou, Hadjikakou, Dagla and Maridaki-Kassotaki, (2015) reported that children with hearing loss perceived their fathers as less authoritarian and strict than hearing adolescents do.

Literature on parental self-efficacy has shown that there is a direct link between parenting and parental-self-efficacy and quality of care provided to children (Sanders & Woolley, 2005). Most research on parental self-efficacy tend to be viewed along Bandura's (1997) theoretical assertions which is defined as a parent's belief and competence in their parental role and in their abilities to perform each task confidently. Parental self-efficacy is anchored on the parent's personal beliefs and capabilities to function competently and adequately, coping with stressful demands and challenges (Coleman & Karraker, 2003; Luszczynska, Gutierez-Dona & Schwarzer, 2005) that are faced by parents. Literature has shown that parents with high self-efficacy beliefs tend to use supportive parenting approaches and are more positive towards their children (Mouton, Loop, Stievenart, Roskram, 2018). Conversely, parents with low self-efficacy beliefs are incline to practice controlling parenting resulting in children displaying high levels of external behaviour (Roskam & Meunier, 2012).

However, to understand parental self-efficacy better, the concept of general self-efficacy may be useful to understand in the broader context of parents parenting children with disabilities. General self-efficacy may be interpreted as the overall adjustment and self-competencies of parents parenting children with disabilities (Benzies, Trute & Worthington, 2013). For example, parents of children with hearing loss may feel overwhelmed and inadequate for the task of raising a child with hearing loss (Kurtzer-White & Luterman, 2003) which may affect parents' confidence in their parenting abilities. Research on parents' self-efficacy among parents of children with hearing loss have been limited or has mostly focussed on mothers (Desjardin & Eisenberg, 2007). Luterman (1999) maintained that the self-confidence of parents, particularly of the mother, is the decisive key to the child's success,

For these parents, parental-efficacy may imply that hearing parents don't just experience challenges in relation to their child's hearing loss but their experiences are further intensified by navigating through other challenges such as stress, communication, social support and access to information. These challenges may contribute significantly to the type of parenting approach hearing parents adopt and may affect their confidence in their ability to handle day to day challenges when parenting a child with hearing loss. Movallali and Poorseyed (2015) observed that mothers of children with hearing loss reported higher levels of stress displaying negative parenting behaviours by showing no warmth and intimacy as well as being inconsistent in their discipline.

Similarly communication constraints may also cause disruption in interaction between parents and child affecting parenting roles and responsibilities negatively (Tamis-LeMonda, Uzgiris & Bornstein, 2002) prompting parents to adopt strict or punitive measures of child discipline (Sullivan, Brookhouser, Scanlan, Knutson & Schulte, 1991). A study conducted by Jackson (2011) on family support and resources for parents of children with a hearing loss, observed the need for informational resources, social resources, social-emotional support, and educational support for parents. Hintermiar (2006); Zaidman-Zait (2007) stresses the importance of parent support especially in reducing stress when parenting a child with hearing loss. They reported that sharing with other parents who also have children with hearing loss is a vital source of social emotional support for parents.

This area of research, focusing on parenting approaches in the field of disability, is not known in the South African context. Parenting research in South African have mainly focused on parents who do not have a child with a disability, even though there are studies which focus on both mothers and fathers. These studies show significant differences between the parenting approaches of mothers and fathers (Roman, Makwakwa & Lacante, 2016) with mothers being more authoritative than fathers in their parenting approaches.

In order to understand the parenting approaches of hearing parents parenting children with hearing loss, the present study aims to determine and describe the parenting approaches of mothers and fathers. In addition, the study describes the self-efficacy of both mothers and fathers when they parent a child with hearing loss.

2. METHODOLOGY

3.1 Aim of the study

The aim of the study was to determine 1) the parenting approaches and 2) contributory factors affecting the parental self-efficacy of mothers and fathers parenting children with a hearing loss.

3.2 Research approach

A quantitative research approach was followed. Knowledge was gained through careful observation and measurement, making sense of the world through a scientific process taking into account quantitative methods and statistics (Creswell, 2003; Somekh, Burman, Delamont, Meyer, Payne & Thorpe, 2005). We used the statistical data that were gathered in the study to summarise our data, describing patterns, relationships, and connections (Antonius, 2003)

3.3 Sampling

Non-probability sampling was applied for the purposes of this study. Three schools were approached to assist with data collection. Three principals of schools for the deaf were contacted and permission was sought to assist with the study. The purpose of the study was explained and with permission granted, principals distributed questionnaires as part of their correspondence to parents.

3.4 Participants

The participants in the current study involved 103 (n = 103) hearing parents from the Western Cape, South Africa. Each participant represented a family which means that for the current sample, mothers and fathers were from different families. The participants constituted a heterogeneous group in terms of age, household, relationships, educational and socio-economic profiles. Hearing parents were between the ages of 35 and 50 years of age and their children, who had hearing loss, were between the ages of 10 and 17 years. The majority of parents were female (77/74.8%), Coloured (mix race) (46/44.7%), with a majority having female children (62/60.2%)***.*** Of the single parents, the majority was female (38/77.6%).

The analyses of the groups of mothers and fathers were conducted regardless of marital status of the participant. Participants had the right to not participate, omit answering any question if it made them feel uncomfortable and to withdraw at any time during the study.

Table 1. Parents' demographics

Variables	n = 103	%
Gender		
Male	26	25.2
Female	77	74.8
Marital status		
Married	54	57.6
Single	49	52.4
Single Parenting		
Male	11	22.4

Female	38	77.6
Employed		
Male	20	19.4
Female	54	52.4
Unemployed		
Male	6	5.8
Female	23	22.3
Race		
Black	38	36.0
White	20	19.4
Coloured	46	43.7
Relation to child		
Mother	72	69.9
Father	27	26.2
Other (Foster)	4	3.9
Home Language		
English	31	30.0
Afrikaans	38	36.8
isiXhosa	32	31.06
Gender of child		
Male	40	38.8
Female	62	60.2

3.5 Research tools, data collection and data analysis

Mothers and fathers parenting approaches as well as external variables affecting hearing parent self-efficacy was measured by a self-administered questionnaire (SAQ) designed specifically to be completed by the parents'. The self-administered questionnaires were in English and were back-to-back translated into two other languages, isiXhosa and Afrikaans, which are the three dominant languages in the Western Cape, South Africa. The translation of the questionnaires were done with the intention to increase the validity and reliability of the responses of the participants even though there is no known research which suggests that these instruments were previously used in South Africa.

The self-administered questionnaire was made up of three sections that included (a) parents demographic details (b) the adaptation of the Parents as Social Context Questionnaire (PSCQ) and (c) the adaptation of the Parent Self-Efficacy Instrument [PSE].

The adaptation of the Parents Social Context Questionnaire (PSCQ) assisted with determining the parenting approaches to understand the nature of the parenting styles of mothers and fathers. This section consisted of 29 items divided into six subscales: warmth, rejection, structure, chaos, autonomy/support and coercion with each subscale containing five items with the exception of autonomy/supportive parenting dimension which contained four items. The participants were requested to answer each question pertaining to a dimension on a four-point Likert scale, ranging from "not at all true", "not very true", "sort of true" to "very true".

The PSE (Bandura, Adams, Hardy and Howells 1980) was adapted to describe parent's belief in their ability to accomplish the role of parenting successfully. The PSE included ten items that specifically looked at the external variables that may affect mother and father parental self-efficacy when parenting a child with hearing loss. These variables reflected both general parenting tasks and specific tasks relating to parenting children with a hearing loss, producing a task-specific measure of parental confidence. Each of the 10 items were rated on a 6-point scale rating parents responses, from 0 = low to 6 = high.

Both mothers and fathers completed a self-administered questionnaire. The questionnaires were entered into the Statistical Package for Social Sciences (SPSS version 25).The data were coded, cleaned and checked for errors. Both descriptive (means and standard deviations) and inferential statistics (independent samples non-parametric test – Mann-Whitney U test) were used in the analyses.

3.6 Trustworthiness

Joppe (2000:1) defines reliability as: “the extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable”. The same instruments used on the same participants should yield more or less the same score over time. Reliability was analyzed using Cronbach’s alpha. The results of the analysis showed that the items in the 2 scales indicated the satisfactory level of construct validity and internal consistency of this modified questionnaire (Taber, 2018) The Cronbach’s alpha for the PSCQ was 0.95 and PSE was 0.90

3.7 Ethics consideration

Ethical approval to conduct the present study was obtained from the University of the Western Cape, South Africa. Permission from the Western Cape Education Department was also obtained. The principals of schools for the deaf were approached to assist with the study. The purpose of the study was explained and with permission granted, principals distributed questionnaires as part of their correspondence to parents. A letter detailing ethical considerations for the study and ensuring confidentiality and anonymity by using pseudonyms and ensuring no harm to participants was included in the letter.

3. RESULTS

4.1 Table 2 presents prevalence of parenting approaches between mothers and fathers. The findings show that mothers scored higher on chaotic parenting (*M* = 2.52, *SD* = 0.62), as well as on structured parenting (*M* = 3.31, *SD* = 0.79) than fathers (*M* = 2.48, *SD* = 0.67; *M* = 3.18, *SD* = 0.89). Fathers scored higher on autonomy and supportive parenting approaches (*M* = 3.02, *SD* = 0.43), as well as, parental warmth (*M* = 3.26, *SD* = 0.68) than mothers (*M* = 3.00, *SD* = 0.68; *M* = 3.25, *SD* = 70). There was a slight difference in rating scores on parental rejection, with fathers rating themselves higher (*M* = 2.68, *SD* = 0.72) than mothers (*M* = 2.61, *SD* = 0.71). *SD* = 0.27). These differences were not significant.

Table 2. Parenting dimensions of mothers and fathers (warmth, rejection, structure, chaotic, supportive, coercion)

Variable		N	*M*	*SD*	*t*	*p*
Parental Warmth	Father	25	3.26	0.68	0.055	0.957
	Mother	76	3.25	0.70		
Parental Rejection	Father	24	2.68	0.72	0.418	0.677
	Mother	74	2.61	0.71		
Structure in Parenting	Father	26	3.18	0.89	–0.714	0.477
	Mother	77	3.31	0.79		
Chaotic Parenting	Father	25	2.48	0.67	–0.292	0.771
	Mother	75	2.52	0.62		
Autonomy Supportive Parenting	Father	21	3.02	0.43	0.109	0.913
	Mother	67	3.00	0.68		
Coercion Parenting	Father	24	2.30	0.88	–0.704	0.483
	Mother	75	2.44	0.82		

Table 3 presents mean scores and standard deviations of mother and father responses to the PSE to describe parent’s belief in their ability to accomplish the role of parenting successfully.

Fathers rated themselves higher on their knowledge of how their child grows and develops (*M* = 5.36) compared to the lower self-rating scores by mothers (*M* = 4.73). Fathers also scored higher (*M* = 5.40) on the amount of communication and problem solving with their partners about issues related to their child compare to mothers (*M* = 4.18). In addition, fathers rated themselves higher on the amount of positive or helpful interactions they have with other parents (*M* = 4.84) than mothers who rated themselves lower (*M* = 4.18). Fathers again scored higher on their ability to help their child learn (*M* = 5.42) compared to mothers who scored lower in their ability to help their child learn (*M* = 4.83). Similarly, fathers also rated themselves higher on their confidence and ability to handle the day to day challengers of raising their child with a hearing loss (*M* = 5.54) than mothers confidence and abilities (*M* = 4.97). Fathers also rated themselves higher on their ability to cope with the stress in their life (*M* = 5.24) to mothers (*M* = 4.68).

Table 3 Parental self-efficacy of mothers and fathers

Variable		*N*	*M*	*SD*
Your knowledge of how your child grow and develop	Father	25	5.36	.995
	Mother	73	4.73	1.16
Your confidence that you know what is right for your child	Father	24	5.50	.722
	Mother	75	4.96	1.12
Your confidence in your ability to handle the day-to-day challenges of raising your child	father	24	5.54	.78
	Mother	76	4.97	1.05
Your ability to help your child learn	Father	24	5.42	1.07
	Mother	76	4.83	1.16
Your ability to cope with the stress in your life (self-care/stress management)	Father	25	5.24	1.01
	Mother	75	4.68	1.21
The amount of positive or helpful interactions you have with other parents	father	25	4.84	1.31
	Mother	66	4.18	1.26
Your awareness of community information and resources for parents	father	24	4.46	1.47
	Mother	66	4.18	1.26
The amount of helpful parenting information and support you get from others	Father	25	4.92	1.35
	Mother	62	4.65	1.26
The amount of communication and problem solving with your partner about issues related to your child (*leave blank if you do not have a partner*)	father	25	5.40	.91
	Mother	58	4.76	1.25

Your satisfaction with your experience as a parent	Father	25	5.16	1.25
	Mother	75	4.93	1.16

In Table 4, an independent samples t-test was conducted to determine if mothers and fathers were significantly different in their parental self-efficacy. A Mann-Whitney U test showed there was a significant difference (U= 346.500, p =.002) for parental self-eficacy with fathers (M = 5.21, SD = 0.61) scoring higher than mothers (M = 4.46, SD = 0.98). Fathers scored higher in knowledge, confidence, handling of stress, communication, positive interaction and satisfaction than mothers.

Table 4. Overall parental self-efficacy of mothers and fathers – independent t-test

Variable		**N**	*M*	*SD*	***T***	***U***	***p***
Parental self-efficacy	Father	26	5.21	0.61	4.06	346.500	0.002
	Mother	77	4.46	0.98			

4. DISCUSSION

The aim of the study was to determine and describe the parenting approaches of mothers and fathers. In addition, the study describes the self-efficacy of both mothers' and fathers when they parent a child with hearing loss. This was the first known South African study in this field. The results of the study adds to the research on examining gender differences in terms of the parenting of hearing parents when parenting a child with hearing loss.

Our results revealed that mothers' scored higher on chaotic and coerced parenting approaches as well as higher on their structured parenting approaches. Mothers also scored lower in all of the variables related to self-efficacy. Two of the low scores included mother's confidence in their ability to handle the day to day challenges of raising a child with hearing loss and their satisfaction with their experiences as a parents of a child with hearing loss. These discrepancies in the results may be founded on mothers' experiences of their everyday responsibilities when taking care of their child as the primary caregiver (Zaidman-Zait, Most, Tarrasch, Haddad-Eid & Brand, 2015). Feeling less satisfied as parents may suggest that mothers experience emotional exhaustion and reduced feelings of parental accomplishment and efficacy (Roskam, Raes & Mikolajczak, 2017) when parenting a child with a hearing loss. A further possible explanation for these results may relate to the fact that the majority of the mothers are employed (72.9%) and therefore may assume dual roles in families. These greater responsibilities may result in mothers structuring their parenting responsibilities by assuming the overall rehabilitation (educational, medical, communication) responsibilities for their child but then still having to juggle work and child rearing responsibilities.

These findings may further suggest that child-rearing responsibilities may be exacerbated by navigating through the developmental stages the child found him/herself in. The cohort of parents participating in this study were of children between the ages 10 and 17. Therefore one way to understand these findings is that this age group often presents a difficult transitional period for both parents and child which may cause (i) physical and emotional exhaustion; (ii) emotional distancing from one's children, and (iii) a sense of incompetency in one's parenting role (Mikolajczak, 2018) which may account for the rigidity and inconsistency in mothers parenting approaches.

In addition, mothers scored lower on the stress variable compared to fathers. Parenting stress in parents of children with hearing loss has been associated with negative outcomes for both parents and children which include poor attachment, less positive parent and child interaction as well as marital unhappiness (Asberg, Vogel & Bowers, 2008). One way to understand these findings is related to age, (adolescents) and child gender. The results may suggest that the older the children are the more stress mothers may experience. This age group is coupled with adolescent challenges such as body changes, emotional changes and problems, behavioural changes and psychological problems (Blakemore & Mills, 2014). Pipp-Siegel, Sedey, Yoshinaga-Itano (2002) in their study on predictors of parental stress in mothers of young children with hearing loss found that mothers of older children reported more stress than mothers of younger children due to their perception that their children were more difficult than younger children. However, their study and our study cannot be compared as they involve different samples.

In terms of communication and parental self-efficacy, the findings in the current study indicate differences in scores between mothers and fathers. Communication difficulties has been identified as the main stressor for parents of children with hearing loss (Zaidman-Zait & Most 2005), especially when accommodating the visual needs of child with hearing loss (Davids, Roman & Schenck, 2018). Adapting to meet the communication needs of the child can cause disruption in interaction between parents and child, affecting parenting roles and responsibilities negatively (Tamis-LeMonda, Uzgiris & Bornstein, 2002), especially when children are between the ages of 10 and 17 A reasonable explanation for this finding may also be that mothers often take on the communication responsibilities in the home so that there is conversational interaction in families to avoid misunderstandings. Mothers often become the effective communicator in the family, however mothers may become tired and burdened by this responsibility (Luterman & Ross 1991).

At the same time, social support for parents and community information and resources were associated with lower self-efficacy scores among mothers than fathers. These results would indicate that mothers may have limited interactions with other parents, little awareness on information and resources and very little if any, social support. Studies have shown that mothers of children with hearing loss may experience social isolation, loneliness, reduce levels of social and intimate relationships (Lederberg & Golbach, 2002; Jackson, Wegner & Turnbull, 2010). Although it has been reported that social support for mothers is important as it contributes significantly to positive mother and child interactions (MacTurk, Meadow-Orlans, Koester & Spencer, 1993), mothers lived experiences must to be taken into consideration. These lived experiences may include among other, full time employment, taking care of other children, single parenthood and financial cost.

A further explanation for these findings may be linked to the spatial poverty and inequalities that we still find in South Africa (David, Guilbert, Hamaguchi, Higashi, Hino, Leibbrandt & Shifa, 2018). Unfortunately in South Africa, many parents live outside the geographical areas of schools for the deaf and geographical areas of services providers, making it difficult for mothers on their own to access social support. Two or three modes of transportation is usually required for parents to access service providers of which safety for women is a concern. Lack of transport and far distances to travel may be plausible explanations why mothers may feel isolated from meeting other parents, receiving little information or resources and non-participation in social support services. Mother’s low scores in these variables may be indicative of their experiences. Additional factors that may contribute to maternal stress in this current study are mothers’ perceptions of the amount of support they receive by partners or fathers of their children and should be further explored (Pipp-Siegel et al., 2002).

In contrast Zaidman-Zait, Most, Tarrasch, Haddad-Eid and Brand (2015) study examined the relation between coping resources and parenting stress between mothers and fathers of children with hearing loss and found differences between mothers and fathers sense of self-efficacy with mothers reporting higher levels of parental self-efficacy than fathers. The authors suggest that one plausible reason for these findings of higher levels of self-efficacy among mothers, is the primary involvement of mothers in the daily care of their children and their participation in intervention programmes. The study was also able to report that fathers felt less confident than mothers in helping their child with hearing loss, which was in contrast to the current study with fathers being confident in their ability to handle the day to day challenges of raising their child with a hearing loss compared to mothers.

Hence all of the above findings may provide some explanation for the rigidity and inconsistency scores on coerced and structured parenting approaches by mothers. Additional research is recommended to gain a better understanding on parental exhaustion in relation to parenting adolescents with a hearing loss.

The findings also revealed that fathers scored higher on their warmth and supportive parenting approaches than mothers. Similarly the findings show that fathers scored significantly higher in all the variable related to self-efficacy. Studies show that father involvement in caregiving, development, recognition of and responsiveness to the child and dealing with problems, has almost tripled since 1965 (Teti & Gelfand 1991; Ingber & Most 2012; Zaidman-Zait, Most, Tarrasch & Haddad, 2017). A study conducted by Antonopoulou, Hadjikakou, Dagla, Maridaki-Kassotaki (2015) on examining the link between perceptions of parental typologies, were able to show that adolescents with a hearing loss perceived their fathers as less authoritarian than strict compared to adolescents who can hear. One plausible explanation for these findings in the current study is father’s interaction with their child with a hearing loss may be different to mothers. The nature of interaction may be related for example to the amount of time fathers spend with their child compared to mothers. Further clarification of these findings may be related to fathers own perceptions of their parenting approaches and parental self-efficacy and not rated on how mothers perceive fathers parenting approaches and fathers parental self- efficacy (Ingber & Most, 2012). Additional research is needed to understand the differences in the nature of interaction of mothers and fathers when parenting children with hearing loss. Likewise further research is required to understand father involvement in families of children with a hearing loss

In conclusion, the study holds a number of implication and recommendations for future research and practical considerations. It provides for a greater understanding of the gender differences in parenting approaches and parental self-efficacy when parenting a child with hearing loss. Although the findings suggest that fathers scored higher in positive parenting approaches and significantly higher on parental self-efficacy than mothers, generalization of the study should be cautioned especially when interpreting the findings of maternal self-efficacy. Study methodological limitations of the present study should be noted in terms of the quantitative nature of the study. A mix-methodological study or a qualitative study might show less consistency and might contribute further to the understanding of parent's interpretations of each other's perceptions of parental self-efficacy. This study was based on parents scoring themselves in terms of their own parenting approaches and self-efficacy and not based on observations or parents scoring each other which could create a certain level of bias. Given the sparsity of research on parenting approaches of children with hearing loss, our study has generated new questions that deserve further research. Father participation in research for example should be encouraged so as to facilitate our understanding of paternal effects on children.

CONCLUSION

In conclusion, this study contributes to the literature on parenting children with a hearing loss. Our results support the development of specific interventions for mothers and fathers as well as to be included in guidelines for planning support for hearing parents with children with hearing loss.

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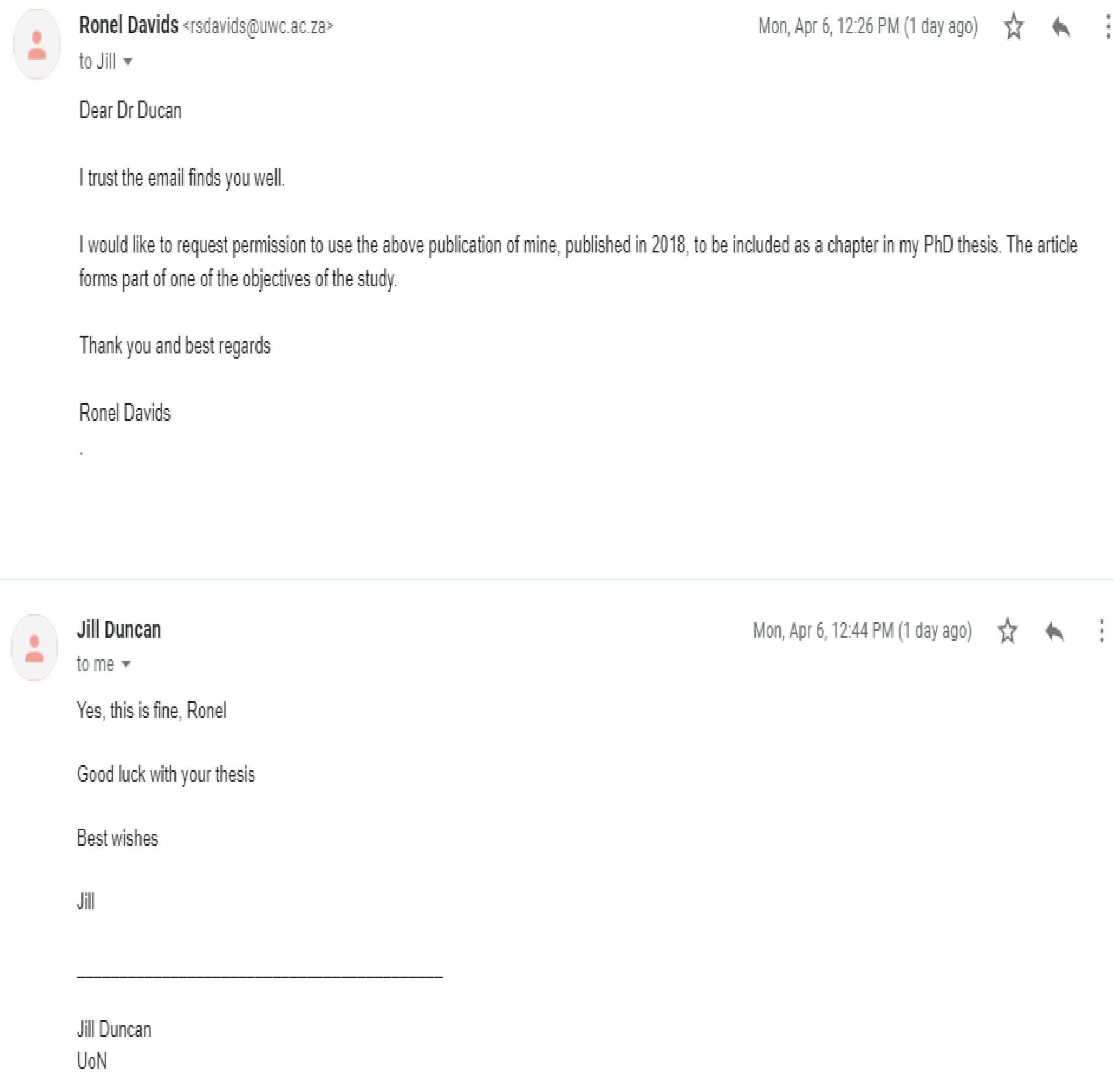
Appendix 9: Correspondence with Journals

Permission from all 3 Journal Editors to use articles in my PhD thesis

1. Permission received from Dr Jill Duncan: Deafness and Education Journal



Ronel Davids <rsdavids@uwc.ac.za>
to Jill

Mon, Apr 6, 12:26 PM (1 day ago)

Dear Dr Ducan

I trust the email finds you well.

I would like to request permission to use the above publication of mine, published in 2018, to be included as a chapter in my PhD thesis. The article forms part of one of the objectives of the study.

Thank you and best regards

Ronel Davids

.

Jill Duncan
to me

Mon, Apr 6, 12:44 PM (1 day ago)

Yes, this is fine, Ronel

Good luck with your thesis

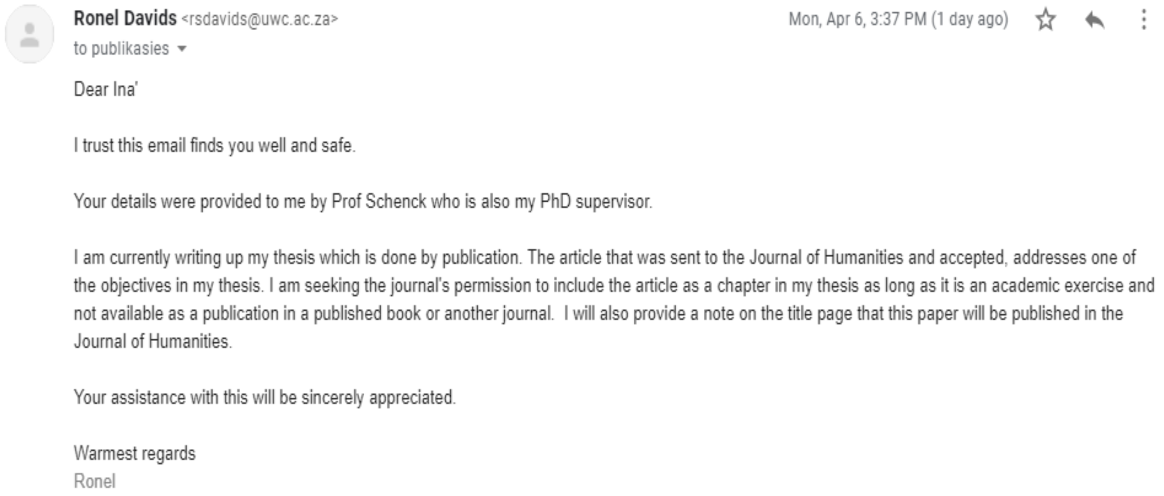
Best wishes

Jill

____

Jill Duncan
UoN

2. Permission from Ina Grabe: Tydskrif vir Geesteswetenskappe SA/Journal of Humanities



Ronel Davids <rsdavids@uwc.ac.za>
to publikasies
Mon, Apr 6, 3:37 PM (1 day ago)

Dear Ina'

I trust this email finds you well and safe.

Your details were provided to me by Prof Schenck who is also my PhD supervisor.

I am currently writing up my thesis which is done by publication. The article that was sent to the Journal of Humanities and accepted, addresses one of the objectives in my thesis. I am seeking the journal's permission to include the article as a chapter in my thesis as long as it is an academic exercise and not available as a publication in a published book or another journal. I will also provide a note on the title page that this paper will be published in the Journal of Humanities.

Your assistance with this will be sincerely appreciated.

Warmest regards
Ronel

Publikasie
to Catherina, me
Apr 6, 2020, 5:45 PM (1 day ago)

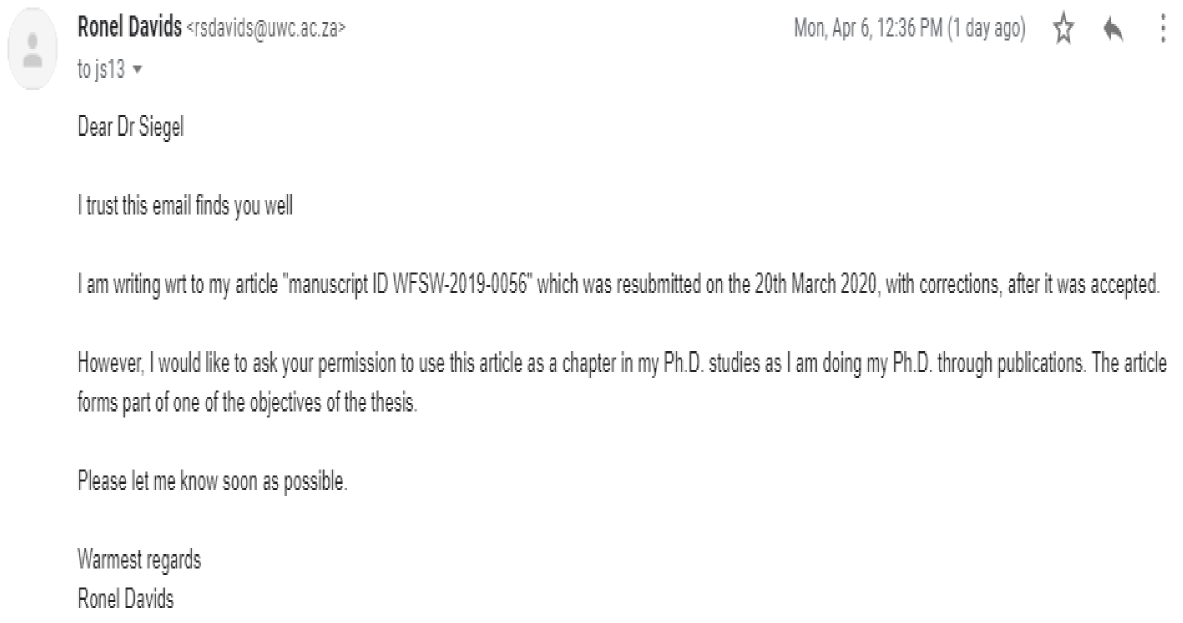
Hi Ronel

Request granted with pleasure, the only requirement being that you cite our journal for the original publication of your articla. Full details to be included in the references, in other words.

Keep up the good work. I have read all of your contributions with interest, but also with trepidation for the dire circumstances in which so any in our SA community have to survive.

Kind regards
Ina

3. Permission from Judith Siegel: Journal of Family Social Work



Ronel Davids <rsdavids@uwc.ac.za>
to js13

Mon, Apr 6, 12:36 PM (1 day ago)

Dear Dr Siegel

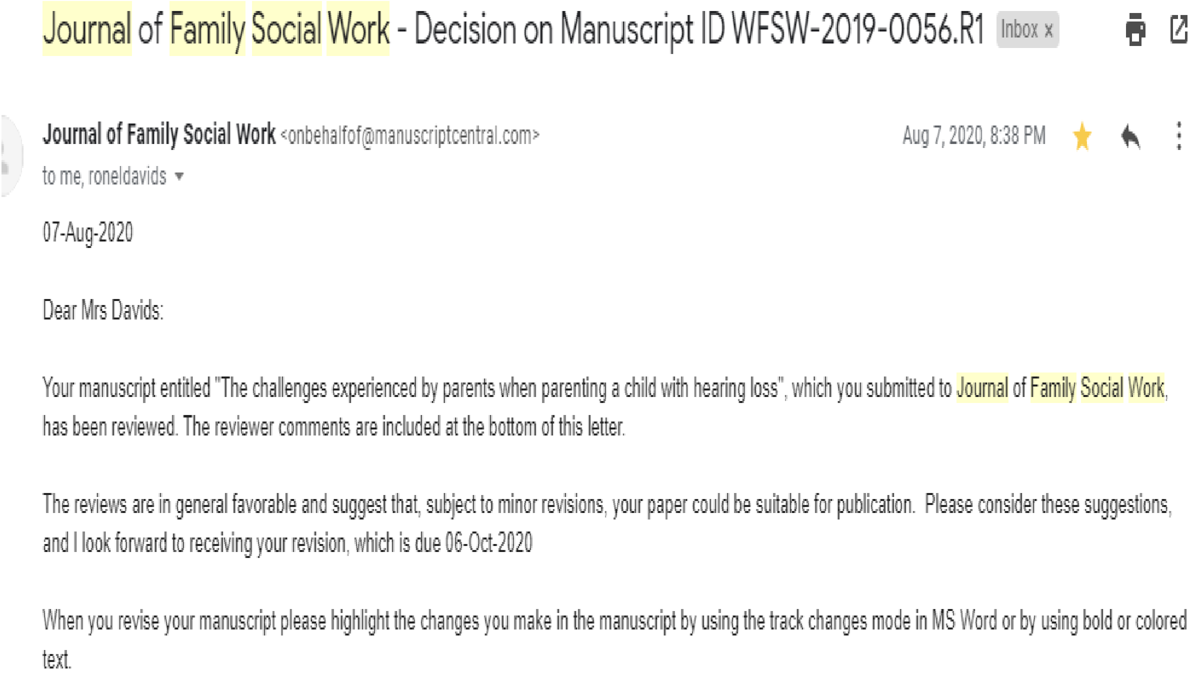
I trust this email finds you well

I am writing wrt to my article "manuscript ID WFSW-2019-0056" which was resubmitted on the 20th March 2020, with corrections, after it was accepted.

However, I would like to ask your permission to use this article as a chapter in my Ph.D. studies as I am doing my Ph.D. through publications. The article forms part of one of the objectives of the thesis.

Please let me know soon as possible.

Warmest regards
Ronel Davids



Journal of Family Social Work - Decision on Manuscript ID WFSW-2019-0056.R1

Journal of Family Social Work <onbehalfof@manuscriptcentral.com>
to me, roneldavids

Aug 7, 2020, 8:38 PM

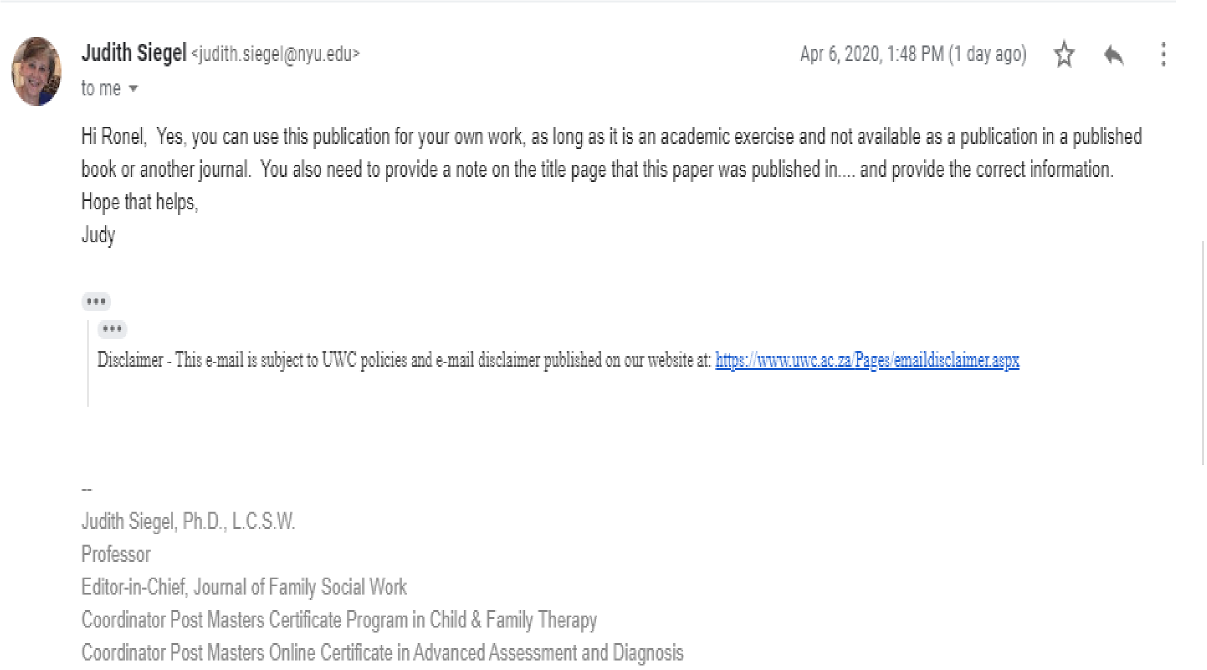
07-Aug-2020

Dear Mrs Davids:

Your manuscript entitled "The challenges experienced by parents when parenting a child with hearing loss", which you submitted to Journal of Family Social Work, has been reviewed. The reviewer comments are included at the bottom of this letter.

The reviews are in general favorable and suggest that, subject to minor revisions, your paper could be suitable for publication. Please consider these suggestions, and I look forward to receiving your revision, which is due 06-Oct-2020

When you revise your manuscript please highlight the changes you make in the manuscript by using the track changes mode in MS Word or by using bold or colored text.



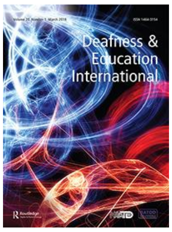
Judith Siegel <judith.siegel@nyu.edu>
to me

Apr 6, 2020, 1:48 PM (1 day ago)

Hi Ronel, Yes, you can use this publication for your own work, as long as it is an academic exercise and not available as a publication in a published book or another journal. You also need to provide a note on the title page that this paper was published in.... and provide the correct information.
Hope that helps,
Judy

--
Judith Siegel, Ph.D., L.C.S.W.
Professor
Editor-in-Chief, Journal of Family Social Work
Coordinator Post Masters Certificate Program in Child & Family Therapy
Coordinator Post Masters Online Certificate in Advanced Assessment and Diagnosis

Appendix 10: Interventions on parenting styles of hearing parents parenting children with a hearing loss: A scoping review



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Ronel S. Davids, Nicolette V. Roman & Catherina J. Schenck

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Interventions on parenting styles of hearing parents parenting children with a hearing loss: a scoping review

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ABSTRACT

Many studies on parenting styles with children with disabilities exist; however, few investigate parenting styles of hearing parents whose children have a hearing loss. The aim of this review is to explore the limited previous literature on interventions targeting this phenomenon. Data was extracted from search engines, Ebscohost (Academic Search Complete, MedLine, PsycARTICLES, SocIndex, Greenfile, Masterfile Premier), Science Direct and Springer Link. Just five studies were found to address issues relating to parenting styles in this demographic, which is surprisingly few. Studies reviewed in this paper were conducted in the United Kingdom Israel, Germany and South Africa. These five articles describe interventions that provide hearing parents with specific knowledge and skills to parent children with a hearing loss. The findings of those studies are explained here, with the purpose being to provide direction for much needed further research into this topic.

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Interventions; programmes; hearing parents; parenting; parenting styles and children with a hearing loss

Introduction

Parenting is multifarious because the challenges and rewards are embedded in both the relationship between the parent and the child (dyad) and individual characteristics of each (Sams, 2012). Parenting incorporates discipline, nurturing and child engagement, which is transactional and developmental (Locke & Prinz, 2002; Sams, 2012). Baumrind (1971) alludes to parenting as seeking a balance of behaviour by conforming to social standards while at the same time encouraging individuality. Parenting forms the basis of any social development for any child, as it is where the child is nurtured, learns to socialize and finds his/her sense of belonging.

An effective way of examining parenting is through the concept of parenting styles (Darling, Flaherty, & Dwyer, 1997) which convey the parents' attitudes

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*R.S.D. conducted the research towards a Ph.D. degree, under the supervision of N.V.R. and C.J.S. All of the authors contributed to and finalised the article.

towards their children. Parenting styles have been studied extensively (Baldwin, Mcintyre, & Hardaway, 2007) and are understood to be normative patterns of behaviour and tactics that parents use to influence a child's behaviour (Jago et al., 2011; Wentzel, Baker, & Russell, 2009). Darling and Steinberg (1993) describe parenting styles as a constellation of parents' attitudes communicated towards the child, creating an emotional climate in which parents' behaviours are expressed. Classic works by Freud (1933) and more recent studies (such as Gadeyne, Ghesquiere, & Onghena, 2004; Kordi & Baharudin, 2010) provide evidence that parenting styles (behaviour and attitude) are important determinants of several aspects of children's outcomes such as school achievement.

For more than fifty years researchers have sought to understand how different parenting styles determine child development outcomes (Carr & Pike, 2012; Kerr, Stattin, & Özdemir, 2012). Early works (such as Baldwin, 1948; Becker, 1964; Rogers, 1960; Schaefer, 1959; Symonds, 1939) examined a variety of two-dimensional parenting styles including responsive/unresponsive, democratic/autocratic emotionally involvement/uninvolvement control/non-control parenting and restrictiveness/permissiveness. Studies conducted by these early researchers revealed that parents who provid their children with warmth, responsiveness, independence and firm control, had children with higher levels of competence and social interaction (Spera, 2005).

Parenting styles of parents with children with a disability has been a focus of several studies (Gau et al., 2010; Gau, Chiu, Soong, & Lee, 2008; Howe, 2006; Woolfson & Grant, 2006). Parenting a child with a disability may necessitate parents to adjust their parenting styles to accommodate the child (Sams, 2012; Woodgate, Edwards, Ripat, Borton, & Rempel, 2015). Parents may often hold different views and attitudes towards their child with a disability which could influence their parenting style (Elhageen, 2004) resulting in altered parenting styles which could affect the quality of the parent-child dyad (Raya, Ruiz-Olivares, Pino, & Herruzo, 2014).

Parenting styles of those with children with a hearing loss have been investigated in relation to academic achievement and self-confidence (Marschark, 2007). However, the impact of child hearing loss has not been fully explored in terms of the parent child dyad and in relation to parenting styles of hearing parents parenting children with a hearing loss (Antonopoulou, Hadjikakou, Dagla, & Maridaki-kassotaki, 2015).

Although 90–95% of children with hearing loss are born to hearing parents (Fitzpatrick, Stevens, Garritty, & Moher, 2013; Garcia & Turk, 2007; Lederberg, Schick, & Spencer, 2013), very little is known about parenting styles in those families. What is known through investigations of parental perspectives and experiences of parents with children with a hearing loss, is that parents' want support (Henderson, 2015). Lam-Cassettari, Wadnerkar-Kamble, and James (2015) identified a gap in understanding the importance and challenges of the parent-child relationship between hearing parents and children with hearing loss. Yet, others cite parental involvement in early childhood interventions as a powerful influence on parenting styles in terms of specific knowledge and skills needed when parenting a child with a hearing loss (DesJardin, 2003). Several studies have observed that hearing parents whose children have a hearing loss often used parenting styles which are punitive, intrusive, less flexible, use physical discipline and more directive during interaction (Knutson, Johnson, & Sullivan, 2004; Spencer & Meadow-Orlans, 1996) as well as displaying less reciprocity (Harrigan & Nikolopoulos, 2002; Spencer, 2004). This may illustrate that raising a child with a hearing loss may require parents to adjust or alter their parenting styles and skills which would affect the quality of the parent child relationship (Raya et al., 2014; Sams, 2012; Woodgate et al., 2015). According to these authors, when parents are reciprocal to their children hearing loss needs and are more flexible in their interactions / parenting styles, positive outcomes could be expected for both the parent and the child.

Intervention programmes are usually intended to support and enhance parents' parenting competencies, for parents to feel competent and confident when experiencing child problems (McWilliam & Scott, 2001; Reedtz & Klest, 2016). For example, Haslam, Mejia, Sanders, and de Vries (2016, p. 2) recognize that 'parenting programs are interventions that aim to improve child and family outcomes by equipping parents with effective parenting skills'. Similarly, Eyberg, Nelson, and Boggs (2008) assert that parenting training should be the desired approach for treating children. These programmes highlight the role of parents' involvement as vital to the child's progress, because they are seen as interactive partners of children, as well as important contributors of opportunities and social activities for their children (Reedtz & Klest, 2016; Zaidman-Zait, Most, Tarrasch, & Haddad, 2017).

To what extent intervention programmes do provide support for parenting styles is unexplored. Against this background, a scoping review was undertaken with the aim of identifying and evaluating previous research on interventions offered that focussed specifically on parenting styles, particularly where parents are hearing and the child has a hearing loss.

Method

Research strategy

Unlike a systematic review where the research question is highly focussed and where the study selections are based on defined study designs, the main aim of a scoping review is to; (1) to examine the extent and range of research done on the topic (2) to summarize and disseminate the research findings and (3) identify research gaps in present literature (Arksey & O'Malley, 2005; Levac, Colquhoun & O'Brien 2010). This scoping review sought to accumulate as much evidence as possible about interventions focussed on parenting styles of hearing parents whose children have a hearing loss. An electronic search was conducted across nine databases (Ebscohost, Academic Search Complete, MedLine, PsycARTICLES, SocIndex, Greenfile, Masterfile Premier, Science Direct, Springer Link). The following search terms were used: interventions, programmes, hearing parents, parenting, parenting styles and children with a hearing loss. Although an initial search yielded 339 items, just twelve of them were found to have investigated interventions relating to parenting styles in the specific circumstance of hearing parents of children with a hearing loss. The search term 'intervention' produced many articles on early identification and universal hearing screening interventions which was not applicable to this study and reduced the number of articles considerably.

All twelve articles were fully reviewed in a supervised process. With that further review, it was found that in fact only 4 articles from that broad search addressed relevant issues relating to the specific topic under investigation. Through the interactions with a specialist in the area on intervention programmes for hearing parents with children with a hearing loss, a further single article addressing parenting styles where the parents as well as the children were hard of hearing was included. Given the very small number of articles identified as relevant to this topic, the study was continued by reviewing the few articles in greater depth than would have been possible if a vast number of relevant studies were identified.

Inclusion and exclusion criteria

Articles met the inclusion criteria if they focussed on:

1. articles written in English;
2. hearing parents;
3. children with a hearing loss; and
4. interventions central to parenting styles

Data extraction

A data extraction sheet (Table 2) was designed and populated with relevant information: author, year of publication, country, population sample and size (age and gender), intervention duration, intervention, who the intervention reached, the efficacy of the intervention, the adoption, implementation and maintenance of the interventions.

In Figure 1, the stages undertaken in the scoping review, leading to the final five articles identified, are illustrated.

A RE-AIM framework (Glasgow, Vogt, & Boles, 1999) was applied to appraise the five articles and systematically break down the evaluation of each intervention into their Reach, Effectiveness, Adoption, Implementation and Adoption dimensions. The RE-AIM framework allowed the effectiveness of interventions reported in the articles to be explored (Frantz & Chandeu, 2011).

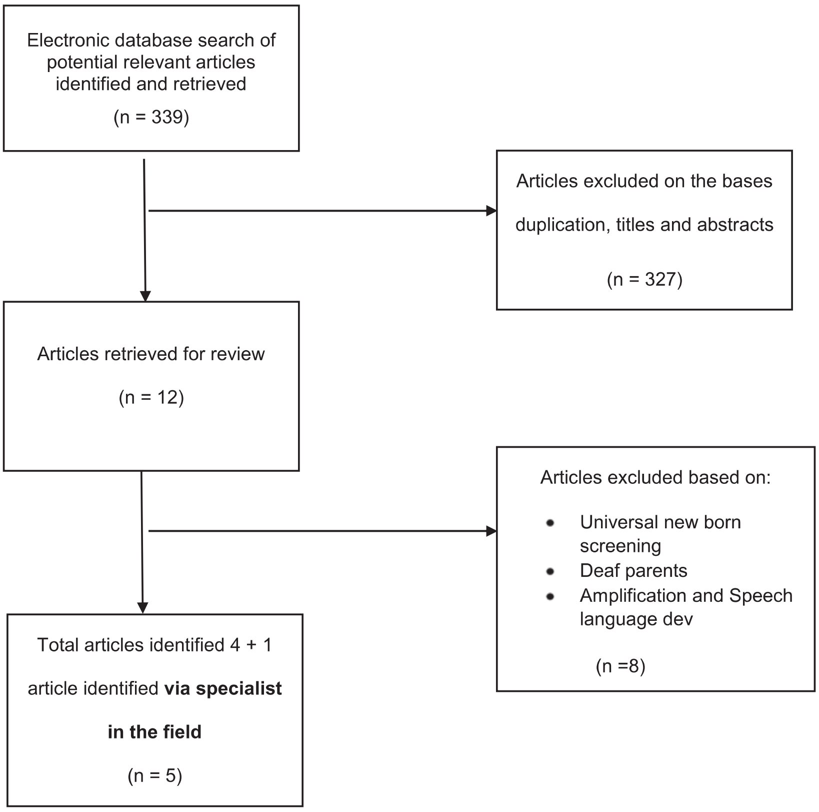

Figure 1. Study selection process.

The analytical process of applying the RE-AIM framework require questions (see Table 1) to be applied to the evaluation of each of the five articles under review.

The interventions reported in these five studies were implemented in Israel (Feigin & Peled, 1998), the United Kingdom (Garcia & Turk, 2007; Lam-Cassettari et al., 2015), Germany (Reichmuth, Embacher, Matulat, Am Zehnhoff-Dinnesen, & Glanemann, 2013) and South Africa (Storbeck & Pittman, 2008) with no reporting on countries in two interventions. Three interventions reported on their study designs. One involved a cross-exploratory/case study (Garcia & Turk, 2007), one a short-term longitudinal design (Lam-Cassettari et al., 2015) one a descriptive research design (Storbeck & Pittman, 2008). The total sample of participants was difficult to ascertain, as the groups were mostly described and not the total number of actual participants e.g. groups of ten.

The results of the scoping review are presented in two sections.

First, the interventions adopted in each of the five studies is summarized and presented in table form. Secondly, the review of the five studies according to the RE AIM framework is presented.

Table 1. RE-AIM appraisal tool.

RE-AIM Dimensions	Definitions	Questions/examples of measure
Reach	This definition affects the target population who would use the intervention.	• Does the article report on the representativeness of the target population? • Does the article indicate who the program is intended for (inclusion and exclusion criteria) • Does the article report on participation rate?
Efficacy	The impact is defined based on the program relevance, importance, limitations and specified primary and multiple outcomes	• Did the program achieve the intended objectives? • Do they report on the limitations of the intervention? • Reports on at least one outcome of the intervention • Reports on attrition
Adoption	This dimension defines the setting where the programme is initiated, the evaluation and adoption of the intervention, access to the intervention who delivered the intervention	• Is the setting clearly described? • Does the evaluation report on the adoption of the intervention by the participants or the organization? • Reports on who delivered the program
Implementation	It defines the extent to which the intervention was delivered	• The duration and frequency of the intervention being described • The staff/participants of the organization/intervention been involved in delivering the program? (cost implications) • Reports on intended and delivered interventions
Maintenance	It defines the long term sustainability of the intervention	• Does the article report on long term effects of the intervention (after 6 months) • Do they report on the indicators used for intervention follow-up?

Summary of interventions

Table 2 provides a full comparison between each of the interventions adopted within the five studies reviewed. A summary of those interventions is provided in this section.

A group intervention model reported by Feigin and Peled (1998) did not specifically describe parenting styles but focuses on improving the communication and interaction between parents and their child who has a hearing loss. It focussed on the parents' individual experiences, their feelings and conflicts as individuals and couples, which included how they coped with their children's difficulties. The group sessions provided parents with the opportunity to speak about the difficulties of raising a child with hearing loss and also provided them with skills and tools, as well as re-enforcing mutual support for hearing parents. The article did not provide the total number of participants, or rate of participation in the programme, but only stated that groups had an average of 10 participants, which largely consisted of the mother's participation, with the occasional participation of fathers, or couples. The parent's ages ranged from twenty-five to fifty years who came from diverse socio-economic and

Table 2. Summary of the interventions.

Ref	Author	Study design	Population and sample size	Country	Duration	Reach	Efficacy	Adoption	Implement	Maintenance
1	Feigin and Peled (1998)		10 participants, mainly mothers, ages 25–50. Children ages: 2 years old	Israel	Groups meet for 15–90 min every other week.	Mostly mothers attended. The participants were between 25 and 50 years old. Came from diverse socioeconomic and educational backgrounds. No report on the participation rate.	The goals and objectives were met. The pilot programme highlighted the community's involvement. The aim of the programme was to improve parent adjustment. No reporting on the limitations of the group intervention. No attrition rate reported.	The setting is the MICHA Centre that cares for pre-school deaf children from infancy to grade 2. This study is evaluated and accepted by participants. Two experienced social workers worked with the parents. The programme will hopefully become part of all therapeutic and educational programmes.	The study reports on 15 sessions of 90 min each but does not report on frequency of attendance of participants. 2 social works conducted the group sessions. Delivery of the intervention was successfully implemented. No cost implications were discussed	No follow-up was reported, but recommendation is made that the intervention become part of family therapeutic and educational frameworks, focussing on communication skills to enhance family interaction
2	Garcia and Turk (2007)	Exploratory /Annotation and case study	Hearing parents. Children ages: 4–15 years old. 1 Participant in the pilot phase	UK	Consists of 12 sessions, each of 2 h duration, the group ran for 13 weeks with sessions taped.	Hearing English speaking parents of deaf children between the ages 4–15 years. Other inclusion criteria: child having an ICD-10 diagnosis of a conduct, oppositional defiant or hyper- kinetic disorder or autistic spectrum disorder with or without additional comorbidity;	Outcome was positive, suggesting that modified Webster-Stratton approaches may well be of use in deaf children of hearing parents. No attrition rate was reported. The limitations of the intervention was not reported on.	This was a pilot project which included two trained facilitators per session and clinicians. Participants evaluated the intervention. Setting: National Deaf Services Children and Young Persons Clinic. The programme needs to be adjusted to include other criteria to suit the deaf child	This pilot phase focussed on one participant. The staff were involved in delivering the program. The intended intervention was reported on.	The study reports on the long term effects and indicators for intervention follow-up.
3	Reichmuth et al. (2013)		Four to six families. Children ages: 3–18 months	Germany	The total time of all sessions comprises 26½ h. sessions in weekly intervals flanked by one individual	Parents of children with moderate to profound hearing loss. Exclusion: parents need to have sufficient language skills i.e. speak German and oral	Objective was achieved and reports on the outcome i.e. The report does not report on the limitations of the	The setting is described as the duration of the programme in the clinic with on-going evaluation. The MPP is conducted by a certified	The programme consists of six group sessions and two single training. Staff are trained and certified to r	The study reports on the long term effects of the intervention: e.g. Positive effects on the parental responsiveness

(*Continued*)

Table 2. Continued.

Ref	Author	Study design	Population and sample size	Country	Duration	Reach	Efficacy	Adoption	Implement	Maintenance
					preparatory and one closing counselling session for each family. Additionally, there is one refresher single training session when the child becomes 24–30 months.	language, sufficient hearing,, no interpretation services are provided	interventions. No report on attrition.	MPP-trainer who have to complete a certified 5-day MPP trainer-course.	deliver the intervention. The study reports on the intended and delivered interventions.	towards their infants. It does not mention the indicators used for follow-up interventions.
4	Lam-Cassettari et al. (2015)	Short-term longitudinal	14 families with hearing mothers of Deaf children ages: 3 yrs and 4 months as well as 1 year and 4 months	UK	Three sessions of video interaction guidance intervention	The intervention does not report on the representation of the target population. The only exclusion criterion was children who were not at a paralinguistic stage of development and could produce more than 50 signed/spoken words as reported by the parent. Participants were compensated for their travelling cost.	The intended objective was achieved i.e. to examine the effect of a family-focussed psychosocial video intervention program on parent–child communication in childhood hearing loss. It does not reports on the limitations of the intervention. It reports on the outcomes. No report on the attrition rate.	Pilot study use observational and self-report measures to show there is a need for a video feedback intervention programme.	The intervention used video feedback of parent–child interactions to increase responsiveness to a child's communicative cues, and promote attuned behaviour between parent and child	This study examined the quality of parent–child interaction and parental self-esteem pre-lingual childhood deafness.
5	Storbeck and Pittman (2008)	Descriptive research design	32 Deaf infants and 32 families	South Africa	12 month programme offering families weekly home-based support.	Parents of deaf children. Does not talk to inclusion or exclusion criteria	The intervention achieved its intended objective. Parents rated the service offered by HI HOPES as excellent and good.	The setting is clearly described as all the provinces in SA. Evaluation is done by the participants. Deaf mentors and interventionist implement the intervention.	The duration is explained with weekly visitation. Staff are trained to deliver the program and reports on the intended delivered interventions	The report speaks to the long term effects of the intervention and

educational background. The ages of their children were pre-school children from infancy to the first grade.

The Webster-Stratton Parenting Programme adapted for children with a hearing loss and other emotional, behavioural and developmental problems, reported by Garcia and Turk (2007) had the aim of enhancing the quality of family functioning. Through the interaction and communication between parent and child, a significant decrease in children's behavioural problems was observed. The design of the intervention was to improve parenting skills and provide parents with peer support. A pilot phase was reported on first, focussing on one child with a hearing loss and their parent with the aim of exploring whether the approach used in the intervention could be justified further with more comprehensive evaluative research. The article continues on to report on the group intervention (13 families), who participated in the next phase of intervention.

The Muenster Parental Programme (MPP) aimed to empower parents to communicate with their children to build parent confidence (Reichmuth et al., 2013). The intervention focussed on empowering parents to communicate with their child (focussing on those aged 3–18 months) by allowing them to become responsive intuitive parents; thereby building confidence in their own parental resources. Only mothers were participants in the study, but fathers did accompany mothers and children to a single training and counselling session that made up the intervention. Between four and six participants made up a group, but never less than three, or more than eight. Responsiveness and intuitive parenting styles were seen to promote the child's language, cognitive, emotional and social development.

The effect of a family-focussed psychosocial video intervention programme on parent-child communication was described by Lam-Cassettari et al. (2015). Although this intervention did not describe parenting styles, it has much to offer with the understanding of how parents' would parent in terms of sensitivity, responsiveness and involvement leading to an increase in parents' self-esteem after the intervention. This intervention used observational and self-report measures to show the effect of family-centred interventions. It is suggested that the intervention which examined the quality of parent – child interaction, can provide hearing parents with support who in turn can provide the best support for the development of their child with a hearing lost Lam-Cassettari et al. (2015).

A home based intervention was described by Storbeck and Pittman (2008). This intervention, the first South African home-based intervention project (Hi-Hopes) aimed to ensure families were fully informed and supported to enable them to make choices in the best interest of their child. The programme seeks to account for cultural and linguistic diversity (South African has eleven official languages). Thirty-two families with their infants participated in the intervention that included a mentorship by staff members who are deaf.

Summary of the findings according to the RE-AIM framework

Reach

The representativeness of the target population was reported as adequate in most of the interventions. However, the review indicated that mothers' participation was higher although fathers attended occasionally (Feigin & Peled, 1998; Lam-Cassettari et al., 2015). One intervention deliberately focussed on 1 participant (Garcia & Turk, 2007) as it explored the possibility of adapting its intervention to be used for children with a hearing loss.

Parents' participation rate varied per intervention for example, in one intervention 13 families were originally approached; however only a few agreed to participate citing financial and practical difficulties, including distance, which eventually left the intervention with a sample of 3 participants (Garcia & Turk, 2007). The parents' age groups varied from 20 to 50 years old across studies. Parents came from diverse socioeconomic and educational backgrounds ranging from high school to academia.

Efficacy

The efficacy of the interventions was reported for all the interventions in terms of whether their stated goals were met. The limitations of each intervention were reported on in only two interventions i.e. in one intervention the potentially limited generalizability of the significant results obtained was recognized and in the other, participation, as well as problems experienced by participants, was viewed as possible limitations. In all the interventions, at least one outcome was observed and expanded on to reveal how the interventions could be of future benefit to hearing parents.

Adoption

Adoption refers to the target staff and various types of settings such as work sites, health departments, organizations or communities (Brace et al., 2015) that adopt these interventions. In four of the interventions (Feigin & Peled, 1998; Garcia & Turk, 2007; Lam-Cassettari et al., 2015; Storbeck & Pittman, 2008) the setting of the intervention is mentioned. The adoption of the intervention is addressed in three interventions, with the ongoing evaluation of the intervention referred to in two interventions (Reichmuth et al., 2013; Storbeck & Pittman, 2008). In these two interventions, the participants evaluated the effectiveness of the intervention and underscored the importance of continued support. In addition, Reichmuth et al. (2013) do not indicate its adoption and suggest that the intervention could become part of/adopted by the state-funded special pedagogic interventions in Germany. The importance of the positive outcomes of the interventions is underscored in all five interventions e.g. the intervention with parent groups of preschool children with hearing loss (Feigin & Peled, 1998) as well as the intervention effectiveness and the anticipation of it being part of further therapeutic and education frameworks. Similarly, the results of Garcia and Turk's (2007) intervention on the applicability of the Webster-Stratton Parenting Programmes to families and their children with a hearing loss with emotional and behavioural problems, as well as autism, provide evidence that it has a place in the therapeutic management of behavioural, emotional and developmental challenges facing this type of client. Similarly, the intervention of Lam-Cassettari et al. (2015) on enhancing the parent-child communication and parental self-esteem with a video feedback intervention reveals the positive outcome of the programme, but not its adoption. Equally Storbeck and Pittman's (2008) pilot programme revealed the advantages of a family-centred intervention, which promotes a holistic approach that values parents' education and support. All five programmes refer to experienced staff members who were involved in the delivery of the programmes, i.e. social workers, trained facilitators, certified therapist, deaf mentors and accredited interventionist.

Implementation

Reporting on the duration and frequency of the intervention was consistent in all five articles however, the frequency of the attendance of the participants is not articulated in some of the articles. Information was provided on the number of sessions and the duration of the sessions. The delivery of services by staff and peers was described in all five articles, with Storbeck and Pittman (2008) providing demographic details on the staff and peers, to accommodate the diversity of the participants participating in the intervention. In addition, Storbeck and Pittman (2008) describe the different roles of staff participating in the implementation of the intervention. Feigin and Peled (1998) and Reichmuth et al. (2013) provided clear and concise details of the group intervention programme in terms of its group implementation as well as the staff who were to deliver the intended intervention. Conversely, the article by Garcia and Turk (2007) reporting on a video application, made it difficult to discern whether the intervention was implemented with hearing parents, or one hearing parent of the boy on whom the case study was eventually conducted.

High positive participation satisfaction with the interventions was recorded in all the articles, which could suggest that the participants were satisfied with the delivery of the interventions by the staff. This could suggest that the interventions were effectively delivered by staff, who seemed to be well trained in the various interventions e.g. social workers (Feigin & Peled, 1998), experienced certified trainers working with hearing parents (Reichmuth et al., 2013) and mentors who are deaf and parent advisors (Storbeck & Pittman, 2008). Two of the articles, Garcia and Turk (2007) and Lam-Cassettari et al. (2015) mentioned staff as interventionists, however, there is little to suggest what their specific tasks were, especially as these were video recording interventions. The majority of the interventions took place through group work. The aims of the groups, as well as the composition, structure and content of the sessions, were outlined.

Maintenance

This dimension provides an account on the sustainability of the participation in the interventions and whether specific elements improved or restricted the sustainability of the intervention (Brace et al., 2015; Gaglio & Glasgow, 2012). Storbeck and Pittman (2008) reported on a pilot project which eventually led to an evidence-based intervention programme that has since been implemented in order to effectively address the needs of families whose children are deaf. The articles of Garcia and Turk (2007) and Lam-Cassettari et al. (2015) did not address the long-term effects of the intervention, or report on the indicators used for intervention follow-up. However, their articles do underscore the importance of further comprehensive and widespread research into the effectiveness of early interventions for children with a hearing loss

The article of Reichmuth et al. (2013), on the Muester Parental programme, which has been implemented since 2009 with on-going evaluation, ideally has become a comprehensive intervention programme module for families with children who has a hearing loss. Of significance is that all the articles made sustainable recommendation for these interventions to become an integral part of future intervention.

Discussion

The aim of the scoping review was to evaluate previous research on interventions focussing on parenting styles that targeted hearing parents of children who have hearing loss. The review had no specific timeframes attached and the articles were sourced from various databases, as previously mentioned in this study. The RE-AIM framework was explorative in nature, as it explored the effectiveness of the interventions (Frantz & Chandeu, 2011).

Although the interventions do not specifically address parenting styles, the review has highlighted a number of important challenges and strengths that clarify the significance of intervention programmes for hearing parents of children with a hearing loss (DesJardin, 2003). The participation in all the family interventions reviewed, appeared to not only benefit the parents, but also improved the outcomes for their children who have a hearing loss (DesJardin, 2003; Yoshinaga-Itano, 2003)and in particular enhance communication skills which is a strong emphasis in most of the interventions.

In addition, the articles reveal that through these interventions, parents believed they had acquired more strength and coping skills which helped them to relate to their child with a hearing loss as their child firstly, and secondly, as their child who has a hearing loss, allowing them to act as parents (Feigin & Peled, 1998). A common theme throughout the articles was that the parents valued the contact with other parents who were experiencing similar challenges and considered this interface very supportive (Jackson, 2011; Zaidman-Zait, 2007). Evidence from these interventions indicates that there was a shift from merely providing services to families, to actually supporting parents (McWilliam & Scott, 2001). Consequently, parents were provided with information that reinforced their self-esteem and confidence in their abilities to raise a child with a hearing loss (Bemrose, 2003; Young, 2003). These programmes provided parents with the specific knowledge and skills for them to parent their young children who have a hearing loss (DesJardin, 2003), and in addition, underscored the importance of supporting parents as they are the most important carers of the child (Hintermair, 2000, 2006; Jackson, 2011).

All the interventions suggested that the parents demonstrated responsive parent behaviours towards their children with a hearing loss with the assistance of qualified and trained staff. Through responsive parenting, the parents were able to expand their interactions with their children, enhancing the parents' own beliefs in their parenting skills and abilities, while, simultaneously, providing them with a sense of empowerment and enjoyment. The interventions could be seen as powerful interventions in relation to parenting styles, providing support in terms of specific knowledge and skills. These interventions may suggest that hearing parents may have to adjust their parenting styles in order to accommodate their children who has a hearing loss.

It could be argued that the strength of all these articles rests in the implementation of the group sessions, which appeared to provide positive outcomes for the parents. The group sessions appeared to reinforce existing good parenting skills and acknowledged the effects that child hearing loss has on the family, parents and parent-child relationships. Support groups play a significant role in increasing parents' social network and reinforcing their self-confidence (Luterman and Ross (1991). It also serves as a strong healing and educational tool for parents provide parents with the opportunity to share their feelings, concerns on issues that they were experiencing (Flasher & Fogle, 2003).

Significantly, the study samples included more female participation than they did males (Feigin & Peled, 1998; Lam-Cassettari et al., 2015). This was consistent with literature as it has been observed that generally, mothers participated more in intervention programmes than fathers. A study conducted by Zaidman-Zait et al. (2017) on mothers' and fathers' involvement in intervention programmes for children who are hard of hearing observed that mothers were notably more involved than fathers were in their children's interventions. Mothers were in regular attendance, displayed a higher interest than fathers, and were more willing to engage with the professionals assisting in the interventions. Specialized interventions targeting fathers should be developed with the goal to promote positive social-emotional outcomes for children who have a hearing loss (Calderon & Greenberg, 2003).

Conclusion

The results of the review advance the argument that intervention programmes for hearing parents with children who have a hearing loss are essential, and has the potential to promote support and positive outcomes for both parent and child. The results also reinforce the need for more research to explore the limited previous literature on interventions targeting this phenomenon. The findings revealed that the effective delivery of programmes with competent staff can be beneficial to the effectiveness and maintenance of these programmes. This scoping review also highlights the limited research and publications in the area of parenting styles of hearing parents with children who have a hearing loss. Therefore, a strong recommendation is made that the implementation of the RE-AIM framework be considered as an effective practice tool to facilitate consistent and useful information when reporting on interventions.

Disclosure statement

No potential conflict of interest was reported by the authors.

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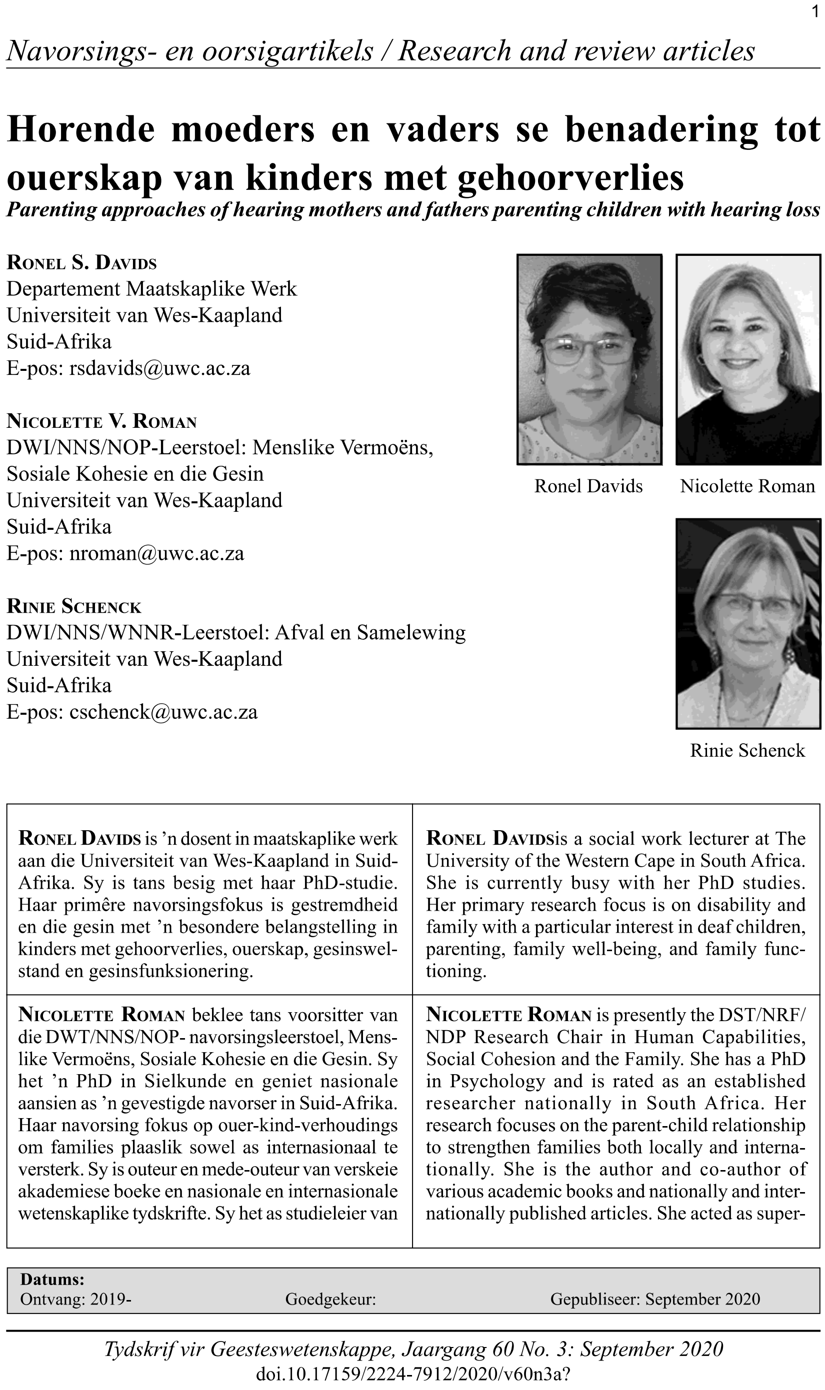
Appendix 11: Horende moeders en vaders se benadering tot ouerskap van kinders met gehoorverlies



Navorsings- en oorsigartikels / Research and review articles

Horende moeders en vaders se benadering tot ouerskap van kinders met gehoorverlies

Parenting approaches of hearing mothers and fathers parenting children with hearing loss

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Nicolette Roman beklee tans voorsitter van die DWT/NNS/NOP- navorsingsleerstoel, Menslike Vermoëns, Sosiale Kohesie en die Gesin. Sy het 'n PhD in Sielkunde en geniet nasionale aansien as 'n gevestigde navorser in Suid-Afrika. Haar navorsing fokus op ouer-kind-verhoudings om families plaaslik sowel as internasionaal te versterk. Sy is outeur en mede-outeur van verskeie akademiese boeke en nasionale en internasionale wetenskaplike tydskrifte. Sy het as studieleier van	**Nicolette Roman** is presently the DST/NRF/NDP Research Chair in Human Capabilities, Social Cohesion and the Family. She has a PhD in Psychology and is rated as an established researcher nationally in South Africa. Her research focuses on the parent-child relationship to strengthen families both locally and internationally. She is the author and co-author of various academic books and nationally and internationally published articles. She acted as super-

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meestersgraad- en doktorale studies opgetree. Sy is 'n lid van die Gesinsdiensteforum in die Wes-Kaap om die nuwe Gesinsbeleid te implementeer, die Vereniging vir Mensontwikkeling en Bekwaamheid: Agentskap, Welstand en Geregtigheid, en die Vereniging vir Navorsing oor Kinderontwikkeling. Sy bou ook kapasiteit in gemeenskapsgebaseerde organisasies deur organisasies op te lei in monitering en evaluering ten einde bewysgebaseerde praktyke te bou.	visor for master's and doctoral studies. She is a member of the Family Services Forum in the Western Cape to implement the new family policy, the Human Development and Capability Association: Agency, Well-Being and Justice and a member of the Society for Research in Child Development. She also builds capacity in community-based organisations to build evidence-based practices by training organisations in monitoring and evaluation.
Rinie Schenck beklee tans die DWI/NNS/WNNR-Leerstoel in Afval en die Samelewing aan die Universiteit van Wes-Kaapland. Sy is ook 'n NNS gegradeerde navorser. Voordat sy by UWK begin werk het, was sy 25 jaar aan Unisa en 6 jaar aan die Universiteit van Pretoria (UP) verbonde. Haar navorsing is gerig op armoede, werkloosheid en in besonder op die persone wat 'n bestaan probeer maak in die informele ekonomie. Professor Schenck en haar navorsingspan gee veral aandag aan die dagloners en vullisherwinners. Sy het reeds wyd in nasionale en internasionale tydskrfte gepubliseer oor die bepaalde onderwerp	**Rinie Schenck** holds the DST/NRF/CSIR Chair in Waste and Society at the University of the Western Cape. She is also a NRF rated researcher. Prior to UWC she lectured at Unisa for 25 years and 6 years at the University of Pretoria (UP). Her research focus is on poverty, unemployment and in particular on people who are making a living in the informal economy, including day labourers and waste pickers. She has published extensively in national and international journals

ABSTRACT

Parenting approaches of hearing mothers and fathers parenting children with hearing loss

It is estimated that there are 32 million children in the world with a hearing loss. Research shows that 90% of children suffering from hearing loss are born to hearing parents who often know nothing or very little about hearing loss. Most research studies on child hearing loss have generally focussed on early intervention, language development and on parents' experiences at the time of diagnosis of child hearing loss. However, the effect of child hearing loss on parents' parenting approaches and on parents' parental self-efficacy in attempting to parent a child with a hearing loss, have received relatively little research attention.

Parenting a child with a hearing loss may necessitate the need for parents to make accommodations for their child by adapting, adjusting, educating themselves about the needs of their child and may modify their parenting approaches, behaviour and attitudes in order to become more engaged in their parenting role. Furthermore, parents parenting a child with this particular disability may lack a sense of parental self-efficacy, and may be unable to put their parenting knowledge into action as they may feel overwhelmed by their extra responsibilities. In many cases, parents of children with a hearing loss are expected to take on new and multiple roles for which they are not prepared. The demands of these roles together with parents' lack of parenting skills (knowledge on hearing loss, communication approaches for example), the need for information resources, social-emotional support leave parents vulnerable. As a result of their vulnerability parents may experience difficulties in developing effective parent child-rearing approaches and may struggle in their parental self-efficacy to parent a child with hearing loss. Research shows that parental self-efficacy is the key to a child's success.

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Given the abovementioned challenges, the aim of the present study was to examine and describe the parenting approaches and the contributory factors to parents' parental self-efficacy when parenting children with a hearing loss. The research involved a sample of 103 hearing parents from the Western Cape, South Africa, whose children were between the ages of 10 and 17. Each parent completed a self-administered questionnaire made up of three sections that included (a) parents' demographic details (b) the adaptation of the Parents as Social Context Questionnaire (PSCQ) and (c) the adaptation of the Parent Self-Efficacy Instrument (PSE). The results of our study show that mothers scored higher on chaotic parenting as well as on structured parenting approaches. Fathers scored higher on autonomy and supportive parenting approaches as well as on parental warmth than mothers. The results also show that there is a significant difference in parental self-efficacy between fathers and mothers, with fathers scoring significantly higher on knowledge, confidence, handling of stress, communication, positive interaction and satisfaction than mothers. The results of the study provide for a greater understanding of mothers' and fathers' differences in parenting approaches as well as the factors influencing their parenting approaches and confidence in parenting a child with a hearing loss.

In summary, children with a hearing loss remain a vulnerable sector in our society just as any other child with a disability. Parents too form part of this vulnerability as they experience a myriad of challenges and a host of relational difficulties when parenting their child thus affected. A clearer awareness and understanding of parents' perspectives of their parenting approaches and the factors contributing to their parental self-efficacy when parenting a child with a hearing loss have important implications for family centred practices. These implications could assist professionals in the development of specific interventions supporting mothers and fathers that will enhance parent child relationships and positive child outcomes. Furthermore, these implications and recommendations made by the current study can also be considered for future research in the field of parenting and childhood hearing loss.

KEYWORDS: hearing parents, child with hearing loss, parenting approaches, contributing factors, parental self-efficacy

TREFWOORDE: horende ouers, kind met gehoorverlies, ouerskapbenaderings, bydraende faktore, self-effektiwiteit van ouers

OPSOMMING

Navorsing toon dat 90% van kinders met gehoorverlies vir horende ouers gebore word (Cole & Flexer 2016; Lederberg, Schick & Spencer 2013). Hierdie ouers kan probleme ondervind om 'n effektiewe benadering tot die grootmaak van kinders te ontwikkel, en hulle kan dit 'n uitdaging vind om 'n kind met gehoorverlies met selfvertroue groot te maak (Calderon, Bargones & Sidman 1998). Studies dui aan dat interaksie tussen gesinslede, familiehulpbronne en ondersteuningsdienste alle areas van die gesinslewe beïnvloed wanneer daar 'n kind met 'n gehoorverlies in die familie is. Boonop ondervind horende ouers nie net uitdagings ten opsigte van hul kind se gehoorverlies nie, maar is daar sprake van verdere uitdagings soos stres, kommunikasie, maatskaplike ondersteuning en toegang tot inligting. Verder beïnvloed gehoorverlies in kinders ouers se vertroue in hulle vermoë om 'n kind met gehoorverlies groot te maak.

In hierdie studie ondersoek ons of daar 'n verskil is tussen moeders en vaders se ouerskapbenadering, en of daar enige bydraende faktore is wat ouers se self-effektiwiteit mag benadeel wanneer hulle 'n kind met gehoorverlies grootmaak.

1. INLEIDING

Om ouerskap te bestudeer kan omstrede wees, want daar is geen voorgeskrewe boeke wat beskryf hoe ’n mens kinders moet grootmaak nie (Roman, Makwakwa & Lacante 2016). Ouerskap is iets persoonliks en hang af van die sosiale omgewing waarin die gesin sig bevind. Wat byvoorbeeld tot die kompleksiteit van ouerskap bydra, is kindergestremdheid in ’n gesin, wat onvermydelik van ouers ’n ander benadering tot ouerskap vereis.

Deur die jare het navorsers verskillende benaderings tot ouerskap en tot kinders grootmaak bestudeer (Carr & Pike 2012). Dit sluit in die verskeidenheid van ouerskapstyle en die uitwerking wat dit op ’n kind mag hê. Elke ouerskapstyl het verskillende eienskappe en lei tot verskillende reaksies by kinders. Hierdie verskillende eienskappe word uitgebeeld as dimensies (Baumrind 1971), wat gedefinieer word as die beskrywende eienskappe wat gebruik word om die aard van ouerskapstyle te vertolk (Ekim & Ocaksi 2016). Sodanige dimensies sluit in die gedrag of dissiplinêre strategieë wat ouers gebruik om kindergedrag te beïnvloed (Jago, Davison, Thompson, Page, Brockman & Fox 2011).

Die meeste navorsing oor ouerskap is beïnvloed deur die navorsing van Diana Baumrind in die vroeë 1960’s. Hierdie navorsing het die patrone van ouerskapbeheer en kindersosialisering beskryf. Ouerskapstyle word in vier kategorieë beskryf: outoritêr, gesaghebbend, permissief en onbetrokke. Met betrekking tot outoritêre en gesaghebbende ouerskapstyle, lê die verskil tussen die twee style daarin hoe ouers met hulle kinders kommunikeer, en hoe die kinders gestraf word. Outoritêre (“authoritarian”) ouerskap word gekenmerk deur hoë vereistes en min reaksie. Ouers met ’n outoritêre ouerskapstyl het baie hoë verwagtinge van hulle kinders, maar gee baie min terugvoer en aanmoediging. In teenstelling daarmee, is ’n gesaghebbende (“authoritative”) ouerskapstyl een wat hoë vereistes stel én hoë reaksie bied. Gesaghebbende ouers stel hoë standaarde en reageer op die kind se emosionele behoeftes. Hulle stel grense en is baie konsekwent in die afdwing van die grense. Lewis (1981) beweer egter dat dit nie soseer gaan oor gesaghebbende ouers se streng beheer met behulp van reëls wat kinders help om tot onafhanklikheid te ontwikkel nie. Gesaghebbende ouerskap gaan eerder oor gedeelde kommunikasie en die wysiging van ouers se reëls deur middel van gesprek met onafhanklike kinders as uitkoms. Vir ouers wat ’n kind met ’n gestremdheid grootmaak, mag dit anders wees (Woodgate, Edwards, Ripat, Borton & Rempel 2015), en dit mag vir dergelike ouers nodig wees om hulle ouerskapbenadering te heroorweeg. Ouers kan toegewings maak vir ’n kind met ’n gestremdheid deur aanpassings en veranderings te maak, hulleself toe te rus met kennis omtrent die behoeftes van hulle kind, en hul ouerskapgedrag en houding aan te pas sodat hulle meer betrokke raak vir sover dit hulle benadering tot ouerskap aangaan.

Literatuur oor ouerskap-selfeffektiwiteit (“parental self-efficacy”) – ouers se selfvertroue omtrent hulle vermoë om kinders suksesvol te kan grootmaak – toon dat daar ’n direkte verband is tussen ouerskap en ouerskap-effektiwiteit en die gehalte van sorg wat aan kinders voorsien word (Sanders & Woolley 2005). Gehoorverlies word deur die Wêreld Gesondheidsorganisasie (WHO 2015) gedefinieer as stremmend wanneer die verlies aan gehoor meer as 30 desibels is in die oor waarmee die kind die beste hoor. Die implikasies van gehoorverlies kan verreikende gevolge inhou vir die kind se kwaliteit van lewe, vermoë om te kommunikeer en vermoë om ekonomies onafhanklik te word, ongeag die ouderdom wanneer gehoorverlies ’n aanvang neem. Vir ouers wat kinders met gehoorverlies het, kan ouerskap-effektiwiteit nie net uitdagings ten opsigte van hulle kind se gehoorverlies inhou nie. Ander uitdagings wat ouers met betrekking tot hulle kinders se gehoorverlies mag ervaar, hou verband met stres, kommunikasie, maatskaplike ondersteuning en toegang tot inligting. Hierdie uitdagings kan betekenisvol bydra tot die soort ouerskapbenadering wat horende ouers aanvaar . Dit kan ’n invloed uitoefen op hulle selfvertroue rakende hulle vermoë om die daaglikse uitdagings te hanteer terwyl hulle ’n kind met gehoorverlies grootmaak.

2. PROBLEEMSTELLING

In die konteks van die huidige studie, kan die teenwoordigheid van ’n kind met gehoorverlies die ouerskapbenadering van horende ouers beïnvloed. Sommige ouers beskryf hulle ouerondervinding met so ’n kind as bevredigend, uitputtend en lewensveranderend (Fox 2009). Gehoorverlies in kinders kan gevolge hê wat inhou dat ouers probleme ondervind om ’n effektiewe benadering tot kinderopvoeding te ontwikkel. Hierdie gevolge mag bydra tot ouers se onsekerheid oor die manier waarop hulle hul kind moet grootmaak (Calderon & Greenberg 2003; Calderon, Bargones & Sidman 1998). Gesinsinteraksie, gesinshulpmiddele, ouerskap en ondersteuningsdienste is alles gebiede van die gesinslewe wat beïnvloed word as ouers ’n kind met gehoorverlies het (Haddad, Steuerwald & Garland 2019).

Baumrind (1971) verwys na die geslagsverskille in ouerskapstyle, en merk op dat moeders meer versorgend en gesaghebbend (“authoritative”) as oorheersend (“authoritarian”) is, in vergelyking met vaders wat meer outoritêr (“authoritarian”) as gesaghebbend (“authoritative”) is. Antonopoulou, Hadjikakou, Stampoltzis en Nicolaou (2015) se studie oor onderskeidende ouerskap- en dissiplinêre voorkeure van moeders met dowe of hardhorende kinders en horende sibbe, het getoon dat die dominante ouerskapstyl van moeders vir albei groepe gesaghebbend is, en dat die toegeeflike en streng ouerskaptipes oor die algemeen die minste voorkom. Ander studies het bevind dat moeders wat oormatig oorbeskermend teenoor hulle kinders is, hulle kinders se sosiale lewe (Gregory 1979) onnodig beperk, wat moederlike indringerigheid tot gevolg het en die selfstandigheid van die kinders beperk (Meadow-Orlans 1990; Vaccari & Marschark 1970).

In teenstelling met Baumrind (1991) se stellings is daar by een van die paar studies wat fokus op vaders wat kinders met gehoorverlies grootmaak, waargeneem dat dergelike vaders oorbeskermend teenoor hulle kinders is, en in vergelyking met vaders van horende kinders, minder demokraties en gedissiplineerd is in hulle benadering (Sahli 2011). Die resultate van ’n studie deur Antonopoulou, Hadjikakou, Dagla en Maridaki-Kassotaki (2015) meld eweneens dat kinders met gehoorverlies hulle vaders as minder outoritêr en streng ervaar as horende adolessente.

Die meeste navorsing oor self-effektiwiteit (“parental self-efficacy”) van ouers neig om Bandura (1997) se teoretiese stellings te volg wat gedefinieer word as ouers se vertroue en bekwaamheid in hulle ouerskapsrol, en in hulle vermoëns om elke taak met selfvertroue uit te voer. Self-effektiwiteit van ouers is geanker in die ouer se persoonlike vertroue en vermoëns om bekwaam en toereikend te funksioneer, en stresvolle eise en uitdagings wat ouers in die gesig staar, te kan hanteer (Coleman & Karraker 2003; Luszczynska, Gutierez-Dona & Schwarzer 2005). Die literatuur toon dat ouers met ’n hoë ouerskap-effektiwiteitsvertroue neig om ondersteunende ouerskapbenaderinge te gebruik en meer positief teenoor hulle kinders te wees (Mouton, Loop, Stievenart & Roskram 2018). Daarenteen is ouers met min vertroue in hul eie effektiwiteit geneig om in hul ouerskap strenger beheer uit te oefen, wat tot gevolg het dat kinders hoë vlakke van ekstreme gedrag toon (Roskam & Meunier 2012).

Nietemin, om die self-effektiwiteit van ouers beter te verstaan, kan die konsep van algemene effektiwiteit nuttig wees om die breër konteks van ouers wat kinders met gestremdheid grootmaak, te verstaan. Algemene self-effektiwiteit kan vertolk word as die algehele aanpassing en self-bevoegdheid van ouers wat dergelik geaffekteerde kinders grootmaak (Benzies, Trute & Worthington 2013). Ouers van kinders met gehoorverlies kan byvoorbeeld oorweldig voel en onbevoeg vir die taak om so ’n kind groot te maak (Kurtzer-White & Luterman 2003), en dit kan die ouers se vertroue in hulle ouerskapvermoëns beïnvloed. Navorsing oor self-effektiwiteit van ouers van kinders met gehoorverlies is beperk, of meestal gefokus op moeders (Desjardin & Eisenberg 2007). Volgens Luterman (1999) is die selfvertroue van ouers, veral dié van moeders, deurslaggewend vir die kind se sukses. Studies wys daarop dat daar min navorsing gedoen is oor die uitdagings wat ervaar word deur ouers wat kinders met gehoorverlies grootmaak (Movallali & Nemati 2009). Hierdie uitdagings kan betekenisvol bydra tot die soort ouerskapbenadering wat horende ouers aanvaar. Navorsers Movallali en Poorseyed (2015) neem waar dat moeders van kinders met gehoorverlies hoër vlakke van stres aandui, negatiewe ouerskapgedrag sonder warmte en intimiteit toon, en inkonsekwent in hulle dissipline is. Op dieselfde wyse kan kommunikasiebeperkings ook ontwrigting in die interaksie tussen ouers en kind veroorsaak en derhalwe ouerskaprolle en verantwoordelikhede negatief beïnvloed (Tamis-LeMonda, Uzgiris & Bornstein 2002), en daartoe aanleiding gee dat ouers streng optree en strafmaatreëls toepas om kinders te dissiplineer (Sullivan, Brookhouser, Scanlan, Knutson & Schulte 1991). ’n Studie deur Jackson (2011) oor gesinsondersteuning en middele vir ouers van kinders met gehoorverlies het bevind dat daar ’n behoefte is aan insiggewende bronne, maatskaplike bronne, sosiaal-emosionele ondersteuning, en opvoedkundige ondersteuning vir ouers. Hintermiar (2006) en Zaidman-Zait (2007) beklemtoon die belangrikheid van ouerondersteuning, veral om stres te verminder wanneer ouers ’n kind met gehoorverlies grootmaak. Hulle verslag toon dat die deel van ervarings met ander ouers van kinders met gehoorverlies ’n uiters belangrike bron van sosiaal-emosionele ondersteuning vir ouers is.

Hierdie ondersoekterrein, wat op ouerskapbenaderings in gestremdheid fokus, is onbekend in die Suid-Afrikaanse konteks. Navorsing oor ouerskap in Suid-Afrika het hoofsaaklik gefokus op ouers wat nie ’n kind met ’n gestremdheid het nie, selfs al is daar studies wat op beide moeders en vaders fokus. Hierdie studies toon dat daar beduidende verskille is tussen die ouerskapbenaderings van moeders en vaders (Roman, Makwakwa & Lacante 2016; Gamble, Ramakumar, & Diaz 2007), met moeders wat meer gesaghebbend is as vaders in hul benaderings tot ouerskap. Die uitkomste van hierdie studie mag implikasies hê vir praktisyns in Suid-Afrika en bydra tot die navorsing oor insae in die ouerskapbenadering van horende ouers wat kinders met gehoorverlies grootmaak.

Ten einde insig te verkry in die benadering tot ouerskap van horende ouers wat kinders met gehoorverlies grootmaak, beoog die huidige studie om die onderskeie benaderings van moeders en vaders vas te stel en die self-effektiwiteit van beide moeders en vaders in die opvoeding van ’n kind met gehoorverlies te beskryf.

3. EMPIRIESE ONDERSOEK

3.1 Doel van die navorsing

Die doel van die navorsing was om 1) die ouerskapbenaderings en 2) bydraende faktore tot die self-effektiwiteit van moeders en vaders betreffende die opvoeding van hul kinders met gehoorverlies te ondersoek.

’n Verdere doelwit van die navorsing is om ouerlike intervensies te ontwikkel wat gebaseer is op horende moeders en vaders se ouerskapbenaderings teenoor hul kinders met gehoorverlies.

3.2 Navorsingsoriëntasie

’n Kwantitatiewe navorsingsbenadering is gevolg. Kennis is verkry deur middel van sorgvuldige waarneming en meting, om sin te maak van die wêreld deur middel van ’n wetenskaplike proses wat die kwantitatiewe metodes en statistiek in aanmerking neem (Creswell 2003; Somekh, Burman, Delamont, Meyer, Payne & Thorpe 2005). Ons het die statistiese data wat in die studie ingesamel is, gebruik om ons data op te som, en patrone, verhoudings en konneksies te beskryf (Antonius 2003).

3.3 Navorsingsontwerp en -metode

’n Nie-waarskynlikheidsteekproef (“Non-probability sampling”) is vir die doel van hierdie studie aangewend. Drie skole is genader om met die data-insameling te help. Drie skoolhoofde van skole vir kinders met ’n gehoorverlies is gekontak en om toestemming vir hulle samewerking gevra. Die doel van die studie is aan hulle verduidelik, en nadat toestemming verkry is, het die skoolhoofde die vraelyste uitgedeel as deel van hulle korrespondensie met ouers.

’n Kwantitatiewe navorsingsmetode is in die studie gebruik. Daar is gepoog om by die ouers uit te vind hoe hulle ouerskap met die opvoeding van ’n kind met gehoorverlies benader, en watter bydraende faktore hulle self-effektiwiteit (“self-efficacy”) rakende die opvoeding van sulke kinders kan beïnvloed.

3.4 Deelnemers

Die deelnemers aan die huidige studie was 103 (n=103) horende ouers van die Wes-Kaap, Suid-Afrika. Elke deelnemer het ’n gesin verteenwoordig, wat beteken dat moeders en vaders vir die huidige steekproef uit verskillende gesinne afkomstig was. Die deelnemers het bestaan uit ’n heterogene groep ten opsigte van ouderdom, huishouding, verhoudings, en opvoedkundige en sosio-ekonomiese profiele. Horende ouers was tussen die ouderdomme van 35 en 50 jaar, en hulle kinders, wat gehoorverlies het, tussen 10 en 17 jaar oud. Die meerderheid ouers was vroulik (77/74.8%), en bruin (gemengde ras) (46/44.7%), en die meerderheid het vroulike kinders (62/60.2%). Van die enkelouers was die meerderheid vroulik (38/77.6%). In die kategorie “verhouding tot kind” word ’n **verwysing** na pleegouers gemaak. Pleegouers in hierdie geval, pleegmoeders, word genoem om die samestelling van die ouers wat die vraelys beantwoord het, aan te dui. Hulle is opgeneem in die moeder groep, aangesien al vier pleegouers moeders is.

Die analise van die groepe moeders en vaders is onderneem sonder om te let op die huwelikstatus van die deelnemer. Deelnemers het die reg om nie deel te neem nie, om enige vraag wat hulle ongemaklik laat voel weg te laat, en om te eniger tyd gedurende die ondersoek te onttrek.

TABEL 1: Demografie van ouers

Veranderlikes	**n = 103**	**%**
Geslag		
Manlik	26	25.2
Vroulik	77	74.8
Huwelikstatus		
Getroud	54	57.6
Enkellopend	49	52.4
Enkelouerskap		
Manlik	11	22.4
Vroulik	38	77.6
Indiensneming		
Manlik	20	19.4
Vroulik	54	52.4
Werkloosheid		
Manlik	6	5.8
Vroulik	23	22.3
Ras		
Swart	38	36.0
Wit	20	19.4
Bruin	46	43.7
Verhouding tot kind		
Moeder	72	69.9
Vader	27	26.2
Ander (Pleegmoeder)	4	3.9
Huistaal		
Engels	31	30.0
Afrikaans	38	36.8
isiXhosa	32	31.06
Geslag van kind		
Manlik	40	38.8
Vroulik	62	60.2

3.5 Navorsingsinstrument, data-insameling en -analise

Die volgende navorsinginstrumente is by die opstel van die kwantitatiewe vraelys ingesluit: die aangepaste *Parents as Social Context Questionnaire* (PSCQ) (Skinner, Johnson & Snyder 2005) en die aangepaste *Parent Self-Efficcy Instrument* (PSE) (Coleman & Karraker 1998). Die aanpassings van die instrumente is gedoen om die woorde "kind met gehoorverlies" in te sluit, byvoorbeeld van 'n vraag; "Ek weet baie wat met my kind aangaan". Die verandering was; "ek weet baie wat met my kind met 'n gehoorverlies aangaan". Daar was geen verandering van die betekenis van die skale nie.

Die aangepaste *Parents Social Context Questionnaire* (PSCQ) is gebruik om vas te stel wat die horende ouers se benadering is om die aard van die ouerskapstyle van moeders en vaders ten opsigte van ouerskapbenaderings tot hul kind met gehoorverlies te verstaan. Hierdie afdeling het uit 29 items bestaan en is verdeel in ses onderafdelings: warmte, verwerping, struktuur, chaos, outonomie/ondersteuning en dwang. Ons het die ses onderafdelings vir hierdie ontleding gebruik omdat dit die meer algemene aspekte van ouerskapbenadering behels in die konteks van ouerskap van kinders met gehoorverlies. Elkeen van die ses onderafdelings bevat vyf items, met die uitsondering van outonomie/ondersteunende ouerskapdimensie (“parenting dimension”) wat vier items bevat. Die deelnemers is gevra om elke vraag te beantwoord wat betrekking het op ’n dimensie op ’n 4 punt-Likertskaal, wat wissel van “glad nie waar nie”, “nie heeltemal waar nie”, “min of meer waar” tot “heeltemal waar”.

Die aangepaste *Parent Self-Efficcy Instrument* (PSE) (Bandura, Adams, Hardy & Howells 1980) is effens gewysig om ouers se vertroue in hulle vermoë om die rol van ouerskap suksesvol te verrig, te beskryf. Die PSE sluit tien items in wat spesifiek kyk na die eksterne veranderlikes wat op die self-effektiwiteit (“self-efficcy”) van moeder- en vaderouerskap inwerk wanneer hulle ’n kind met gehoorverlies grootmaak. Hierdie veranderlikes weerspieël algemene ouerskaptake sowel as spesifiee take wat betrekking het op ouerlike benaderings tot dergelike kinders en verskaf ’n taakgerigte meting (“task-specific measure”) van ouers se selfvertroue. Elkeen van die 10 items is op ’n 6 punt-skaal gemeet, wat ouers se reaksies van 0=laag tot 6=hoog meet.

Beide skale is suksevol geïmplementeer in studies met ouerskapbenadering van horende ouers wat kinders met gehoorverlies grootmaak (Ekim & Ocakci 2016) en met betrekking tot ouers se selfeffektiwiteit betreffende volwassenes met gehoorverlies (Adi-Bensaid, Michael, Most & Gali-Cinamon 2012).

Die vraelys het dus uit drie afdelings bestaan: (a) ouers se demografiee besonderhede, *a* (b) die aangepaste *Parents as Social Context Questionnaire* (PSCQ) en (c) die aangepaste *Parent Self-Efficcy Instrument* (PSE).

Die Engelse vraelys is ook in twee ander tale, isiXhosa en Afrikaans vertaal, wat saam die drie dominante tale in die Wes-Kaap, Suid-Afrika is. Die vertaling van die vraelyste is gedoen met die doel om die geldigheid en betroubaarheid van die antwoorde van die deelnemers te verhoog, selfs al is daar geen navorsing bekend wat aandui dat hierdie instrumente voorheen in Suid-Afrika gebruik is nie.

Die vraelyste is in weergawe 25 van die *Statistical Package for Social Sciences* (SPSS) opgeneem. Die data is gekodeer, opgeruim en nagegaan vir foute. Sowel beskrywende (gemiddeldes en standaardafwykings) as inferensiële statistiek (onafhanklike steekproewe, nie-parametriese toets – Mann-Whitney U-toets) is in die analise gebruik.

3.6 Betroubaarheidsaspekte

Joppe (2000i1) defineer betroubaarheid as volg: “the extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability, and if the results of a study can be reproduced under a similar methodology , then the research instrument is considered to be reliable.” Om die betroubaarheid van die instrument vas te stel, is Cronbach se Alpha (’n statistiese wyse vir die vasstelling van betroubaarheid) bepaal met die tellings wat deur PSCQ en PSE verkry is. Die resultate van die analise toon dat die items die tevredenheidsvlak van konstrukgeldigheid en interne konsekwentheid (“internal consistency”) van hierdie aangepaste vraelys (Taber 2018) aandui. Cronbach se alpha vir PSCQ is 0.95 en PSE is 0.90 en dus kan hierdie assessering as betroubaar beskou word, aangesien dit goeie interne konsekwentheid refleteer .

3.7 Etiese aspekte

Tydens die studie is die volgende stappe geneem om aan die etiese voorwaardes van navorsing te voldoen:

- Etiese goedkeuring om die huidige studie uit te voer is verkry van die Universiteit van Wes-Kaapland, Suid-Afrika.
- Toestemming is ook van die Wes-Kaap Onderwysdepartement verkry.
- Die skoolhoofde van die skole vir dowes is genader om met die studie te help. Die doel van die studie is verduidelik en met die skoolhoofde se toestemming is vraelyste versprei as deel van hulle korrespondensie met ouers.
- ’n Brief waarin die etiese oorwegings van die studie in detail uiteengesit is, vertroulikheid en anonimiteit deur die gebuik van skuilname gewaarborg is, en deelnemers van enige leed gevrywaar word, is by die brief ingesluit.

4. RESULTATE

4.1 Ouerlike dimensies deur vaders en moeders

Tabel 2 toon die heersende benaderinge tot ouerskap tussen moeders en vaders. Die bevindings toon dat moeders hoër presteer in chaotiese ouerskap (M = 2.52, SD = 0.62) sowel as in gestruktureerde ouerskap (M = 3.31, SD = 0.79) as vaders (M = 2.48, SD = 0.67; M = 3.18, SD = 0.89). Vaders presteer hoër in outonomie en ondersteunende ouerskapbenaderinge (M – 3.02, SD = 0.43), sowel as ouerlike warmte (M = 3.26, SD = 0.68), as moeders 9M = 3.00, SD = 0.68; M = 3.25, SD = 0.70). Daar was ’n effense verskil in die beoordeling van prestasie in ouerskapverwerping, waarin vaders hulleself hoër aangeslaan het (M = 2.68, SD = 0.72) as moeders (M = 2.61. SD = 0.71). SD = 0.27). Hierdie verskille was nie betekenisvol nie.

TABEL 2: Ouerlike dimensies deur vaders en moeders (warmte, verwerping, struktuur, chaos, ondersteuning, dwang)

Veranderlike		**N**	***G***	***S***	***T-Waarde***	***P-Waarde***
Ouerlike warmte	Vader	25	3.26	0.68	0.055	0.957
	Moeder	76	3.25	0.70		
Ouerlike verwerping	Vader	24	2.68	0.72	0.418	0.677
	Moeder	74	2.61	0.71		
Ouerlike struktuur	Vader	26	3.18	0.89	0.714	0.477
	Moeder	77	3.31	0.79		
Ouerlike chaos	Vader	25	2.48	0.67	0.292	0.771
	Moeder	75	2.52	0.62		
Ouerlike ondersteuning	Vader	21	3.02	0.43	0.109	0.913
	Moeder	67	3.00	0.68		
Ouerlike dwang	Vader	24	2.30	0.88	0.704	0.483
	Moeder	75	2.44	0.82		

4.2 Eksterne faktore wat moeders en vaders se self-effektiwiteit beïnvloed

Tabel 3 bied gemiddelde resultate ("mean scores") en standaardafwykings van moeders en vaders se reaksie op die PSE om ouers se vertroue in hulle vermoë om die rol van ouerskap suksesvol te verrig, te bepaal.

Vaders beoordeel hulleself hoër wat betref hul kennis van hoe hulle kind groei en ontwikkel (M = 5.36) in vergelyking met moeders wat hulself laer beoordeel (M = 4.73). Vaders presteer ook hoër (M = 5.40) wat betref die hoeveelheid kommunikasie en probleemoplossing met hulle metgeselle omtrent kwessies wat met hulle kind verband hou in vergelyking met moeders (M = 4.18). Daarby beoordeel vaders hulleself hoër wat betref die aantal positiewe of behulpsame interaksies wat hulle met ander ouers het (M= 4.84) as moeders wat hulleself laer aanslaan (M = 4.18). Vaders presteer weer eens hoër in hul beoordeling van hulle vermoë om hulle kind te help leer (M = 4.83). Eweneens beoordeel vaders hulle selfvertroue en vermoë om die daaglikse uitdagings van kinders met gehoorverlies groot te maak (M = 5.54) hoër as moeders se beoordeling van hul selfvertroue en vermoëns (M = 4. 97). Vaders takseer hulleself ook hoër vir hulle vermoë om die stres in hulle lewe te hanteer (M = 5.24) in vergelyking met moeders (M = 4.68).

TABEL 3: Die self-effektiwiteit van moeders en vaders

Veranderlikes		***N***	***M***	***SD***
U kennis van hoe u kind groei en ontwikkel	Vader	25	5.36	.995
	Moeder	73	4.73	1.16
U vertroue dat u weet wat reg is vir u kind	Vader	24	5.50	.722
	Moeder	75	4.96	1.12
U vertroue in u vermoë om die daaglikse uitdagings van ouerskap in die gesig te staar	Vader	24	5.54	.78
	Moeder	76	4.97	1.05
U vermoë om u kind te help leer	Vader	24	5.42	1.07
	Moeder	76	4.83	1.16
U vermoë om die spanning in u lewe die hoof te bied	Vader	25	5.24	1.01
	Moeder	75	4.68	1.21
Die hoeveelheid positiewe interaksies wat u met ander ouers het	Vader	25	4.84	1.31
	Moeder	66	4.18	1.26
U bewustheid van gemeenskapsinligting en bronne vir ouers	Vader	24	4.46	1.47
	Moeder	66	4.18	1.26
Die hoeveelheid nuttige inligting vir ouers en ondersteuning wat u van ander kry	Vader	25	4.92	1.35
	Moeder	62	4.65	1.26
Die hoeveelheid kommunikasie en probleem-oplossing met die ander ouers oor kwessies in verband met u kind	Vader	25	5.40	.91
	Moeder	58	4.76	1.25
U tevredenheid met u ervaring as ouer	Vader	25	5.16	1.25
	Moeder	75	4.93	1.16

4.3 Algehele ouerskapeffektiwiteit van moeders en vaders – onafhanklike t-toets

In Tabel 4 is 'n onafhanklike steekproef t-toets onderneem om te bepaal of moeders en vaders beduidend verskil ten opsigte van ouerskap-selfeffektiwiteit. A Mann-Whitney U-toets het getoon dat daar 'n beduidende verskil is (U= 346.500, p =.002) in ouerskap-selfeffektiwiteit waar vaders (M = 5.21, SD = 0.61) 'n hoër telling behaal as moeders (M = 4.46, SD = 0.98). Vaders het 'n hoër telling behaal in kennis, selfvertroue, streshantering, kommunikasie, positiewe interaksie en tevredenheid as moeders.

TABEL 4: Algehele ouerskapeffektiwiteit van moeders en vaders – onafhanklike t-toets

Veranderlike		**N**	***M***	***SD***	***T***	***U***	***p***
Self-effektiwiteit van ouers	Vader	26	5.21	0.61	4.06	346.500	0.002
	Moeder	77	4.46	0.98			

5. BESPREKING

Die doel van die studie was om die onderskeie benaderings tot ouerskap van moeders en vaders te bepaal en die self-effektiwiteit van sowel moeders as vaders in hul opvoeding van 'n kind met gehoorverlies voorts te beskryf. Dit was sover bekend die eerste Suid-Afrikaanse studie in hierdie veld. Die resultate van die studie dra by tot die navorsing oor geslagsverskille betreffende die ouerskap van horende ouers in hul opvoeding van 'n kind met gehoorverlies.

Ons resultate het getoon dat moeders hoër presteer in chaotiese en onder dwang-ouerskapbenadering, én ook hoër in hulle gestruktureerde ouerskapbenadering. Moeders presteer laer in al die veranderlikes wat met self-effektiwiteit verband hou. Twee van die laer tellings sluit in moeders se selfvertroue rakende hulle vermoë om die daaglikse uitdagings wat ouerskap van kinders met gehoorverlies vereis, te hanteer, en hulle tevredenheid met hulle ondervindings as ouer van 'n kind met gehoorverlies. Die versorging van 'n kind met 'n sodanige gestremdheid affekteer die rol van beide ouers, maar veral die daaglikse lewens van moeders, omdat hulle gewoonlik die kind se primêre sorggewers is (Singogo, Mweshi & Rhoda 2015). Hierdie teenstrydighede in die resultate kan gebaseer wees op moeders se ondervinding van hulle daaglikse verantwoordelikhede as ouer as die primêre versorger van hulle kind (Zaidman-Zait, Most, Tarrasch, Haddad-Eid & Brand 2015). Om as ouer minder tevrede te voel, kan beteken dat moeders emosionele uitputting en verminderde gevoelens van ouerskapprestasie en effektiwiteit (Roskam, Raes & Mikolajczak 2017) ondervind wanneer hulle 'n kind met gehoorverlies grootmaak. 'n Verdere moontlike verduideliking vir hierdie resultate kan verband hou met die feit dat die meerderheid van die moeders enkelouers is (77.6), of dat hulle werk (72.9%) en maklik dubbele rolle in hulle gesinne vertolk. Hierdie groter verantwoordelikhede kan tot gevolg hê dat moeders hulle ouerskapverantwoordelikhede so moet struktureer dat hulle al die verantwoordelikhede vir die rehabilitasie (opvoedkundig, medies, bywoning van kommunikasie-afsprake) van hulle kind aanvaar , maar nog steeds werk en dus die verantwoordelikheid vir die kinderopvoeding met hul werk moet kombineer. Dit kan veral uitdagend en uitputtend vir 'n enkelouer wees wat alleen verantwoordelik is vir die daaglikse eise van ouerskap van 'n kind met gehoorverlies.

Hierdie bevindings kan verder daarop dui dat verantwoordelikhede vir kinderopvoeding groter word terwyl ouers hulle pad baan deur die ontwikkelingstadium waarin die kind hom of haar bevind. Die grootste groep ouers wat aan hierdie studie deelgeneem het, se kinders is tussen die ouderdomme van 10 en 17 jaar. Een manier om hierdie bevindings te verstaan, is dat hierdie ouderdomsgroep dikwels ’n moeilike oorgangstadium verteenwoordig, vir ouers sowel as die kinders. Dit kan (i) fisieke en emosionele uitputting, (ii) emosionele afstand van ’n mens se kinders, en (iii) ’n gevoel van onbevoegdheid in ’n mens se ouerskaprol tot gevolg hê (Mikolajczak 2018), wat die rigiditeit en teenstrydigheid in moeders se ouerskapbenadering kan verklaar.

Daarby presteer moeders laer betreffende die stresveranderlikes in vergelyking met vaders. Ouerskapstres by ouers van kinders met gehoorverlies word geassosieer met negatiewe uitkomste vir ouers sowel as kinders, wat insluit swak gehegtheid aan (“attachment”), minder positiewe ouer-kind-interaksie, sowel as ongelukkigheid in die huwelik (Asberg, Vogel & Bowers 2008). Een manier om hierdie bevindings te verstaan, hou verband met ouderdom (adolessente) en kindergeslag. Die resultate kan beteken dat hoe ouer die kinders is, hoe meer stres kan die moeders ondervind. Hierdie ouderdomsgroep is gekoppel aan adolessente-uitdagings soos liggaamsveranderinge, emosionele veranderinge en probleme, gedragsveranderinge en psigologiese probleme (Blakemore & Mills 2014). Pipp-Siegel, Sedey, Yoshinaga-Itano (2002) het in hulle studie oor voorspellers van ouerskapstres in moeders van jong kinders met gehoorverlies bevind dat moeders van ouer kinders meer stres gerapporteer het as moeders van jonger kinders as gevolg van hulle persepsie dat hulle kinders moeiliker as jonger kinders is. Maar hulle studie en ons studie kan nie vergelyk word nie omdat daar verskillende steekproewe (“samples”) betrokke was.

Ten opsigte van kommunikasie en ouerskapeffektiwiteit, dui die bevindings in die huidige studie op verskille in prestasie tussen moeders en vaders. Kommunikasieprobleme is geïdentifiseer as die hoofstressor vir ouers van kinders met gehoorverlies (Zaidman-Zait & Most 2005), veral wanneer die visuele behoeftes van ’n kind met gehoorverlies in aanmerking geneem word (Davids, Roman & Schenck 2018). Aanpassing om aan die kommunikasiebehoeftes van die kind te voldoen, kan ontwrigting veroorsaak in die interaksie tussen ouer en kind en ouerskaprolle en -verantwoordelikhede negatief affekteer (Tamis-LeMonda, Uzgiris & Bornstein 2002), veral as kinders tussen die ouderdomme van 10 en 17 is. ’n Redelike verduideliking vir die bevinding kan ook wees dat moeders dikwels die kommunikasieverantwoordelikhede in die huis aanvaar sodat daar gespreksinteraksie in gesinne kan wees om misverstande te vermy. Moeders word dikwels die effektiewe kommunikeerders in die gesin, maar moeders kan ook moeg word deurdat hulle voortdurend met hierdie verantwoordelikheid belas word (Luterman & Ross 1991).

Terselfdertyd word maatskaplike ondersteuning vir ouers en gemeenskapsinligting en hulpbronne geassosieer met ’n laer self-effektiwiteittelling by moeders as by vaders. Hierdie resultate sal aandui dat moeders dalk beperkte interaksies met ander ouers het, minder bewus is van inligting en hulpbronne, en baie min, indien enige, sosiale ondersteuning het. Studies toon dat moeders van kinders met gehoorverlies sosiale isolasie, eensaamheid en verlaagde vlakke van sosiale en intieme verhoudings ondervind (Lederberg & Golbach 2002; Jackson, Wegner & Turnbull 2010). Alhoewel daar gemeld is dat sosiale ondersteuning vir moeders belangrik is omdat dit betekenisvol bydra tot positiewe moeder-en-kind-interaksies (MacTurk, Meadow-Orlans, Koester & Spencer 1993), moet moeders se belewenis in aanmerking geneem word. Hierdie belewenisse kan onder andere insluit: voltydse werk, versorging van ander kinders, enkelouerskap en finansiële koste. Addisionele navorsing word aanbeveel om ’n beter begrip te kry veral rondom moeders en enkelouerskap van kinders met gehoorverlies.

’n Verdere verduideliking vir hierdie bevindinge kan gekoppel word aan die wyd verspreide armoede en ongelykheid wat ons nog steeds in Suid-Afrika ondervind (David, Guilbert, Hamaguchi, Higashi, Hino, Leibbrandt & Shifa 2018). Ongelukkig woon baie ouers in Suid-Afrika buite die geografiese areas van skole vir kinders met gehoorverlies, en buite geografiese areas van diensverskaffers. Dit maak dit vir moeders moeilik om op hul eie maatskaplike ondersteuning te kry. Twee of drie wyses van vervoer is gewoonlik nodig vir ouers om toegang tot diensverskaffers te verkry, terwyl die veiligheid van vroue ’n bykomende bekommernis is. Gebrek aan vervoer en groot afstande om te reis kan geloofwaardige verduidelikings wees vir moeders se gevoel van isolasie van ander ouers, min inligting of hulpmiddele en nie-deelneming aan maatskaplike ondersteuningsdienste. Moeders se lae prestasie in hierdie veranderlikes kan ’n aanduiding van hulle ondervindings wees. Bykomende faktore wat kan bydra tot moederlike stres in hierdie huidige studie, is moeders se persepsie van die hoeveelheid ondersteuning wat hulle van lewensmaats of vaders van hulle kinders ontvang, en moet verder ondersoek word (Pipp-Siegel *et al*. 2002).

In teenstelling hiermee, het die studie van Zaidman-Zait, Most, Tarrasch, Haddad-Eid en Brand (2015) die verband ondersoek tussen middele om by te hou en ouerskapstres tussen moeders en vaders van kinders met gehoorverlies. Ten opsigte van verskille tussen moeders en vaders se sin vir self-effektiwiteit, het moeders hoër vlakke van ouerskapeffektiwiteit gerapporteer. Die outeurs dui aan dat die primêre betrokkenheid van moeders in die daaglikse sorg van hulle kinders, asook hulle deelname aan intervensieprogramme een aanvaarbare rede vir die bevindinge van hoër vlakke van self-effektiwiteit onder moeders is. Die studie was ook in staat om aan te dui dat vaders minder selfvertroue het as moeders wat betref hulpverlening aan hulle kind met gehoorverlies, wat strydig is met die huidige studie waarin vaders meer vertroue het in hulle vermoë om die daaglikse uitdagings van hulle kind met gehoorverlies te hanteer, vergeleke met moeders.

Gevolglik kan al die bogenoemde bevindings ’n mate van verduideliking bied vir die rigiditeit (“rigidity”) en teenstrydige stellings van dwang- en gestruktureerde ouerskapbenadering by moeders. Addisionele navorsing word aanbeveel om ’n beter begrip te kry van ouerskapuitputting met die grootmaak van adolessente met gehoorverlies.

Die bevindings het ook aan die lig gebring dat vaders hoër presteer in hul warmte en ondersteunende ouerskapbenadering as moeders. Net so toon die bevindings dat vaders betekenisvol hoër presteer in al die veranderlikes in verband met self-effektiwitet. Studies toon dat vaderbetrokkenheid by sorg, ontwikkeling, herkenning van en reaksie op die kind, en hantering van probleme sedert 1965 bykans verdriedubbel het (Teti & Gelfand 1991; Ingber & Most 2012; Zaidman-Zait, Most, Tarrasch & Haddad 2017). ’n Studie, uitgevoer deur Antonopoulou, Hadjikakou, Dagla, Maridaki-Kassotaki (2015), waarin die skakel tussen persepsies van ouerskaptipologie ondersoek word, het getoon dat adolessente met gehoorverlies hulle vaders as minder outoritêr en streng ervaar in vergelyking met adolessente wat kan hoor. Een aanvaarbare verduideliking vir hierdie bevindings in die huidige studie is dat vaders se interaksie met hulle kind met gehoorverlies van moeders s’n kan verskil. Die aard van interaksie kan verband hou met byvoorbeeld die hoeveelheid tyd wat vaders, in vergelyking met moeders, met hulle kind deurbring. Verdere duidelikheid oor hierdie bevindings kan verband hou met vaders se eie persepsie van hulle ouerskapbenadering en ouerskap-selfeffektiwiteit, en nie volgens hoe moeders vaders se ouerskapbenadering en self-effektiwiteit sien nie. Verdere navorsing is nodig om te verstaan wat die verskil is in die aard van interaksie van moeders en vaders wanneer hulle kinders met gehoorverlies grootmaak. Verdere navorsing is ook nodig om vaderbetrokkenheid in gesinne van kinders met ’n gehoorverlies te verstaan.

Ten slotte: kinders met ’n gehoorverlies bly ’n kwesbare groep in ons samelewing. Ouers vorm ook deel van hierdie kwesbare groep omdat hulle talle uitdagings ervaar en ’n hele aantal verhoudingsprobleme ondervind wanneer hulle hul kind met ’n gehoorverlies opvoed. Hierdie uitdagings sluit in ekstra emosionele eise op ouers en gesinne. Ouers en hul gesin kan byvoorbeeld meer sosiaal geïsoleer voel, wat die vermindering van hulle ondersteuningsnetwerke veroorsaak. Terselfdertyd ervaar ouers probleme met die tekort aan hulpbronne en ondersteuning wat dus gesinstresvlakke negatief kan beïnvloed.

Gevolglik bevat die studie ’n hele aantal implikasies en aanbevelings vir toekomstige navorsing en praktiese oorwegings. Dit maak voorsiening vir beter begrip van die genderverskille in ouerskapbenadering en ouerskap-selfeffektiwiteit in die grootmaak van kinders met gehoorverlies. Hoewel die bevindings aandui dat vaders hoër presteer in positiewe ouerskapbenadering en betekenisvol hoër as moeders in ouerskap-selfeffektiwiteit, moet daar gewaak word teen veralgemening van die studie, veral by die interpretasie van moeders se ouerskap-selfeffektiwiteit. Daar moet gelet word op die metodologiese beperkings van die huidige studie, spesifiek ten opsigte van die kwantitatiewe aard daarvan. ’n Gemengde metodologiestudie of ’n kwalitatiewe studie kan minder konsekwentheid toon, en kan verder bydra tot die begrip van ouers se interpretasie van mekaar se persepsies van ouerskap-selfeffektiwiteit. Hierdie studie is gebaseer op ouers wat hulleself beoordeel het ten opsigte van hulle eie ouerskapbenadering en self-effektiwiteit, en is nie gebaseer op observasies of ouers wat mekaar beoordeel nie, wat ’n sekere vlak van vooroordeel kan skep. Hoewel die steekproef en die lokaliteit van die steekproef beperk was tot skole in die Wes-Kaap en as ’n beperking van die studie beskou kan word, is daar min navorsing oor ouerskapbenadering teenoor kinders met gehoorverlies onderneem. Ons studie bied ’n begrip aan van die horende moeders en vaders se ouerskapsbenadering teenoor hul kinders met gehoorverlies en beklemtoon die noodsaak van ’n omvattende benadering om die kompleksiteite van hierdie ouers te beoordeel.

Hierdie benadering stel die ontwikkeling van ouerlike intervensies voor wat die uiteenlopende behoeftes van horende ouers aanspreek. Dergelike ouerlike intervensies sluit maatskaplike dienste in wat spreek tot spesifieke kennis en vaardighede betreffende gehoorverlies, veral in kinders. Maatskaplike dienste sluit in emosionele en sosiale ondersteuning en die fasilitering van ouer-groepsessies waar ouers die geleentheid kry om met ander ouers kontak te maak en hul ervarings met ouerskapbenadering te deel.

6. SAMEVATTING

Samevattend word gekonstateer dat hierdie studie bydra tot die literatuur oor ouerskap van kinders met gehoorverlies. Ons resultate ondersteun die ontwikkeling van spesifieke intervensies vir moeders en vaders van kinders met ’n gehoorverlies. Die resultate van hierdie studie kan ingesluit word by die riglyne vir die beplanning van ondersteuning vir horende ouers van kinders met ’n gehoorverlies en kan as ’n effektiewe instrument vir verandering gebruik word.

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Appendix 12: Editor's Letter

Lee-Anne Roux

PROFESSIONAL EDITING SERVICES

BTH (Honors) Practical Theology UNISA 2006 ● BA Honors (Psychology) UNISA 2009 ● MTH (Practical Theology) Stellenbosch University 2013
PHD (Practical Theology) Stellenbosch University 2019

20 September 2020

TO WHOM IT MAY CONCERN

RE: LANGUAGE EDITING

This letter serves to confirm that I have edited the thesis titled:

THE DEVELOPMENT OF GUIDELINES FOR HEARING PARENTS PARENTING CHILDREN WITH A HEARING LOSS

by

RONEL SANET DAVIDS
(Student Number: 8842015)

(excluding Chapters 4, 5 and 6 – as these have already been published)

Please feel free to contact me if you need any further information.

Yours sincerely,

Dr Lee-Anne Roux

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