TABLE OF CONTENTS

---oOo---

Page

CHAPTER 2
THEORETICAL FRAMEWORK & LITERATURE REVIEW

Page

---oOo---

Page

CHAPTER 3
METHODOLOGY OF THE STUDY

Page

---oOo---

Page

CHAPTER 4
PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS ACCESSING COUNSELING SERVICES: RESEARCH RESULTS

---oOo---

Page

CHAPTER 5
DISCUSSION OF RESULTS

---oOo---

Page

CHAPTER 6
CONCLUSIVE FINDINGS AND RECOMMENDATIONS

---oOo---

---oOo---

LIST OF FIGURES

Page

---oOo---

LIST OF TABLES

Page

Page

---oooOooo---

1 INTRODUCTION, PROBLEM STATEMENT AND RESEARCH DESIGN

1.1 INTRODUCTION AND STATEMENT OF THE PROBLEM

The present system of guidance and counseling by individuals and/organizations in Zimbabwe does not seem to address the problems faced by parents of children who have hearing impairments (Richards, 2000:147). This is evidenced by the fact that many parents of children with hearing impairments fail to cope with the needs of their children. Richards (1996:94) pointed out that most parents of children with disabilities are not aware of how they can access other counseling services available in the country apart from special schools. These parents frequently fail to access the services they require. Makoni (1996:5) endorses the fact that counseling services in Zimbabwe are limited and not many people know where they are situated. This lack of fit between the needs of families and the provision of services may be accounted for in a number of ways. Some of these explanations concern the families while others relate to the provision of the services. Early in the 1990s Lea and Clarke (1991:159) carried out a study in the United States of America and found that even families who requested help from health professionals, thus seeming eager to help themselves, often failed to attend appointments possibly due to difficulties in traveling to specialized centres, lack of funds, lack of knowledge of what the services offer or fear of stigmatization. It appears their expectations tend to lack a thorough understanding of the child's problems. It is generally the practice of these parents to come back to the school where their children learnt, for guidance and help after failing to cope in day-to-day life. In some cases parents dump children in special schools for years and then pitch up during the final year of primary or secondary school (Makoni, 1996:4). Stewart (1986:113) points out that most parents who do not receive proper guidance and counseling fail to cope in any practical way with their hearing impaired children.

Guidance and counseling, according to Backenroth (2001:27), is of utmost importance in order for the family to lay a good foundation in preparing and planning ahead for the future of the child with disabilities. Therefore it is important to know how parents of children

with hearing impairments access counseling services. Backenroth (2001:27) goes on to point out that counselors should collaborate with family organizations, educators and managers in order to lay foundations for the development of competencies required in the labor market. A study carried out by Burnett and Van Dorssen (2000:243) indicates that in counseling, clients transfer what they have learnt to subsequent problem situations rather than returning for further counseling each time a difficult situation arises. They also found that parents develop lifelong skills to cope with difficult situations that are encountered throughout the passage of life. However, depending on the quality of the counseling service, Howard (1996:46) points out that if parents are not properly and adequately counseled, they will continue to seek further counseling or resort to alternative means. He attributes poor counseling to unqualified and inexperienced 'counselors'. Where appropriate counseling is offered, parents are empowered to control their situations. In their research study Blackorby and Wagner (1996:393) found that, out of 8000 youngsters with disabilities aged 13 to 21, who were enrolled in special schools, only one third of the children were employed. Upon investigation, it was noted that most of those children who were employed had parents who had received guidance and counseling.

The situation in Zimbabwe is not an exception. During my 23 years of teaching and working with both parents and children with hearing impairments, I witnessed many children with hearing impairments who dropped out of school and others who could not get stable jobs. Those who were employed either got part-time jobs or were in positions that offer little opportunity for advancement. With the high unemployment rate in Zimbabwe, it has become extremely difficult for people with disabilities to get employment particularly if no career guidance and planning has been put in place. It would stand to reason that counseling plays an important role in helping parents to cope, plan and prepare their children for independent living. Another study by Frank and Sitlington (1997:49) in the United States of America from 1985 to 1986 with high school and college students, indicate that statistics of students with disabilities who drop out of high schools and colleges due to lack of parental support and counseling, continue to get worse. They reported that only 8% completed high school and earned a diploma, while the rest dropped out due to a number of reasons such as lack of parental support, lack of counseling and lack of proper career guidance. Intuitively I agree with Frank and Sitlington's findings as they relate well to my experiences in Zimbabwe working with students with hearing impairments at high school

and at vocational level. Students with disabilities need a lot of support from their immediate families, family organizations and educators if they are to make it in life. The role of parents has been reflected in a variety of parental functions, noted by (Roffey, 2001:33) as moral support, developing community school relations, future planning and parental guidance. It is of paramount importance for parents to access counseling services if they are to nurture, plan and support their children with hearing impairments. Counseling empowers parents (Roffey, 2001:46) to take an active role in the education of their children. If such parents do not access guidance and counseling services, there is likely to be a negative effect in the lives of children with disabilities (Gartner, *et al*., 1991:95).

In this study the guidance and counseling situation for parents of children with hearing impairments during the period preceding the economic collapse in Zimbabwe will be explored. A review of literature indicates a paucity of documented research on counseling for parents of children with hearing impairments in Zimbabwe. Lack of research work and empirical evidence within this sector of the educational system is regrettable, particularly in view of the additional potential vulnerability of the parent body. The recent expansion of guidance and counseling in the field of education, as with all other public services, has brought with it a necessity to use the increasingly stringent funding allocations to the best human and financial advantage. Unfortunately, counseling in special education is not a priority and has been overshadowed by counseling in the area of HIV and AIDS that presently tops the list. As pointed out by the World Health Organization and UNAIDS, (1987:78), Dilley, Pies, and Helquist (1993:92), the outbreak of the AIDS epidemic in Southern Africa, created a lot of fear, panic and uncertainty that upset medical research and presented a great challenge. Most institutions embarked on research to find the cure for AIDS and to counsel those already infected. For a considerable period of time, from 1986, the focus of research was and remains on AIDS (Barnett & Blackie, 1992:46). The same authors endorsed that in Southern Africa where resources are limited, AIDS had become the main attraction for researchers and government officials while research in special education continued to lag behind. According to World Health Organization and UNAIDS (1998:29) however, the support given to children with disabilities remains a major issue of concern worldwide.

The availability of parental guidance and counseling services for parents who have children with hearing impairments may impact on the long-term support given to a child with a hearing impairment within his or her own family. Any preferential access to counseling by one group over another must inevitably infringe equal-opportunity considerations and limits the realization of individual potential and aspirations. According to Nystul (1999:10) counseling helps an individual to come to terms with his/her problem by viewing it from a different perspective and finding solutions to it. It has been noted that parents take time to accept the idea of having a child with hearing impairments in the family and some of them live with these feelings for the rest of their lives (Howe, 1996:369). Such long lasting effects which are likely to cause negative attitudes towards the child with hearing impairments, have been attributed to lack of counseling from the time the child is born (Burn, 1992:579; McLeod, 1994:42; Luterman, 1991:64, and Thomas, 1989:87). It is important for educationists to identify the organizations involved in guiding and counseling parents of children with hearing impairments as well as the qualities of the services offered. In this context counseling refers to a service provided by those who have mastered the necessary skills to enable clients find solutions to their problems. Alongside counseling is appropriate guidance, which is intended to enable the parent to plan and prepare for his child's educational and future career needs.

Most studies carried out on counseling in special education (South of the Sahara), as pointed out by Kisanji (1990:37), McConkey and Templer (1986:78) and Ross (1988:102), pay more attention to teachers and children and less attention to parents. This study sought to explore the counseling situation of parents of children with hearing impairments in Zimbabwe during the period 1999 to 2000. The research study focused on:

* Parents of children with hearing impairments
* Counseling service organizations
* Individual counselors

There are five distinct but related aspects to this inquiry. The first seeks to find out whether parents of children with hearing impairments received counseling or not. The second will establish whether the same parents are aware of service organizations that offer counseling. The third finds out parents' perceptions about the counseling they received. The fourth will

establish the qualifications of the counselors. The fifth explores parents' views on how counseling services could be made more accessible.

1.2 RESEARCH QUESTION

In what ways did parents of children with hearing impairments in Zimbabwe access counseling services during the period 1999 to 2000?

1.3 OBJECTIVES OF THE RESEARCH

The objectives of the research were to:

- investigate whether parents who received or did not receive counseling were aware of organizations that offered guidance and counseling.
- find out parents' perceptions on whether or not counseling helped them to cope with their children.
- to establish the qualifications of the counselors who counseled parents of children with hearing impairments.
- explore recommendations by parents on ways in which counseling services could be made more accessible in Zimbabwe.

1.4 PURPOSE OF THE STUDY

The main purpose of the study is to explain the ways in which parents of children with hearing impairments accessed counseling services in Zimbabwe during the period 1999-2000.

This research will explain whether parents of children with disabilities received any counseling and from where the parents in question got counseling. The qualifications of the counselors involved will also be known. The study will also explore whether the parents who received counseling were able to cope with their children thereafter. Parents' perceptions of the counseling they received and their views on how the counseling services can be made more accessible will be explained.

1.5 THEORETICAL FRAMEWORK

I will use humanistic counseling to guide the conceptualization of the terms "guidance" and "counseling". According to Colledge (2002:75) humanistic counseling is largely associated with the work of Carl Rogers (1952), Fritz Perls (1969), Eric Berne (1966) and William Glasser (1968). Humanistic counseling focuses on counseling relationships, human values, beliefs, support networks, feelings of belonging and worthiness (Colledge, 2002:82). Emphasis is on the client's responsibility and capacity to overcome challenges of life through understanding of one's problems, insight, problem solving, making of informed choices and decisions, as well as change and growth. The study will also reflect on psychodynamic counseling which is the work of Sigmund Freud (1938) and Alfred Adler (1913) and behavioral counseling, which is largely associated with Krumboltz (1966). Central to psychodynamic and behavioral counseling in relation to this study is denial of parents, of having a child with hearing impairments in the family and the change of behavior by parents, necessary to accept and be able to cope with the situation. Humanistic counseling can be compared to the counseling situation in Zimbabwe, where parents of children with hearing impairments need to access helping relationship services where they can be accepted, understood in terms of their cultural values, beliefs and social networks and thus be empowered to change their behavior and attitudes in order to find solutions to their problems. Given the extensive and growing literature on the multicultural challenge to practitioners of counseling, Sue and Sue (1990:123) and Mearns and Thorne (2000:78), point out that the humanistic approach is multi-culturally and universally applicable since it focuses on individuals with their different needs, values, beliefs and support systems. In their study with Kenyan and Zimbabwean university students studying counseling at the university of Durham in the United Kingdom, McGuiness, *et al*. (2001:298) found that the humanistic approach could be applied in any culture without necessarily violating the norms, beliefs and values of the people involved.

In the conceptualization of "parents of children with hearing impairments" I will use the explanations by Moores (1987:187), Meadow (1980:214), Kauffman (1992:172), Hallahan and Kauffman (1994:314), Nolan and Tucker (1981:78) and Harry (1997:98) who have written and carried out a lot of work in the area of hearing impairment. The above authors agree that once a family has a child with hearing impairments, the parents' course of life

changes. Hardman, Drew, Egan and Wolf (1993:278) point out such parents need professional help in terms of diagnosis, treatment, counseling and relevant schools to approach. These parents go through shock, grief, guilt, anger and denial (Dale, 1984:59), and counseling is likely to be their hope in dealing with their emotions in order to come to terms with their situation. Kretschmer and Kretschmer (1978:106) pointed out that parents take time to accept the situation and the child. Once parents do accept the situation, it marks the starting point of progress in terms of early intervention, treatment, correction and planning for individual educational programmes. Therefore the importance of counseling to such parents cannot be underestimated.

The body of literature on children with hearing impairments is dominated by research on language development, reading and deafness, (Webster, 1986:52; Meadow, 1980:67 and Webster & Ellwood, 1987:152), integration, mainstreaming and inclusion, (Hegarty, 1987:183; Dale, 1984:37; Chorost, 1988:10; Chimedza, 1986:9 and Dean & Nettles, 1987:28), and the testing and screening of hearing impairments, (Tucker & Nolan, 1984:123; Green, 1986:17 and McCormick, 1988:245). I will use the concepts explained by Hardman, Drew, Egan and Wolf (1993:277), Hallahan and Kauffman (1994:309), Ogden, (1996:51) and Kauffman (1992:168) to define my understanding of children with hearing impairments. They assert that children with hearing impairments have a hearing loss ranging from slight to profound. Hearing loss affects children's educational development in many ways, academically, socially, and psychologically due to poor language development, concept formation and communication as a whole. This explanation is complemented by the work of Kirk, Gallagher and Anastasiow (1997:235), Cartwright, Cartwright and Ward (1994:134), Kretschmer and Kretschmer (1978:215) and Nolan and Tucker (1981:79).

1.6 DEFINITION OF KEY CONCEPTS

In the next section, I will provide synoptic definitions of some of the key concepts that will be used in this study. However, each of these concepts will be further elaborated upon in the discussion of the theoretical/conceptual framework for this study (see chapter 2).

1.6.1 COUNSELING

Rogers (1957:16) points out that the term 'Counseling' is used in a number of ways: it may be viewed as a kind of helping relationship, a repertoire of interventions or a psychological process, in terms of its goals or relationship to psychotherapy. Capuzzi and Gross (1999:1) define Counseling and Psychotherapy as terms that encompass a number of relationship modalities in which the counselor or therapist needs to be proficient in facilitating the process of counseling in order for the client to identify his/her problems, find possible solutions to them and come to terms with reality. Nystul (1999:2) defines counseling as a dynamic process associated with an emerging profession that involves a professionally trained counselor assisting a client with particular concerns. He goes on to say that in the process the counselor can use a variety of counseling strategies such as individual, group, or family counseling to assist the client to bring about beneficial changes. Some of these are facilitating behavior change, enhancing coping skills, promoting decision making, and improving relationships. More definitions of 'Counseling' are given in chapter 2. As pointed out by Nystul (1999:7), counseling is differentiated from psychotherapy in terms of clients, goals treatment and settings. It is part of the helping profession, which includes psychiatrists, psychologists, mental health counselors and school counselors. According to Locke (1990:47) 'psychotherapy' is the psychological treatment of mental disorders.

However, for the purposes of this study, the terms 'Counseling and Psychotherapy' are used interchangeably to mean the work carried out by professionals in government, non-governmental and private institutions as well as those who are in private practice as individuals or groups.

1.6.2 PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS

These are parents whose children have 'hearing impairments'. Under normal circumstances, as mentioned in section 1.4, these parents go through difficult times during which they experience embarrassment and feelings of inadequacy (Tucker & Nolan, 1984:109). Such parents may differ in many ways due to their family structures, socio-economic status and level of education. Parents of children with hearing impairments are in different categories depending on the nature and severity of the hearing loss and how

hearing loss has impacted on the family (McCormick, 1988:9). Some children are 'hard of hearing' which means they have residual hearing. Such children can hear if whoever is talking to them speaks loudly or shouts. As pointed out by Tucker and Nolan (1984:106) parents of children with such hearing loss may not have had such devastating experiences as those who have children with profound hearing loss. Children with profound hearing loss have very little or no residual hearing at all. They only benefit with the use of hearing aids. Such children are normally referred to as "deaf" (Webster, 1986:39). According to Tucker and Nolan (1984:114) parents of children with moderate hearing loss react to their children's impairments with mixed feelings, feeling bad and yet relieved that at least its not anything worse than hearing loss. These children benefit a lot from hearing aids and speech programmers. The different degrees of hearing loss impact differently on parents (Allen & Allen, 1979:83). In this study, all parents with their different situations are simply referred to as parents of children with hearing impairments.

1.6.3 HEARING IMPAIRMENTS

McCormick (1988:3) defines hearing impairment as either part or total loss of hearing. Webster (1990:17) takes hearing impairment to be a relatively permanent condition of partial or total loss of hearing that necessitates the use of hearing devices. Tucker and Nolan (1984:23) point out that hearing impairment is caused by conductive or sensori-neural hearing loss. Martin and Clark (1996:47) define hearing impairment as an inability to hear due to a number of causes, such as diseases, malformation of parts of the hearing system and accidents. Hearing impairments have varying degrees dependent upon the nature and severity of the hearing loss. However, in this study hearing impairment refers to the condition of 'not hearing' normally due to hearing loss, irrespective of the degree of this loss (Hunt & Marshall, 1994:338).

1.6.4 SERVICES IN SPECIAL EDUCATION

Services in Special Education refer to support given to parents and guardians of children with disabilities. Such services, as indicated by Lynas (1986:176), include counseling, guidance, and referrals to organizations such as Social Welfare who can offer financial assistance and referrals to other professionals such as psychologists, speech therapists and

doctors. Parents are also advised as to whether the child can be mainstreamed, put in a resource room or a special class. Mittler and Mittler (1982:13) point out that advice given to parents is vital since it helps them to plan for the future of their child. In Zimbabwe all Special Schools offer the above-mentioned services. Such services are therefore within the context of this study.

Hegarty and Moses (1988:41) assert that special schools cater for children with special needs. Specialized personnel run such schools. These include specialist teachers, physio, occupational and speech therapists, psychologists, counselors, audiologists, nurses and visiting doctors. In developed countries Hunt and Marshall (1994:86) suggest all the above-mentioned personnel have a part to play in facilitating the educational needs of children with special needs.

However, in this study special schools refer to schools that cater for children with hearing impairments. The main special schools that offer education to children with hearing impairments in Zimbabwe are, St. Mary's in Bulawayo, St. John's in Gweru, St. Paul's and St. Joseph's in Harare, St. James' in Masvingo along with units in Mutare. These are pseudonyms given to the schools to maintain their anonymity. These are the special schools and units referred to in this study. In these schools and units are specialist teachers, teacher-aids, nurses and social workers. However, there are also resource rooms and units in mainstream schools all over the country, which are not specifically referred to in this study.

1.6.5 SCHOOL COUNSELORS

School counselors, as pointed out by Tucker and Nolan (1984:122), are teachers qualified in both teaching and counseling. Some schools have counselors only qualified in counseling. Hunt and Marshall (1994:37) suggest that effective school counselors must have training in child counseling. In this study school counselors are specialist teachers, qualified in special education with or without additional courses in counseling. Not all teachers in special schools have specialist training. Some of the teachers who have been co-opted to teach in special schools are just qualified to teach in regular schools. Some of the special schools have social workers that visit parents and offer counseling services,

while others rely on visiting social workers. All the special schools in Zimbabwe have nurses who provide medical services to children with special needs. Physio, Occupational and Speech therapists are employed by the government and therefore attend to children in special schools by way of routine visits.

1.6.6 COUNSELING ORGANIZATIONS

Power (1986:125) defines Counseling Organizations as independent or government institutions that offer counseling services to individuals, groups of people and families who may require such a service. Ospow (1996:337) confirms that counseling organizations are institutions with qualified personnel who offer counseling to any individual, group or family members who may need to put their lives in order, strengthen or re-establish their relationships. Such organizations may do this on a voluntary basis or for financial gain. In this study counseling organizations are special schools, independent organizations, churches and counseling units within hospitals.

1.6.7 CHURCHES

According to Fukuyama (1997:241) a church is a Christian denomination or group of people who come together and worship. Wright (1978:83) takes a church as a body of Christians. In this study a church is taken as a group of people who worship together. Therefore churches refer to religious organizations that worship as a group and offer counseling services to either their members only or to their members and also members of the community. As pointed out by Power (1988:65) churches offer counseling as a moral service to their member families and individuals. In many churches there is a perception that if one of their members has a counseling need, it is the church's responsibility to make sure that the need is met and therefore the church works as a family to help their fellow family members (Fukuyama, 1997:237). This means that for the purposes of this study, the counseling that is provided to parents of children with hearing impairments by churches, will also be explored and explained.

1.6.8 SOCIAL SERVICES

Health workers, welfare officers and social workers provide health, welfare and social security services, respectively to the needy (Hegarty, 1987:98). Hart and Bond (1995:207) endorse that in most developed countries each of the following departments, health, education, welfare and security, has a body that caters for people in need particularly children who have been abandoned or are without parents. Social services in Zimbabwe are offered by government organizations that help orphans and the needy. These services are set up in major provinces of the country within which lie the towns where data were collected. Such services are no longer effective due to lack of resources. As pointed out by Chimedza (1996:10) the social services in Zimbabwe continue to collapse with more and more people getting impoverished and scrambling for basic needs within the ever-dwindling resources. While welfare officers and social workers recommend people who are in need, particularly parents of children with disabilities, the government cannot afford to help at all due to lack of resources. The government's coffers have run dry to such an extent that the health and social welfare departments no longer offer free practical assistance. All sectors that used to provide free service to the needy are on the verge of collapse together with the entire economy of the country.

1.7 PARADIGM FOR THE STUDY

I will use the positivist paradigm for this study. According to empiricist theory of knowledge, the primary source of all knowledge is to be found in experience and observation. In this study I used my experiences gathered during the time I worked with children with hearing impairments and their parents. To be objective I had to clear my mind of pre-set ideas and approach the object of study with a clinical or value-free attitude. In order to achieve this, all survey responses were given equal weight. The instrument for this study had a wide variety of options and open-ended questions that would not allow for pre-set ideas. Positivists are of the view that research should be structured, replicable, allow for experimental control, observation, measurement, quantification, generalization and objectivity. Positivism relies on multiple methods as a way of capturing as much of reality as possible. In the positivist version, it is contended that there is reality to be studied, captured and understood. Whereas post positivists argue that reality can never be

fully apprehended, but can only be approximated (Guba, 1990:22). Gergen (1985:266) explicitly points out that there is no objective social reality that can be known with absolute precision. Instead persons, groups and cultures construct the inter-subjective reality that they experience.

Creswell (1994:117) asserts that positivists employ tight, pre-selected and pre-structured conceptual frameworks, sampling frames, research questions, data collection instruments and methods, data reduction, coding and analytical techniques. Positivists claim that quantitative data is objective and empirical, whereas data collected through qualitative designs is often accused of being subjective, anecdotal, and impressionistic. Positivism emphasizes on internal and external validity, reliability and objectivity. Positivists take these disciplines as conventional benchmarks of 'rigor' in carrying out research. On the other hand those who are of the humanistic persuasion that are in favor of the qualitative designs argue that research in counseling, psychology and special education is better conducted through the qualitative designs. Herbert (1993:34) maintains that qualitative research focuses on experiences and feelings rather than facts, subjectivity rather than objectivity. Its concerns are precisely those excluded from scientific methods.

In this study I used both quantitative and qualitative methods as advocated for by Howard (2000:132) when he pointed out that within counseling research, there is need for increased 'methodological pluralism' thus the combination of qualitative and quantitative approaches within the same study. With the use of a reliable and valid instrument, a survey appears to be the most suitable method of collecting data for this study. This data collection method resonates easily with a positivist paradigm. However, the qualitative aspects of this study mean that the positivist paradigm will be utilized in a flexible, reflective way in this study.

1.8 ASSUMPTIONS OF THE STUDY

Based on the initial literature review in this study, I assume that:

- most parents received counseling from special schools.
- parents were not aware of different counseling organizations in Zimbabwe.
- counseling organizations do not have qualified counselors.

1.9 LIMITATIONS OF THE STUDY

The lack of research carried out in Zimbabwe on counseling the parents of children with disabilities, including parents of children with hearing impairments, as well as lack of relevant Zimbabwean literature, contributed to the limitations of the study. The use of questionnaires does not guarantee future reliability. Questionnaires do not give the participants the freedom to express their views on why they respond negatively or positively to certain items. Counseling is also a sensitive topic for research (Lea & Clarke, 1998:170), therefore what a client might say to a counselor is considered 'private and confidential' and yet research is for the public benefit. In this respect some parents might have held back some useful information during counseling. The actual counseling process is an area I have not tackled at all. This leaves the reader with the question of what type of counseling was offered to these parents? However, this aspect is not part of this particular study and therefore has not been included. In order to address these limitations, a review of literature has been widely spread to obtain counseling information from both developing and developed countries. Open-ended questionnaires were used to allow the participants to air their views and give suggestions.

1.10 METHODOLOGY OF THE RESEARCH STUDY

I used the cross-sectional survey method and interviews in conducting this study. The main focus of this study is on guidance and counseling of parents of children with hearing impairments by Special Schools, Hospitals, Churches and Counseling Organizations. Many authorities in the field of Special Education, Martin and Clark (1996:186), Medwid and Weston (1995:192) and Schwartz (1996:148) strongly emphasize the importance of counseling parents of children with hearing impairments, from the time the children are born up to the time the parents are able to cope with their children. Early guidance and counseling helps parents to accept, cope and plan for their children.

I found the survey method to be the most appropriate methodology to explore this theme, since the study covered the main cities in the country and involved a reasonably large but manageable sample. The method enabled me to identify attributes of a population from small groups of individuals as presented in Fowler (1988), Babbie (1990), Sudman and

Bradburn (1986) and Fink and Kosecoff (1985). This method also helped me to make estimated assertions about the nature of the total population from which the sample had been selected. It is also possible to generalize from a sample to a population, drawing inferences about some characteristics, attitudes, or behaviors of this population. In depth interviews were used to cross check questionnaire responses.

1.11 POPULATION

The population comprised of all parents that had children with hearing impairments who were attending primary or secondary education in special schools and units at the time of the study. Through the schools administration records the population was established to be exactly 900 families. All participants were hearing parents. It is important to point out that parents whose children were not attending school in special schools and units during the time of the study were not included in this population. For those included in the population, Masvingo had 194, Harare 197, Gweru 176, Bulawayo 170 and Mutare 163 parents (n = 900). Five major hospitals from the five cities, 30 churches, that claimed to have proper counseling services, six from each city, five special schools from the following towns: Bulawayo, Gweru, Masvingo, Mutare and Harare and three counseling agencies all from Harare, were also to be included.

1.12 SAMPLE (n = 300)

The sample comprised of families of children with hearing impairments in special schools and units. I used the sample size formula available in Babbie (1990:69) and Fowler (1988:124). Simple random sampling was used to obtain the required sample. Parents were grouped according to the provinces they come from, Masvingo, Harare, Gweru, Bulawayo and Mutare. A random number table was used to prepare cards that were used to randomly select the required sample. Cards were numbered and put in a box. Five boxes labeled with the names of the five towns were mounted in different places outside the administration block. Each box had cards with valid and invalid numbers and parents were asked to pick a card from the box labeled with the name of the town in their province. All parents who volunteered to take part in the study and picked valid numbers up to 300 were considered in the sample. Invalid numbers had the value of their first three digits bigger

than 300. If both a husband and wife took part in the study, they picked up one card and completed one questionnaire. The sampling procedure was conducted in five towns, at special schools for children with hearing impairments, where parents were gathered. The five special schools in the following cities, Bulawayo, Harare, Masvingo, Mutare and Gweru, for children with hearing impairments participated in the study. The sample also included five hospitals, one from each town. All five were included since parents of children with hearing impairments were referred to them for counseling and further help. The only three registered counseling agents, all in Harare, took part in the study. 15 churches, three from each city, were included in the study. These were also sampled through a simple random sampling procedure. Six cards were made for churches that claimed to run proper counseling sessions in each town and three were numbered. The three churches whose church members picked numbered cards were selected to take part in the study. This was done in all the five cities that took part in the study. Parents from rural and urban areas were also involved in this study.

1.13 VARIABLES

Independent variables in this research involve parents of children with hearing impairments, counselors in Special Schools, Hospitals, Churches and Counseling Organizations. Dependent variables involve the questionnaire data on parents of children with hearing impairments, whether or not they received counseling, and from where, as well as whether they were able to cope with their children after counseling.

1.14 PROCEDURE

Letters were written to heads of special schools asking for permission to conduct research at their schools during open days. All heads of special schools granted permission. Letters to heads of counseling agencies were also written and permission was granted to carry out the study. Permission was also sought from pastors of sampled churches. Information was given to all potential participants explaining what the study was all about. Those who volunteered to participate in the study granted informed consent.

A structured questionnaire with multiple choice and open-ended questions was administered to 300 families of children with hearing impairments. The participants of this study came from the five major provinces of Zimbabwe. 60 from Harare, 60 from Masvingo, 60 from Mutare, 60 from Gweru and 60 from Bulawayo. Participants were randomly selected as indicated in the sampling procedure. I organized with heads of special schools to meet parents on open days. Given the time to meet the parents, I explained to the parents the purpose of the study and what parents were expected to do in completing the questionnaires. Parents were given a chance to ask questions on what they did not understand and clarifications were given. I collected the questionnaires, as soon as they were completed. Informal interviews were conducted with individuals during the interval and the lunch break. A different structured questionnaire for service organizations was administered to personnel responsible for counseling at the following general hospitals, Harare, Gweru, Mpilo in Bulawayo, Masvingo and Mutare. The same questionnaire was administered to three registered counseling agencies, all in Harare. Members from 15 churches, three from each of the towns, Harare, Gweru, Masvingo, Bulawayo and Mutare also completed the questionnaire. See the map of Zimbabwe for the location of towns.

FIGURE 1.14.1 THE GEOGRAPHIC DEMARCATION OF THE ZIMBABWEAN TOWNS INCLUDED IN THE STUDY

1.15 INSTRUMENT

As stated, I used questionnaires and interviews to gather data. The questionnaire format made it possible for participants to freely express their views, opinions, and ideas on their experiences in writing. I considered that the anonymity of questionnaires would help elicit more satisfactory information. This claim appears to be corroborated by the assertion of Babbie (1990:198) when he stated that questionnaires are preferable since they avoid the embarrassment of direct questioning and so enhance the validity of the responses. It was intended that the questionnaires would be easy to understand and complete. The patterns of the questionnaires take the following forms:

- the fixed alternative format,
- the multiple choice format,
- the open-ended or self report format.

1.16 DESCRIPTION OF THE MEASUREMENT TECHNIQUES

Two questionnaires were constructed: one for parents of children with hearing impairments and the other for service organizations that offer counseling. A semi-structured interview questionnaire with 15 items was prepared and will be used to cross check parents questionnaire responses. It covers all aspects of the parents' questionnaire. The questionnaire for parents is divided into three parts. Section A has questions on personal information, whether the child was born deaf or not and who counseled the parents. Section B deals with questions that seek to establish:

- whether or not parents received counseling,
- if parents were aware of counseling organizations,
- if counseled parents were able to cope with their children.

Section C has open-ended questions that seek to establish:

- the difficulties parents faced in raising their child,
- the organizations that counseled them,

- whether counseling helped them or not,
- their views on how counseling could benefit them.

The questionnaire for parents has six items in section A 26 items in section B and six items in section C making a total of 38 items altogether. The questionnaire for service organizations has two sections. Section A has six items that seek to establish whether organizations have counseled parents of children with hearing impairments and how many, as well as the qualifications of counselors in these organizations. Section B has seven items that seek to find out whether the counseling given to parents of children with hearing impairments helps them cope with their children. The questionnaire has a total of 13 items.

Questionnaires used in this study can be found in Appendices D, H and K.

1.17 DEVELOPMENT OF THE INSTRUMENT

Despite a thorough survey of all relevant literature, no suitable instrument was found which could be used in this particular study. Some of the key references that were consulted include, Colledge (2002), Nystul (1999), Babbie (1990), Howard (1996, 2000), Satterly (1981), Shepherd (1984), Oppenheim (1966) and Likert (1967). So instruments were made specifically for this study with the help of Babbie (1990:140, 149)'s examples. Some of the items were developed with the use of ideas from Oppenheim (1966:196).

Focusing on the statement of the problem, the instrument for the study was developed from an original pool of 60 items. Section B had 40 items and section C had 20 items. These items were given to staff and students in the Special Education and Counseling Department at the University of Zimbabwe, who were already qualified teachers. The main focus was on:

- clarity of language,
- relevance of each question to the information required,
- equal numbers of positive and negative items,
- no repetition,
- items covering counseling from positive to negative extremes.

In order to have a balanced pool, items in Section B were grouped into three different categories as mentioned before:

- did the parents receive any counseling?
- who counseled them?
- what were their perceptions of the counseling they received?

With the help of experts in counseling at the Special Education Department at the University of Zimbabwe, the wording of certain questions was altered. Changes that were made by students and staff from the Special Education department reduced the items to 40. Section B had 30 items and section C had 10 items. However, before the questions were rewritten, a number of alterations regarding the order, wording, and what the instrument purported to measure were done with the help of professionals in the Special Education and Psychology departments. During the process the number of items dropped to 36. Section B had 28 items and section C had eight items. Satterly (1981:97) and Shepherd (1984:124)'s response sets were considered. Out of different response sets outlined by Shepherd (1984:124), two of them had relevance to this study. These were the positional set and the category set. With the positional set the respondent repeatedly chooses right hand and left hand responses. This was controlled by randomizing scoring direction. As for category set, the respondent repeatedly chooses one type of response. Balancing positive and negative item responses controls for this.

The final process, which was the pilot project, was aimed at the structure of the whole instrument, its relevance to the research questions, repetition of items, terms used in the wording and clarity of items. The pilot project was undertaken with 20 students who were studying for a Bachelor of Education Degree in Counseling, 20 students who were studying for a Bachelor of Education Degree in Special Education (Hearing Impairment) and 40 parents of children with hearing impairments who were not included in the main study. Some lived in villages, some in small towns and others in big cities.

I then carried out an item analysis to select the best statements for the instrument. This further reduced the number of items to the 38 that made up the final questionnaire. After making sure that the questions in section B had an equal balance of positive and negative

items, they were scattered and numbered 1-26 for the whole questionnaire. Section A had six items, section B had 26 items and section C had six items.

The questionnaire to Service Organizations (Hospitals, Churches, Special Schools for children with hearing impairments, and Counseling Organizations), was developed along the same lines, following the same stages. The final questionnaire had 16 items. Section A that deals with personal information had six items, section B that focused on parents of children with hearing impairments had six items and section C that dealt with counselors' perceptions of parents of children with hearing impairments had four open-ended questions.

1.18 SCORING OF THE SCALE

As emphasized by Dawes (1972:16), scoring must be consistent. Thus if it is decided that on a positive statement a high score of 5 is for Strongly Agree, then a score of 1 should be for Strongly Disagree. Negative statements must be scored with a 1 for Strongly Agree and a 5 for Strongly Disagree. Such reversals are important to take note of. On the Likert-type scale constructed for this particular study, responses were graded for each statement, and were expressed in terms of the following five categories, SA; A; U; D and SD. (SA) for Strongly Agree, (A) for Agree, (U) for Undecided, (D) for Disagree and (SD) for Strongly Disagree. The statements were either positive or negative. To score the scale, the responses were credited 5; 4; 3; 2 and 1 from the positive to the negative end or vice-versa. A "Strongly Agree" with a positive statement would receive a score of 5 as would "Strongly Disagree" with a negative statement. The sum of the item credits represented the individual's total score. Scoring keys were made in order to ease the scoring procedure.

1.19 VALIDITY AND RELIABILITY OF INSTRUMENT

I used my practical experiences of working with parents of and with children with hearing impairments for thirteen years as a teacher and counselor. I also reviewed literature from well-known researchers in the field of counseling: Rogers (1942; 1952; 1959), Howe (1989; 1993; 1996), Davis (1993), McLeod (1994; 1996; 1998; 2000), McCleod (1998) Howard (1996; 2000), Colledge (2002) and many others cited in the study.

Oppenheim (1996:23) maintained that reliability of Likert scales tends to be high, partly because of the greater range of answers permitted to participants. He goes on to say that a reliability coefficient of .85 is often achieved. By using the internal-consistency method of item selection, the scale approaches uni-dimensionality in many cases.

As mentioned above the instrument that will be used on parents was administered to 20 students studying for a Bachelor's Degree in Counseling, 20 students who were studying for a Bachelor's Degree in Special Education (Hearing Impairment) and 20 parents of children with hearing impairments from small towns and villages, who did not take part in the main study. It was interesting to note that 38 of the students and 19 parents who marked a positive item also marked its direct negative one. Only four cases marked undecided on item 26 on the questionnaire.

The instrument that was to be used on Service Organizations was administered to 20 students studying counseling and their lecturers in the Education and Psychology Departments. All 20 students and eight lecturers who marked a positive item also marked its direct negative one. This gave the instruments some credibility in reliability and validity. Adams (1966:47) pointed out that the problem with attitude and perception scales is that they deal with verbalized attitude or perceptions rather than actions. The use of such an instrument does not guarantee future validity. The participants may not complete the questionnaires accurately. Attitudes and perceptions are not easy to measure since the responses solemnly depend on the individual's complete honesty and the avoidance of the tendency to give socially acceptable answers (Cohen & Holliday, 1982:253). As a whole however, the instrument was theoretically sound and its content was satisfactory. Experienced staff and students in the Special Education Department, lecturing and studying counseling respectively, checked the content. Above all, an instrument devised for a specific purpose is more suitable than any of the published scales (Satterly, 1981:87). As evidenced in the review of literature, the instrument to be used in this study will represent a first step in exploring the field of counseling parents of children with disabilities in Zimbabwe.

1.20 METHODS OF DATA ANALYSIS

I will present analysis of quantitative data first, followed by qualitative data.

1.20.1 QUANTITATIVE DATA

The quantitative data for this study will be analyzed using descriptive statistics. Descriptive statistics (Kent, 2001: 188) provides a method of reducing large data matrices to manageable summaries to permit easy understanding and interpretation. In this study descriptive statistics and the associations among variables summarize single variables. Using descriptive statistics I will start with a set of data that is categorized, sorted out, recorded and then interpreted. I will then attempt to convey the essential characteristics of the data by arranging the data into a more interpretable form, forming frequency distributions and generating graphical displays as well as calculating numerical indexes such as frequencies and percentages. Variables are summarized in a data set, one at a time, and are also examined in how they interrelated (examining correlations). The key factor in descriptive statistics is how to communicate the essential characteristics of the data. One of the most basic ways to describe the data values of a variable is to construct a frequency distribution. A frequency distribution is a systematic arrangement of data values in which the data are rank ordered and the frequencies of all unique data values are shown (Babbie, 1998: 68). In this study descriptive statistics will be used to establish parents' perceptions of the counseling they received, whether or not they were able to cope with their children after counseling, who counseled them and also the qualifications of the people who counseled them.

1.20.2 QUALITATIVE DATA

Qualitative analysis is used to analyze parents and counselors' responses to open-ended questions where they give their views and suggestions. Analysis of qualitative data is often complex and time consuming. The process involves categorization, sorting, recording and interpretation. McLeod (2000:328) suggests that qualitative data provides for a description and interpretation of what things mean to people. This data will be used to supplement the

quantitative data and to gain a deeper understanding of the responses of the participants in the study.

1.21 ETHICAL CONSIDERATIONS IN RESEARCH

Informed consent was sought and it was explained to the parents that participation in the study was voluntary. According to Capuzzi and Gross (1997:94) ethics is the philosophical study of moral value of human conduct and of the rules and principles that ought to govern it, or a code of behavior considered correct especially that of a particular group, profession or individual. It also involves the moral fitness of a decision and course of action taken. McCleod (2000:327) points out the paradox between research and counseling and psychotherapy where the therapy is normally conducted in private between client and counselor. On the other hand research implies making results public. According to Heppner (1992:78) "ethics are expressions of our values and a guide to achieving them". This closely follows the work of Hill, Thompson and Williams (1993:115) on ethics in research where they point out that ethics are central to research. Since counseling is about privacy between the client and the counselor, whereas research is a public affair, ethics become the guiding principle that ensures the protection of the client as a participant in the research process (Woolfe & Dryden, 1998:57). Heppner goes on to point out that it is in the interest of ethics for the researcher to discuss his/her study limitations and problems experienced during data collection and how these problems impacted on the quality of conclusions drawn from the results.

In this study parents were verbally notified of the purpose of the study and of how the information they contributed was going to be used. They were also assured that they would be informed of the results of the study should they want to know. Anonymity and confidentiality of individual contributions were upheld. Schools, churches, counseling organizations and hospitals were also informed of confidentiality and anonymity.

Trust is an important cornerstone in the counseling relationship, and central to the development of the maintenance of trust is the principle of confidentiality. The obligation of counselors to maintain confidentiality in their relationships with their clients is not absolute (McLeod, 2000:3). However, counselors need to be aware of both the ethical and

legal guidelines that apply. In distinguishing between "confidentiality" and "privileged communication," as pointed out by Miles and Huberman (1994:10), in a research context, it is important to keep in mind that confidentiality is an ethical concept, whereas privileged communication is a legal concept. Confidentiality is defined as ethical responsibility and a professional duty, which demands that information learned in private interaction with a client not be revealed to others. Professional ethical standards mandate this behavior except when the counselor's commitment to uphold client confidences must be set aside due to special or compelling circumstances or legal mandate (Arthur & Swanson, 1993:3). For example when a client is a danger to self or others, the law places physical safety above considerations of confidentiality or the right of privacy. Protection of the person takes precedence and includes the duty to warn. In this research anonymity is maintained within these boundaries. In chapter 2, the accumulated experience of the literature on the topic of counseling will be examined.

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2 THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1 INTRODUCTION

I will start this chapter by exploring the concept of 'counseling', and then I will provide some historical background to the development of counseling, as we know it today. This will be followed with a discussion of different theories of counseling and the application of these theories in practice. Group counseling, as it applies to this study will be explored and the main distinctions between traditional and western counseling will be delineated. This will lead into the discussion of counseling for parents of children with hearing impairment at large and in Zimbabwe in particular. The various ways in which parents access counseling are also explained, based on our preceding knowledge base on this topic. I will also give a scrutiny and critique on how counseling organizations in Zimbabwe operate.

2.2 COUNSELING

Rogers (1942:231) says counseling is a process where counselors help clients to come to terms with their feelings and thoughts. In this way they gain insight into their problems in such a way that they view problems in a new or different light, which helps them to make rational, constructive decisions to change behavior and find solutions to their problems. Rogers (1942:234) also suggested that one view of human beings is that they are by nature irrational, un-socialized and destructive of themselves and others. He goes on to say that counseling reverses this and views the client as basically rational, socialized, forward moving and realistic. Burn (1992:17) takes counseling as a conversation where two groups of people take turns in exchanging views but with the counselor as more of a listener while the counselee does most of the talking. Fear and Wool (1996:89) say counseling is help given to a client to gain insight into his own thoughts, feelings and behavior in such a way that he can make rational constructive decisions to solve his problems. The British Association for Counseling (BAC) (1993) says that the overall aim of counseling is to provide an opportunity for the client to work towards living in a more satisfying and a

resourceful way. The association goes on to say that counseling may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crises, developing personal insight and knowledge, working through feelings of inner conflict or improving relationships with others. In this case the counselor's role is to facilitate the client's work in ways, which respect the client's values, personal resources and capacity for self-determination. Gibson and Mitchell (1993:164) assert that counseling is a one-to-one relationship that focuses on a person's growth, adjustment, problem solving and decision making needs. This process is initiated by establishing a state of psychological contact or relationship between the counselor and the counselee and progresses to the extent that certain conditions essential to the success of the counseling process prevail. Many counseling practitioners La Forge (1990:457), Lee (1991:6), Lucking and Mitchum (1990:270) and Nelson (1992:218) believe that such conditions include counselor genuineness, or congruence, respect for client and an emphatic understanding of the client's internal form of reference. These authorities go on to point out that effective counseling requires counselors with the highest level of training and professional skills as well as the necessary qualities. Counseling programs will suffer in effectiveness and credibility unless counselors exhibit understanding, warmth, humanness and positive attitudes towards humankind. Considering the above definitions and expressed views, it would stand to reason that the philosophy of counseling is based on individual respect, worthiness and the right to choices and direction. McLeod (1996:142) points out that the less defensive human beings are, the more positive and constructive they become. Since the various definitions of counseling differ little in actual meaning, one might assume that all counselors function similarly in like situations, interpret client information in the same manner, and agree on desired outcomes in specific situations. However, these counselors may differ as much as the approaches they employ.

2.3 HISTORICAL PERSPECTIVES

2.3.1 OUR HERITAGE FROM THE PAST

Counseling is a response to human needs. As pointed out by Howard (1996:38) and Corey (1986:126) it is possible that the earliest (although unconfirmed) occasion in which humans sought a counselor was when Adam reaped the consequences of his eating the apple in the

Garden of Eden. The two assert that there is no proof of this early beginning to counseling, but an abundance of evidence suggests that persons throughout the ages have sought the advice and counsel of others believed to posses superior knowledge, insights and/or experiences. Perhaps the first counterparts of the present day counselor were the chieftains and elders of the ancient tribal societies to whom youth turned or were often sent for advice and guidance (Webb, 2000:302). In these primitive societies the tribal members shared fundamental economic enterprises such as hunting, fishing and farming. No elaborate career guidance programs were developed or needed because occupational limitations were usually determined by two criteria, age and sex. However, as time went on people acquired skills necessary for societal needs and the occupational determinant of inheritance became common, with parents passing on social and trade skills to their children. Adler (1959:72) clearly shows that a study of primitive society can lead one to conclude that most of the conflicts existing in present day society regarding career decision-making were absent. This absence of a career dilemma should not be interpreted to mean that workers did not enjoy or take pride in choosing a career if they were given a chance. Even the earliest evidence of humankind's existence indicated that pride and pleasure resulted from developing and demonstrating one's skills in developing one's potential. In the early civilizations (Shumba, 1995:32), the grandparents, church priests, elders in the community and philosophers assumed the function of advising and counsel. It was generally believed that within the individual were forces that could be stimulated and guided towards goals beneficial to both the individual and the community. Of these early Greek 'counselors', Plato is one of the first to organize systematic theory (Adler, 1959: 67). Plato's interests were varied, and he examined the psychology of the individual in all of its ramifications: in moral issues, in terms of education, in relation to society, and theological perspective. He explored the things that make man virtuous among the following: inheritance, upbringing, education and effective teaching and also which techniques have been successfully used in persuading and influencing people in their decisions and beliefs. It is his way of questioning and methods that made the path for the counseling relationship. His methods were dramatic and his questioning had the dynamics of very real human interactions in which the characters are as important as the things they say. The second great counselor of the early civilizations was Aristotle (Adler, 1959: 68) who made many significant changes to the field of psychology, which was not well established at the time. He carried out a study of people interacting with their environment and with others, as well as how those

interactions created relationships. Hippocrates and other Greek physicians contributed towards the possible solutions in treating and setting the human mind at peace. As time progressed, in the Hebrew society individuality and the right of self-determination and direction were assumed. The early Christian societies emphasized, at least in theory if not always in practice, many of the humanistic ideals that later became basic to democratic societies, and in this century, the counseling fraternity.

Philosophers who were also educators such as Luis Vives (1492-1540) recognized the need to counsel and guide persons according to their attitudes and aptitudes. In the middle ages attempts at counseling increasingly came under the control of the church. The early Middle Ages had centered the duty of counseling, advising and directing youth in the parish priest. At the time, education was largely under the church jurisdiction. Efforts to place youth in appropriate vocations occurred during the rise of European Kingdoms and the subsequent expansion of the colonial empires (Whitely, 1984:185). Books aimed at helping youth choose an occupation began to appear in the 17th century (Zytowski, 1972:231). Tomasco Garzoni, an Italian, produced a book with almost 1000 pages which treated various professionals and occupations in great detail. His publication, 'The Universal Plaza of All the Professions of the World' had 24 Italian editions and was translated into Latin, German and Spanish. Zytowski (1972:275) labeled it the Occupational Outlook Handbook of the 16th and 17th century. In the early 17th century Powell published 'Tom of All Trades' in 1631 in London. Powell gave information on the professions and how to gain access to them, he even suggested sources of financial aid and the preferred schools in which to prepare (Zytowski, 1972:270). The most famous United States educator of the 19th century, Horace Mann, included in his 12th Annual Report the advantages of including guidance and counseling in American education, especially when it involved dealing with students with disabilities and their parents (Johansen, Collins & Johnson, 1975:328). The scientific study by Herbert Spencer (1820-1903) had important significance on human behavior and was of special significance to the eventual development of counseling. The 20th century was considered the ripe time for the development of counseling and other therapy programs that best help meet human needs.

2.3.2 VOCATIONAL COUNSELING

In 1908 Frank Parsons organized the Boston Vocational Bureau to provide vocational assistance to young people and to train teachers to serve as vocational counselors. The teacher's work was to assist students in choosing a vocation wisely and in making the transition from school to suitable work. In 1909, Parsons published 'Choosing a Vocation' and in this book he discussed the role of the counselor and techniques that may be employed in vocational counseling. He divided his book into three parts: personal investigation, industrial investigation and the organization and work. He considered three factors necessary for the wise choice of a vocation:

- A clear understanding of oneself, one's aptitude, abilities, interests, ambition, resources and limitations.
- Knowledge of the requirements and conditions of success, advantages and disadvantages, compensation, opportunities, and prospects in different lines of work.
- True reasoning on the relations of these two groups of facts.

It is expected of counselors who work with parents of children with hearing impairments that they should guide them in clear terms so that they are in a position to plan carefully the future of their children. As illustrated by Parsons, vocational counseling is a crucial transition stage for students who are leaving school and joining vocational training which will largely determine their lives. Berry (2000:52) endorsed Parsons' ideas with particular attention to children with disabilities whose future in the job market is not so bright.

Parsons conducted extensive interviews that covered language, memory, and quickness of thinking, enthusiasm, expression, manner and voice. Considering Parsons' standpoint, it would stand to reason that counselors should be thoroughly familiar with all relevant details concerning job opportunities and distribution of demand in industries and courses of study, before they embarked on vocational counseling. A detailed analysis should be made of industrial opportunities for men and women, including location and demand, work conditions and pay. Vocational counselors were trained for four to twelve months, but such

candidates were required to have sound judgment, character, and relevant occupational background and to be mature. The following were also required of them:

- A practical working knowledge of the fundamental principles and methods of modern psychology.

- An experience involving sufficient human contact to give him an intimate acquaintance with human nature in a considerable number of its different phases. He/She must understand the dominance motives, interests and ambitions that control the lives of men and be able to recognize the symptoms that indicate the presence or absence of important elements of character.

- An ability to deal with young people in a sympathetic, earnest, searching, candid, helpful and attractive way.

- A scientific method analysis and principles of investigation by which laws and causes are ascertained, facts are classified and correct conclusions drawn. Ability to recognize the essential facts and principles involved in each case, group them according to their true relations and draw the conclusion they justify.

In recognition of the work he has done, Parsons is generally referred to as the 'father of the guidance movement in American Education'. Other early leaders who contributed in the guidance and counseling movement were Davis, Reed, Weaver and Hill according to Rockwell and Rothney (1961:402).

The first quarter of the 20th century saw the introduction of intelligence tests to complement the efforts of guidance and counseling. In the 1920s counseling increased its popularity to such an extent that it became a topic of discussion and debate in educational circles. In the 1930s and 1940s the trait – factor approach to counseling became increasingly popular. In 1939 the often-labeled 'directive theory' received stimulus from Williamson when he wrote 'How to Counsel Students', A manual of Techniques for Clinical Counselors. During the period 1902-1987 Carl Rogers became a significant contributor to the new direction with an impact on counseling in both school and non-school settings. Rogers set forth a new

counseling theory in two significant books, Counseling and Psychotherapy (1942) and a refinement of his early position, Client-Centered Therapy (1951) in which he offered non directive counseling as an alternative to the older, more traditional methods. Another dimension to the techniques of counselors of the 1940s was group counseling to which Rogers was again a major contributor. Feingold (1947:548) called for a different approach towards guidance and counseling, targeting people who really needed it such as those who had family, relationship or social problems. In 1958 legislation was passed in the United States of America to enforce that personnel employed in guidance and counseling were well trained. As pointed out by Gibson, Mitchell and Basile (1993:206) there was a rapid growth in counseling and guidance such that the standard of training and qualifications were upgraded. In the 1960s, Gibert Wrenn contributed by writing 'The Counselor in a Changing World' where he examined the counselor's role in a society with changing ideas about human behavior. Wrenn (1962:109) noted the growing complexity of the counselor's task. He further suggested that counselors should not only understand clients in isolation, as it were but also understand the social structure of the community. They should exhibit awareness of today and of the future since clients continuously attempt to adjust to a rapidly changing world.

In African countries counseling used to be undertaken by relatives who guided the young in taking up occupations, marriages and relationships with other people in the community. Most of this counseling was in the form of giving advice and making suggestions towards the solving of clients' problems. It was assumed and expected that elders through their experiences of life had solutions to the problems of the young (Richards, 2000:148).

This brief review of some historic highlights in the development of guidance and counseling gives us an insight into the origin of counseling. In the light of these premises, we can suggest that a fundamental basis for counseling program development must be rooted in our understanding of the characteristics and needs of all our clientele, plus an understanding of the environment that shapes them. As the past illuminates the future, it is possible to predict that, regardless of the wonderful scientific and technological advances that await humankind, many persons will search out the counsel and advice of trained counselors. Looking at the current major social concerns in society, one sees the unprecedented opportunities for the counseling profession to serve that society.

Undoubtedly parents of children with hearing impairment face frustrations, anger, guilt and helplessness and it is clear that they will benefit from the support of and the helping relationship with a counselor. Therefore the need to explore the ways in which parents access counseling services during this challenging time seems eminent.

2.4 THEORIES OF COUNSELING

Theories of counseling were initially developed by Anglo European Counselors. Theoretical models for counseling have their origins in the values and beliefs of persons who, in turn, have converted these into a philosophy and a theoretical model for counseling (Brammer, Shostrom & Abrego, 1989:263). Theory helps to explain what happens in a counseling relationship and assists the counselor in predicting, evaluating, and improving results. It also provides a framework for making systematic observations about counseling and encourages the coherence and production of new ideas. Hence counseling theory can be viewed as a practical means of helping to make sense of the counselor's observations. A theory suggests guidelines that provide signs of success or failure of counseling activities. Essentially the theory becomes a working model to explain what clients may be like and what may be helpful to them, in this case parents of children with hearing impairments.

The end result is twofold, counselors reach a deeper and richer understanding of the nature of their client, and their theory is enriched in ways that make it useful in working with future clients. Perhaps most importantly for counselors, is the fact that a theory can directly influence the strategies they use with their clients. If a counselor strictly follows a theory without being flexible, it can affect the counseling procedures that are most applicable with a given client or with a particular presenting problem. Theories can be enhanced by multi-cultural/cultural awareness and considerations. In fact the counselor's failure to recognize the unique cultures of clients from diverse backgrounds is likely to handicap interaction with those clients (McWhirter & McWhirter, 1991:96). A study by Webb (2000:302) in New Zealand, where the white settlers did not recognize the cultural differences and what partnership with the Maori people meant, shows that counseling could not make any headway. It is therefore important for counselors to consider the extended background family support networks, coping styles and the cultural context of the client for integration into their theoretical orientation.

The ten commonly used theories, which are sometimes referred to as types of therapy are as follows:

- Psychoanalytic Theory
- Individual Psychology Theory
- Client-Centered Therapy
- Behavioral Theory
- Rational Emotive Therapy
- Reality Therapy
- Transactional Analysis
- Gestalt Therapy
- Integrated Theories and Eclectic Counseling.

It is not the writer's intention to discuss the details of these theories since it is not the aim of this study. Therefore only a brief explanation of how they were developed and how they work is given. This is done in view of the fact those counselors who may have counseled parents of children with hearing impairment could have used any and/or a combination of these.

2.4.1 PSYCHOANALYTIC THEORY

According to Corey (1986:148) Freud gave psychology a new look and new horizons. He called attention to psychodynamic factors that motivate behavior, focused on the role of the unconscious and developed most of the first therapeutic procedures for understanding and modifying the structure of one's basic character. He stimulated a great deal of controversy, exploration, and further development of personality theory and laid the foundation on which later psychodynamic systems rest. His theory is a benchmark against which many other theories are measured. The psychoanalytic theory views the structure of personality as separated into three major systems, the id, the ego and superego. Hereditary factors are represented by the id, which functions in the inner world of one's personality and is largely unconscious. It is usually viewed as the original system personality that is inherent and present at birth. It is believed that the id is ruled by the 'pleasure principle', and thus it seeks to avoid tension and pain, seeking instead gratification and pleasure. Corey

(1986:304) describes it as 'the spoiled brat of personality'. The ego, which is only viewed as the only rational element of personality, has contact with the world of reality, controls consciousness and provides realistic and logical thinking and planning. If counseling could bring parents of children with hearing impairment to this realization, then they would apply logic and reason to solve their problems and to plan ahead for their children.

The superego represents the conscience of the mind and operates on the principle of moral realism. It represents the moral code of the person, usually based on one's perceptions of the moralities and values of society. As a result of its role, the superego provides rewards such as pride and self-love, and punishments, such as feelings of guilt or inferiority, to its owner. When a child with hearing impairments is born in a family, parents lose pride, self-love, feel punished by the creator and suffer feelings of guilt and inferiority (Moores, 1987:182, Quigley & Kretschmer, 1982:78, Allen & Allen, 1979:34 and Nolan & Tucker, 1981:23).

As a result of this triangle, (id, the ego and superego) the Psychoanalytic Theory views tension, conflict and anxiety as inevitable in humans and the major goal of counseling is seeking to direct behavior towards reduction of this tension. Since personality conflict is present in all people, nearly everyone can benefit from professional counseling. The Psychoanalytic approach requires insight that relies on openness and self-disclosure. Multi-culturally oriented counselors would be aware that these traits might sometimes be seen as signs of immaturity.

The goals of psychoanalytic theory, according to Wadsworth (1990), aim to provide a climate that helps clients re-experience early family relationships and uncover buried feelings associated with past events that carry over into current behavior. Also, to facilitate insight into the origins of faulty psychological development as well as to stimulate a corrective emotional experience.

2.4.2 THE INDIVIDUAL PSYCHOLOGY THEORY

This theory is often called Adlerian therapy. It sees the person as a unity, an indivisible whole, and it focuses on the individuality of persons. At the core of this theory is the belief

that there exists within a human being an innate drive to overcome inferiorities and develop one's potential and self-actualization. The theory hinges on social interest, which is central to the growth and actualization of the individual and the good of the society. Because social interest is viewed as an innate aptitude, it must be consciously developed over time (Manaster & Corsini, 1982:291). Social interest, also referred to as one's ability to give and take, is accomplished through the life tasks in which all human beings participate. These tasks include work, friendship, and love (Sweeney, 1989:49). When a person comes for therapy, it is in one or more of these areas that he/she is experiencing incongruence or discomfort. The counseling process then is seen as a means by which the therapist and counselee work together to help the counselee develop awareness as well as healthier attitudes and behavior so as to function fully in society. The Adlerian counseling process involves four stages:

- establishing relationship
- diagnosis
- insight/ interpretation
- reorientation

In the first session the counselor establishes a relationship with the client through an interview in which the client is helped to feel comfortable, accepted, respected and cared about. The client is then encouraged to explain what helped her/him to determine the need for counseling. The counseling process is explained and discussed with the client. The client is then asked to discuss how things are going in each of the life task areas. The diagnostic stage involves the 'life-style interview'. The interpretation phase is the time during which the counselor and client develop insight from the lifestyle interview into the client's problems. The orientation stage is the most critical. The therapist helps the client to move from intellectual insight to reality. With the counselor's support, encouragement and direction, the counselee changes from unhealthy ways of thinking, feeling and behaving to ways more satisfying to him/her and society. Wallace (1986:157) believes that this theory is most effective in marriage, child and family counseling and less effective in one to one therapy. The Adlerian theory creates a therapeutic relationship that encourages participants to explore their basic life assumptions and to achieve a broader understanding of lifestyles. It helps clients recognize their strengths and their power to change and also

encourages them to accept full responsibility for their chosen lifestyle as well as for any changes they want to make.

2.4.3 CLIENT-CENTERED THERAPY

Client-centered (now frequently referred to as 'person centered') counseling is another historically significant and influential theory. This theory was originally developed by Carl Rogers as a reaction against what he considered the basic limitations of psychoanalysis. Due to his major contributions, the approach is referred to as 'Rogerian Counseling'. The approach focuses on the client's responsibility and capacity to discover ways to more fully encounter reality. Therapists concern themselves mainly with the client's perception of self and of the world. Rogers points out that the therapist should be genuine, non-possessive, warm, accepting and have empathy. These aspects constitute the necessary and sufficient conditions for therapeutic effectiveness. The therapist's function is to be immediately present and accessible to the client and to focus on the here and now experience created by their relationship. The client-centered model is optimistic and positive in its view of humankind. Clients are viewed as being good, possessing the capability of self-understanding, insight, problem solving and decision-making, as well as change and growth. The counselor facilitates the counselee's self-understanding, clarifies and reflects back to the client the expressed feelings and attitudes of the client. The aim is to help the client bring about change in himself/herself.

The theory provides a safe climate in which members can explore the full range of their feelings. It helps members to become increasingly open to new experiences and develop confidence in themselves and their own judgments. Clients are encouraged to live in the present, develop openness, honesty, and spontaneity. The theory makes it possible for clients to encounter others in the here and now and to use the group as a place to overcome feelings of alienation.

2.4.4 BEHAVIORAL THEORY

Behavioral theory and conditioning can be traced directly from Pavlov's 19th century discoveries, and from further research carried out by Watson, Thorndike and Skinner who

developed the theory to its present popularity. The behaviorist views behavior as a set of learned responses to events, experiences or stimuli in a person's life history. For the behaviorist counseling involves the systematic use of a variety of procedures that are intended specifically to change behavior in terms of mutually established goals between a client and a counselor. Behaviorists also believe that stating the goals of counseling in terms of behavior that is observable is more useful than stating the goals that are more broadly defined, such as self-understanding or acceptance of self. Therefore counseling outcomes must be identifiable in terms of overt behavior changes. Counselors utilizing behavioral theory assume that the client's behavior is the result of conditioning. The counselor further assumes that each individual behaves in a predictable way to any given situation or stimulus, depending on what has been learnt (Ivey, *et al*., 1993:264). Gilliland, James and Bowman (1989:173) point out that modern counseling involves the client in the analysis, planning, process and evaluation of his/her behavior management program. The counselor is expected to have training and experience in human behavior modification and also to serve as consultant, teacher, adviser, reinforcer and facilitator. The theory helps group members eliminate maladaptive behaviors and learn new more effective behavioral patterns.

2.4.5 RATIONAL EMOTIVE THERAPY (RET)

The Rational Emotive theory was developed by Albert Ellis. This theory is based on the assumption that people have the capacity to act in either a rational or irrational manner. Rational behavior is viewed as effective and potentially productive whereas irrational behavior results in unhappiness and non-productivity. Ellis assumes that many types of emotional problems result from irrational patterns of thinking. This irrational pattern may begin early in life and be reinforced by significant events in the individual's life as well as by the general culture and environment. The RET approach to counseling declares that most people in our society have developed many irrational ways of thinking and that these irrational thoughts lead to irrational or inappropriate behavior. Therefore counseling is designed to help people recognize and change these irrational beliefs into more rational ones. The accomplishment of this goal requires an active, confrontive, and authoritative counselor who has the capacity to utilize the whole variety of techniques (Hansen, *et al*., 1986:482). The RET therapist does not believe that a personal relationship between the

client and counselor is a prerequisite to successful counseling. In fact it is believed that the therapist may frequently challenge and provoke the irrational beliefs of the client. Rational Emotional Therapy can be applied to individual and group therapy, marathon encounter groups, marriage counseling and family therapy.

The goal of this theory is to teach group members that they are responsible for their own disturbances and help them identify and abandon the process of self-indoctrination by which they keep their disturbances alive. It also aims at eliminating the clients' irrational and self-defeating outlook on life and to replace it with a more tolerant and rational one.

2.4.6 REALITY THERAPY

Reality therapy was largely developed by William Glasser (Adler, 1959: 96). Glasser's approach places confidence in the counselee's ability to deal with his or her actions through a realistic or rational process. From a reality therapy standpoint, counseling is simply a special kind of teaching or training that attempts to teach an individual what he should have learnt during normal growth in a short period of his life. However, it appears that Glasser's theory leaves a lot to be desired. If counseling were learnt through a natural growth process, a mechanism would have been built within humans to be able to think logically and resolve their problems during difficult times. This is not normally the case. Nystul (1999:319) points out that when a client is in a helpless state, he/she needs someone who can listen with full attention, allow the client to go through his/her emotions, acknowledge the client's problems, create a positive environment for the client to think logically and rationally and allow the client time to find solutions to his/her problems. Glasser (1984:61) holds that reality therapy is applicable to individuals with any sort of psychological problem, from mild upset to complete psychotic withdrawal. It works well with behavior and drug-and alcohol–related problems. It has been applied widely in schools, institutions, hospitals, families and business management. It focuses on the present and upon getting people to understand that essentially they choose all their actions in an attempt to fulfill basic needs. When they are unable to do this, they suffer or cause others to suffer. The therapist's task is to lead them towards the better or more responsible choices that are almost always available. Reality therapy does not emphasize the client's past history but emphasizes a major psychological need that is present throughout life, the need for identity.

It includes a need for feeling worthy, a sense of uniqueness as well as separateness and distinctiveness. The need for identity is considered to be universal among individuals in all cultures (Corey, 1982:89). Reality therapy is based on the assumption that a client will assume personal responsibility for his/her well-being. The acceptance of this responsibility, in a sense, helps a person achieve autonomy or a state of maturity by which one relies on one's own internal support. Whereas many of the counseling theories suggest that the counselor should function in a noncommittal way. Reality therapists praise clients when they act responsibly and indicate disapproval when they do not.

The theory helps members toward learning realistic and responsible behavior developing a 'success identity'. Group members are assisted in making value judgments about their behaviors and in deciding on a plan of action for change.

2.4.7 TRANSACTIONAL ANALYSIS (TA)

Transactional analysis is a humanistic approach that assumes a person has the potential to choose and direct or reshape his/her own destiny. Eric Berne developed and popularized this theory in the 1960s. It is designed to help the client renew and evaluate early decisions and to make new, more appropriate choices. Transactional analysis stresses understanding the transactions between people as a way of understanding the different personalities that comprise each of us. The theory places a great deal of emphasis on the ego. The client is assisted in gaining social control of her/his life by learning to use all ego states where appropriate. The ultimate goal of the counselor is to help clients change from inappropriate life positions and behaviors to new and more productive behaviors. An essential technique in TA counseling is the contract that precedes each counseling step. The contract between counselor and counselee is by mutual agreement, in terms of time, when to stop and whether to record the session or not. Once signed the contract becomes binding and legal. The theory can be used with individuals but is more suitable for persons within a group setting. Transactional analysis counselors feel that the group setting facilitates the process of providing feedback to persons about the kind of transactions in which they engage. The counseling group then represents a microcosm of the real world. In this setting the individual group members are able to work on their own objectives, and the counselor acts as a group leader.

The theory assists clients in becoming free of scripts and games in their interactions and also challenges them to reexamine early decisions as well as make new ones based on awareness.

2.4.8 GESTALT COUNSELING

The Gestalt therapy was developed by Fredrick Perls and is a humanistic approach in which the therapist assists the client towards self-integration (George & Cristiani, 1995:127). This helps him/her to learn to utilize his/her energy in appropriate ways, to grow, develop and actualize. The primary focus of this approach is the present, the 'here and now'. The implication being that the past is gone and the future have yet to arrive. Therefore, only the present is important. Gestalt counseling has as its major objective the integration of the person or "getting it all together". The treatment is finished when the client has achieved the basic requirements. These are: a change in outlook, a technique of adequate self-expression and assimilation, and the ability to extend awareness to the verbal level. In this state a client has reached integration, which facilitates its own development. Thereafter, progress can be left to the counselee. In order to achieve this togetherness the counselor seeks to increase the client's awareness by providing an atmosphere conducive to the discovery of the client's needs or what the client has lost because of environmental demands. The counselor can create the atmosphere in which the client can experience the necessary discovery and growth. From these assumptions we can conclude that the Gestalt therapist has a positive view of the individual's capacity self-direction. Furthermore the client is encouraged to utilize his/her capacity and to take responsibility for his own life. The main goal is to enable members to pay close attention to their moment-to-moment experiences, so they recognize and integrate disowned aspects of themselves.

2.4.9 INTEGRATED THEORY

This theory takes into account a number of aspects from other theories. Ivey, *et al*. (1987:59) note that an integrated knowledge of skills, theory, and practice is essential for culturally intentional counseling and therapy. The culturally intentional therapist knows how to construct a creative decision-making interview and can use micro-skills to attend to and to influence clients in a predicted direction. Important in this process are individual

and cultural empathy, client observation skills, assessment of person and environment, and the application of positive techniques of growth and change. Cultural values are central to counseling. Richards (2000:149), points out that culture demands, and society enforces, adherence.

The theory provides organizing principles for counseling and therapy, hence the culturally intentional counselor has knowledge of alternative theoretical approaches and treatment modalities. Practice is the integration of skills and theory. Therefore, the culturally intentional counselor or therapist is competent in skills and theory, and is able to apply them to research and practice for client benefit.

The main aim of this theory is to provide conditions that maximize self-awareness and reduce blocks to growth. It helps clients discover and use freedom of choice and assume responsibility for their own choices.

2.4.10 ECLECTIC COUNSELING

The eclectic approach to counseling is one of long standing traditional, and one of equally long-standing controversy. It originally provided a safe middle-of-the-road theory, for counselors who neither desired nor felt capable of functioning as purely directive or non-directive counselors. This approach allows the counselor to construct his/her own theory by drawing on established theories. It has often been suggested that an eclectic counselor can choose the best of all counseling worlds. Others contend that the theory encourages counselors to become theoretical 'jacks of all trades'. Left to the counselor's decision, the approach can develop deficiencies and be open to abuse. The counselor is likely to be influenced by his/her values, views, and beliefs. This can only be avoided by self-study of client-counselor relationships as well as personal therapeutic experiences resulting in increased self-understanding. As observed by Wallace (1986:95), counselors cannot shelve their responsibility for constructing a personal theory of counseling by turning it into an intellectual game or academic exercise. Their obligation to the clients is far too real for that. I strongly feel that this approach should only be used by highly skilled counselors who are capable of weaving a number of approaches into their counseling practice.

Developing an eclectic approach to therapy requires an enterprising juxtaposition and a genuine confrontation of one's work with the values, thoughts, and research of others. While independence of observation and thought is essential to an eclectic stance, so are understanding and respect for other theorists. Before counselors in search of a personal theory of counseling and psychotherapy can choose the best, they must become fully aware of all that are available. The eclectic approach then is no shortcut to theory formulation. Indeed, when properly traveled, it is one of the most difficult paths to follow.

All the above-mentioned theories are interwoven to such an extent that one cannot compartmentalize one from the others during the process of counseling. They all aim at one goal, that of creating a conducive environment for the client to find solutions to his problems. As pointed out by Colledge (2000:264), that counseling theories work like a web where one thread pulls the other. However, some differences have been noted, where some theories give the counselor authority and power whilst others try and empower the clients. According to my experiences with parents of children with hearing impairments, most theories work so long as they are applied appropriately. The writer applied the Client-Centered Therapy and the Individual Psychology Theory and found them helpful. The theories seem to have worked because they allowed parents an opportunity to review their situations and workout solutions to their problems. Reality Therapy and Behavioral Theory may produce short lived results in that clients, especially parents of children with hearing impairments, may be dependent on the counselor for solutions since there is teaching and conditioning.

2.5 APPLICATION OF THEORIES IN COUNSELING

Theories of counseling are usually insight or action-oriented because families of children with hearing impairments in general do not require a highly psychiatric oriented approach. Rather they appreciate the counselor's general style of social behavior and the type of relationship he develops with his client. All counseling theories are based on the 'therapeutic alliance' (Van Hecke, 1994:523). Person-centered therapy known as Non-directive Psychotherapy, originally advanced by Rogers (1959:28), holds the view that at some level of consciousness, patients or clients know what is best for them. Whereas behavioral counseling, unlike the Rogerian approach, is a directive method. Parents are

advised that they derive reward by making environmental changes, which will produce positive behavioral changes. The client-centered approach views the client as one who is rational, socialized and realistic. Rogers (1942:125) points out that the responsibility for the counseling process rests with the client whilst the counselor facilitates rather than directs his /her efforts at insight. The efforts and decisions regarding change of behavior after counseling also remain the responsibility of the client. On the other hand, the action theorists are much more problem-oriented and would try to find the problem then, using various techniques, try to change behavior in the hope that the problem would be alleviated. The counselor is expected to observe that the process from maladjustment to adjustment is a self-regulatory one. The basic philosophy of the counselor is represented by an attitude of respect for the client, for his capacity and right to self-direction and for the worth and significance of each individual. There is the basic assumption in the theory that individuals are capable of changing by themselves in ways they choose without the direction or manipulation of the therapist. The counselor is expected to accept the client as an individual with all his/her conflicts and inconsistencies, bad and good points, being a consistent person with no inherent contradictions between what he/she is and what he/she says. The client must see the counselor as accepting and understanding. In this case the counselor-client relationship will be seen by the client as safe, secure, free from threat and supporting but not supportive.

2.6 GROUPS AND COUNSELING

Parents can be counseled as a group, as a family and as individuals. It is important to understand that there are advantages and disadvantages with each and every approach.

Before getting into the details of group counseling, it is important to understand what ‘group’ means. To clarify the various labels in group counseling and guidance, including a definition of group, I will use the work of Capuzzi and Gross (1997:166). They define “group” as ‘a number of individuals bound together by a community of interest, purpose or function’. However, within and across the professional disciplines engaged in the study and practice of groups, there are wide variations in definition. To narrow the definition of group for discussion in this study, it should be noted that counseling groups are characterized by interaction. They are functional or goal-oriented groups. Counselors view

various group activities as occurring at three levels: the guidance level, the counseling level and the therapy level.

It is almost impossible to go it alone in today's group-oriented, group-dominated and group processed society. In fact today, to be well adjusted in a given society, usually means that the individual has mastered the society's norms of social interaction and of functioning appropriately in groups. The following observations were drawn after a study of the influence and dependence on groups of the individual's functioning in today's society.

Humans are group oriented. People are meant to complement, assist, and enjoy each other. Groups are natural environments for these processes to occur. Humans seek to meet most of their basic and personal social needs through groups, including the need to know and grow mentally. Groups are a most natural and expeditious way to learn. Consequently groups are influential in how a person grows, learns, and develops behavioral patterns and adjustment techniques. Apart from understanding the organization, influences and dynamics of groups, group counseling may be more effective for some people and individuals than individual counseling.

2.6.1 GROUP COUNSELING

More than 100 years ago the psychologist William James (1890) wrote 'We are not only gregarious animals liking to be in sight of our fellows, but we have an innate propensity to get ourselves noticed, and noticed favorably, by our kind. The most dreadful punishment would be that of being turned loose in society and remaining absolutely unnoticed by all members within one's environment. The importance of human relationships is meeting basic needs and influencing personal development and adjustment of members of the society. Most relationships are established and maintained in a group setting. For many, daily adjustment problems and developmental needs also have their origins in groups. Since most frequent and common human relationship experiences occur in groups, groups also hold the potential to provide positive developmental and adjustment experiences for many people.

Group counseling is the routine adjustment to developmental experiences provided in a group setting. It focuses on assisting counselors to cope with their day-to-day adjustment and development concerns. Examples might focus on behavior modification, developing personal relationship skills, concerns of human sexuality, values and attitudes, or career decision-making. Gazda (1989:304) suggests that group counseling can be growth engendering insofar as it provides participation incentives and motivation to make changes that are in the clients' best interest. On the other hand, it is remedial for those persons who have entered into a spiral of self-defeating behavior but who are capable of reversing the spiral with counseling intervention.

2.6.2 GROUP GUIDANCE

Group guidance refers to group activities that focus on providing information or experiences through a planned and/organized group activity (Ivey & Ivey, 1993: 45). These include orientation groups, career exploration groups and classroom guidance. Group guidance is also organized to prevent the development of problems. The content could include educational, vocational, personal or social information, with the goal of providing students with accurate information that will help them make more appropriate plans and life decisions.

2.6.3 GROUP THERAPY

Group therapy provides intense experiences for people with serious adjustment, emotional and developmental needs. Therapy groups are usually distinguished from counseling groups by both the length of time and the experience for those involved. Counselors devote most of their time to help clients learn to recognize and cope with self-defeating behavior and to master developmental tasks (Capuzzi & Gross, 1997:168). In group therapy parents come together, help one another, engage in interaction, share experiences and ideas. The counselor acts as a facilitator.

2.6.4 T-GROUPS

T-Groups are derivatives of training groups. They present the application of laboratory training methods to group work. T-Groups represent an effort to create a society in

miniature in which an environment is created for learning. These are relatively unstructured groups in which the participants become responsible for what they learn and how they learn it. This learning experience frequently includes learning about one's own behavior in groups. A basic assumption appropriate to T-groups is that learning is more effective when the individual establishes authentic relationships with others.

2.6.5 SENSITIVITY GROUPS

A sensitivity group is a form of T-group that focuses on personal and interpersonal issues and on the personal growth of the individual. Sensitivity groups emphasize on self-insight, which means that the central focus is not the group and its progress but rather the individual member.

2.6.6 ENCOUNTER GROUPS

Encounter groups are also in the T-group family, but are more therapy oriented. Rogers (1967:183) defines an encounter group as a group that stresses personal growth through the development and improvement of interpersonal relationships via an experiential group process. Such groups seek to release the potential of the participant in an intensive group. With much freedom and little structure, the individual will gradually feel safe enough to drop some of his defenses and facades, he will relate more directly on the feeling basis with other members of the group, he will change in his personal attitudes and behavior and he will subsequently relate more effectively to others in his everyday life situation. Extended encounter groups are often referred to as marathon groups. The marathon encounter group uses an extended block of time in which massed experience and accompanying fatigue are used to break through the participants' defenses. While encounter groups offer great potential for the group members' increased self-awareness and sensitivity to others, such groups can also create high levels of anxiety and frustration. Therefore if encounter groups are to have maximum potential and minimal risk, highly skilled and experienced counselor leaders must conduct them. Parents of children with hearing impairments tend to be defensive of their situations at the expense of facing reality and solving their problems (Martin & Clark, 1996:184). In the light of Martin and Clark's assertions, group counseling could help break such parents' defenses.

2.6.7 MINI-GROUPS

While two or more people can constitute a group, the term mini-group has become increasingly popular to denote a counseling group that is smaller than usual. A mini-group usually consists of one counselor and a maximum of four clients. Due to the smaller number of participants, the potential exists for certain advantages resulting from the more frequent and direct interaction of its members. Mercurio and Weiner (1975:68) indicate that because of the increased dynamics that occur in a group of limited size, members of the mini-group are less able to withdraw or hide, and interaction seems to be more complete and responses fuller. Mini groups may either function as the singular treatment focus or be used in conjunction with individual counseling.

2.6.8 GROUP PROCESS AND GROUP DYNAMICS

Two terms commonly used interchangeably in describing group activities are process and dynamics, (Allen & Sawyer 1984:28). However, the terms have different meanings when used to describe group-counseling activities. Group process is the continuous ongoing movement towards achievement of its goals, representing the flow of the group from its starting point to its termination. It is a means of describing or identifying the stages through which the group passes. Group dynamics, on the other hand, refers to social forces and interplay operative within the group at any given time. It describes the interaction of a group, which may include a focus on the impact of leadership group roles and membership participation in groups. It is a means of analyzing the interaction between and among the individuals within a group. Group dynamics is also used on occasion to refer to certain group techniques such as role-playing, decision-making, 'rap' sessions, and observation.

2.6.9 IN-GROUP AND OUT-GROUP

These are groups organized or overseen by counselors, but are important in understanding influences on client behaviors. These groups can be based on almost any criteria, such as socio-economic status, athletic or artistic accomplishments in a particular area of ability, racial-cultural origins and so forth. In-groups are characterized by association largely limited by peers of like characteristics, while out-groups consist of those excluded from in-

groups. Such members are non-participants in athletics, drama, and/or have not been invited by participants to become involved in such social clubs. In many counseling situations, it is important for counselors to understand how clients see themselves and others in terms of 'in' or 'out'. Parents of children with hearing impairments normally group themselves according to how they perceive their problems. Hegarty (1986:104) asserts that parents who have similar problems tend to group and share their experiences.

2.6.10 SOCIAL NETWORKS

These are not groups in a formal sense: however, social networks result from the choices that individuals make in becoming members of various groups. Counselors may be concerned with how these choices are made and their impact on individuals. Engaging in social network analyses helps to determine how the interconnectedness of certain individuals in a society can produce interaction patterns influencing others both within and without the network. Social networks are important. Dale (1984:85) states that parents of children with hearing impairments need continuous support during and after counseling until they can cope on their own. This support can be offered by professional counselors, members of the extended family, relatives and/or friends.

2.6.11 TRADITIONAL *VERSUS* WESTERN COUNSELING

Counseling has always been practiced and appears to have achieved some if not most of its intended purposes. Most of the African countries have been using the traditional approach and most of the European countries have been using the western approach. The two approaches to counseling differed. What is interesting is that the approaches work towards the same goal. A brief explanation of each approach is given and the advantages as well as disadvantages are highlighted. The traditional counseling is based on that in Zimbabwe.

2.6.12 TRADITIONAL COUNSELING

Counseling has historically been an integral part of the traditional African culture, Zimbabwe being one of the countries in which it was practiced. Its importance in the traditional setting is reflected in the way it was institutionalized, with specific roles of

counseling being allocated to particular people within families. These family members include the aunts, uncles, grandparents, and elders in the community, traditional healers, church-elders and ministers. In the Zimbabwean indigenous culture, the family and community interact as collective structures. The individual exists not as an individual, but as part of a family and community system (Shumba, 1995:17). Self-affirmation and feelings of connection with the world are gained from family and community relationships with which the individual participates. Because of this dynamic situation, there is a multi-generational and inter-community support system that is interdependent. Zimbabwean society is dominated by the tenets of traditional culture, with approximately 80% of Zimbabweans living in rural areas where traditional customs are strictly followed. Culture demands and society enforces adherence to traditional values and practices. With increased urbanization, many people in towns have acculturated into the western world-view and are slowly drifting away from their cultural socialization (Makoni, 1996:3). While I do not claim Zimbabwe to be totally representative of other African countries, most do follow a similar pattern (Palmer & Varma, 1997:253). It is important to point out that the traditional African culture is not homogeneous, with significant differences being noted among different ethnic groups. These speak different languages and many practice rituals in different ways.

The afore mentioned people involved in counseling are normally members of the extended family and are deemed to have accumulated wisdom to counsel through experience in their lives. In most cases they counsel people who are younger than themselves and over whom they have authority. Before I discuss the role of such members of the extended family, it is necessary to define the terms that have wider meanings such as ‘aunts, uncles, elders and traditional healers.’ Aunt, normally refers to one’s father’s or mother’s sister, Uncle, refers to one’s father and mother’s brother, father and their cousins. Elder, refers to all the elderly people in the community who are respected for the role they play in mending relationships and promoting harmony among family members, friends and members of the extended family. Traditional healers refer to people who claim to communicate with spirits of dead ancestors. Their role is supposed to be safe guarding people against witchcraft and evil spirits. They also advise families and people in the community of possible causes and solutions to misfortunes. Traditional counseling is widely practiced in the rural areas of

African countries. It has encroached upon cities as many people have moved into towns to find better living conditions.

In traditional counseling the people described above have specific counseling roles to play. The aunts usually deal with marriage issues: preparation for weddings and solving problems in a marriage. They counsel and guide the women towards successful marriages. As marriage counselors, their role complements that of the mother but is more pronounced when a girl is preparing for marriage. During dating, the aunts guide young ladies and discuss their love relationships as well as the suitability of their partners. The aunts teach the young unmarried ladies about their bodies, sex, and sexual hygiene as well as the behavior expected of a wife and mother. When the young ladies date, the aunts are heavily involved until the marriage has taken place. They guide the young unmarried ladies towards what is expected of a married woman who eventually becomes the mother of the home. Uncles do the same with the young men who are preparing to marry and with those who are already married but are experiencing problems. Elders in the community counsel and guide families who clash in one-way or another. Church elders and traditional healers help people who visit them or who are referred to them for help. It is these who normally deal with parents of children with disabilities, for example those who are hearing impaired. It is of paramount importance to emphasize that most of this counseling takes the form of giving advice and suggesting solutions without necessarily giving clients the chance to suggest possible solutions to their problems. It is expected that the clients implement fully the advice, which is given to them. In the event that the outcome is not positive, the client is normally the one to blame. The reason normally given is that either he/she (the client) did not follow given instructions or did not do it properly. When it involves counseling of parents whose child is hearing impaired, or disabled in any other way, a lot of causative factors come into play. Sometimes the cause of the disability is blamed on the parents or angry ancestors.

2.6.13 WESTERN COUNSELING

Western counseling is undertaken by trained, qualified counselors. It is the client's responsibility to seek counseling services, which are paid for. The service is by appointment and it may be individual, group and/or family counseling. One or more

counselors may be involved. The western way of counseling gives room for the counselor to establish a relationship with the client by creating a relationship and then presenting the problem. The counselor's role is to listen and to widen the client's problem by determining all the people and systems involved. The counselor will then help the client to view his/her behavior and hence his or her course of action. Clients are thus helped to find reasonable solutions to their problems. The onus is on the client to change attitude and behavior as well as solve his /her own problems.

The two approaches have some similarities and differences. In both systems, there is need for mutual trust and a good relationship. Both aim at resolving the problem and confidentiality is emphasized. As for differences, in the western system the client has to find solutions to his/her problems whereas in the traditional system the counselor or counselors provide solutions. In the western system the counselor and client may be strangers and yet in the traditional system the counselors and clients are normally relatives or people who know one another well. In most cases counselors who operate in the western system are qualified whereas traditional counselors are normally not trained. The western approaches to counseling are based on strategies and techniques that were initially developed by Anglo-European counselors. These techniques and strategies were designed to cater for the needs of the majority groups. In the United States of America where there is a fusion of diverse cultures, this monolithic approach has been found to be highly inadequate because it ignores the needs and cultural concerns of the minority groups. According to Nelson-Jones (1995:168) American counselors have therefore adopted a pluralistic approach, which calls for a multi-cultural perspective where in counselors are to be creative and flexible without necessarily ignoring the commonality of human beings. A critique of the appropriateness of western approaches to counseling in African countries has been advanced by a number of African counselors (Locke, 1990:32). They argue that western approaches are not appropriate to the situation and the needs of the majority in African countries South of the Sahara. The basis of their argument is that western techniques and strategies are sophisticated, time consuming and expensive, therefore catering for only a small elite group. However, it must be noted that, due to urbanization and educational developments, most Africans in urban areas are practicing the western system and/or both. Some have borrowed certain aspects from both systems. Although there is no universal culture in Africa, there are some basic common elements found in their

cultural beliefs and practices that involve the role of the extended family. However, it must be pointed out that in their study, McGuiness, *et al*. (2001:298) with students from different cultures, noted that humanistic counseling when employed correctly does not violate cultural boundaries.

In Zimbabwe prior to the 20th century, traditional counseling had been the most common practice among the Black Africans (Shumba, 1995:19). The 20th century saw the gradual spread of western counseling (Makoni, 1996:5), and the establishment of free guidance and counseling by Non Governmental Organizations as well as the establishment of counseling agencies. To date both the traditional and the western systems are practiced with the former being well established and the latter gaining ground. As pointed out before, this is mainly a product of urbanization and educational developments.

2.7 COUNSELING PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS

As stated in chapter 1, I will use the explanations by Hardman, Drew and Egan (1984:419), Hardman, Drew and Egan (1993:278), Tucker and Nolan (1984:108), Nolan and Tucker (1981:78), Moores (1987:182), Quigley and Kretschmer (1982:78), and Allen and Allen (1979:34) to explain the conceptualization of "parents of children with hearing impairments". These authors have written extensively on children with hearing impairments and their families. I will use their combined conceptualization to inform my study. All the above concur that parents of a child with hearing impairments, of course unexpected, go through feelings of shock, guilt, inferiority, denial and in some cases confusion. Hardman, Drew and Egan (1984:419) assert that the birth of a disordered infant is likely to alter the family as a social unit in a variety of ways. Parents and siblings may react with shock, disappointment, anger, depression, guilt, and/or confusion, to mention only a few. Relationships between family members often change, in either a positive or a negative manner. The impact of such an event is great, and it is unlikely that the family unit will ever be the same. Hardman, Drew, Egan and Wolf (1993:278), further endorse that such parents may consult professionals, doctors, traditional healers, counselors, specialist teachers, physiotherapists, audiologists, psychologists and others, searching for

treatment, correction and any other help that they can obtain in aiding them to raise their child.

Parents of children with hearing impairments need counseling to help offset their reactions to the child's handicap. As pointed out by Martin and Clark (1996:357) they (parents) become patients. There is ample evidence that at the initial diagnosis of hearing loss, logic often takes a back seat to emotion and families become incapable of assimilating and processing the new and stressful facts (Harry, 1997:87). As important as it is that families are given the data they need to have on which to base their decisions regarding their child, it is useless to force–feed individuals who cannot digest facts that carry an emotional message. Even when emotions do not appear to dominate the counseling session, information is often misinterpreted or forgotten (Martin, Krueger and Bernstein, 1990:106). Hearing parents naturally expect to have children with normal hearing and therefore become worried about their family's future based on the discovery of hearing loss which, more often than not is unanticipated. Emotions can cloud logical thinking and perception, therefore the counselor must determine whether parents are prepared to accept and understand new ideas and information before they embark on the actual counseling. Apart from emotional reactions, it is apparent that parents have counseling and guidance needs related to the practical steps they could take to help their child benefit from amplification. The goal of the counselor is to help parents accept the situation, achieve independence and learn to solve problems engendered by their child's hearing loss. The great diversity of reactions and family situations requires a worker who uses counseling skills effectively and is capable of handling a variety of responses. Recovery rate in anxiety type cases is reported as faster where the counselor is warm, permissive, interested in and likes the client and is able to empathize with him. Studies carried out on counselors who worked with parents of children with hearing impairments, Tucker and Nolan (1984:120), Martin and Clark (1996:186) and Peavy (1996:149), indicate success, not due to particular techniques, but dependent more on the personality and attitudes of the counselor. According to Clark (1994:73) many non-professional counselors lack the necessary skills and a positive attitude, when it comes to dealing with families of children with hearing impairments. These non-professional counselors include physicians, dentists, teachers, attorneys, the clergy and friends. Uncertified counselors with basic training in counseling and hearing impairment, who do not assume authority, who empathize with clients and adopt a positive

attitude, form a warm relationship, attach value to clients, accommodate clients' emotions and create a conducive atmosphere for clients to find solutions to their problems, do well in counseling (Blocher, 2000:209). I tend to go along with Blocher's line of thought because a study by McCormick (1986:143) in the United Kingdom where he screened children with hearing impairments using physical methods, with the use of trained health visitors, also indicated that there was no difference in the results obtained by health visitors and those obtained by audiologists.

It is important for parents of children with hearing impairments to be referred to counselors who have knowledge about hearing impairment. Peavy (1996:136) points out that effective counseling should assist the individuals to clarify various aspects of their life-worlds. He further spelt out these aspects:

- Reducing mental confusion and doubt, paving way for decision-making.
- Enabling a forum of 'self-encounter', which helps one to make distinctions about self and
- other, and self and ambient world, thus making one understand his personal reality and life experiences in context.
- Alerting individuals on how they are being influenced by the field of power in which they are embedded.
- Provides hope and encouragement, since individuals without hope have no windows in their future
- Identifying the pros and cons of any coping strategy.
- Provides comfort and/or support. Comfort is a deep human need that can be met through church
- Gatherings, family clans and neighborhood groups.

2.7.1 HOW PARENTS ACCESS COUNSELING SERVICES

Parents can access counseling services by approaching individuals in the counseling profession, counseling service organizations, churches and/or special schools where counselors operate. Some families prefer to invite counselors into their homes and work from there. Others prefer to visit counseling clinics where they can work with one or more

counselors. Kirk, *et al*. (1997:157) point out that in the initial stages parents have no direction of what to do, therefore they rely on advice from those who have or claim to have superior knowledge about hearing impairment than they themselves. Sometimes they are reluctant to take counseling because they are not sure of what they will be told, for they will be afraid of the worst.

A study by Howe (1996:127) in the United States of America, with 34 families who had children with disabilities, produced important observations in counseling. Out of the 34 families that were offered counseling, 23 accepted the offer for therapy. Eleven declined family therapy offer or failed to keep their first appointment and therefore were not considered. Ten of the 11 who declined therapy accepted to be interviewed, as well as 22 out of the 23 who accepted therapy. The purpose of the study was to seek the clients' views on family therapy. Most families who dropped out of the program or remained anxious had not engaged right from the beginning. The families were put into four categories, namely

- the non-takers who were offered therapy but did not accept it,
- the early leavers, who began therapy but withdrew after one, two or three sessions,
- the ambivalent, who remained in therapy but were not fully engaged, and
- the relaxed and satisfied who became fully engaged and remained in treatment.

Interviews with the second group, the early leavers, revealed that family members experienced considerable anxiety over tape recording and video recording. They were also not sure of what they were going to meet in the counseling situation. The methods used and the manner the sessions were run was of some concern. The place of counseling mattered. They preferred home rather than clinic. The style of questioning and the use of supervisors who remained unseen raised the family's feelings of anxiety. This clearly indicates that counseling is a sensitive area, which needs careful planning and handling. It is important that clients are counseled under conditions that do not raise anxiety. As proposed by Gartner, *et al*. (1991), I believe that counseling should be conducted in non-threatening environment where nobody knows or suspects that there is a third party listening.

Another study carried out by Davis (1993:128) focused upon the professional – parent relationship and the parents' experiences. The psychosocial adaptation of parents was of central concern to every professional simply because of the crucial role of parents in all aspects of the care and treatment of the child. One group of parents only attended counseling sessions, but did not develop social relationships. Nor did they get extra support outside counseling sessions. Another group received counseling, developed social relationships with counselors and also received constant support. A number of parents from the first group remarked that after the counseling session or sessions they were left to deal with their problems alone and the counselors disappeared forever. Parents who received counseling and support outside counseling sessions indicated that it is necessary to retain support from counselors. Counselors who employed the partnership model, had mutual respect, kept their lines of communication open, were honest and had an impact on their clients. Church counselors who had close contact with their clients and continued to support them socially, morally and physically proved to be effective and had good counseling results.

On evaluating the two groups, the first group of parents that did not get much support indicated that their situations did not change much. The second group that obtained a lot of support indicated that their situations changed in individual and family life. They changed in the way in which they perceived situations and in the way they planned for their children. They developed a new understanding of their problem which enabled them to set clear goals, to plan how to achieve them, to implement the plans and to evaluate the results at every stage. Their objectives included outings on their own or with the children and family trips. They also set goals for the future of their child with hearing impairment. Some parents expressed that they faced pressure from members of the extended family, friends, relatives and professionals at the expense of their own views. This is a clear indication that counseling should not be terminated before the clients are free to go it alone and are confident enough to handle further problems and obstacles as they come. The study also indicates the importance of the relationship between the counselor and the clients during and after counseling. It is vital that the counselor makes follow-ups of clients counseled to find what progress is being made. The inclusion of close relatives and friends in counseling sessions should be considered. I am of the opinion that where possible counseling should involve the close network of members of the extended family.

It is important to situate this study within the broader context in which it took place. In the next section I will explore the political and socio-economic status of Zimbabwe during the period of the study.

2.7.2 ZIMBABWE IN THE PERIOD 1999 TO 2000

In Zimbabwe the beginning of political disturbances, constitutional changes and the collapse of the economy characterize the period 1999 to 2000. The formation of the strong Movement for Democratic Change political party (MDC) forced the ruling Zimbabwe African National Union Patriotic Front (ZANU PF) to use and engage haphazardly the land redistribution programme in order for them to gain political mileage (Zimbabwe Country Report, 2001:4). The ruling party misused the long overdue land reform programme to win votes. White farmers were displaced and their farms were designated for distribution to the so-called landless blacks, who turned out to be party supporters and high-ranking government officials (Zimbabwe Country Report, 2001:8)

Zimbabwe heavily relies on agricultural products, and therefore the seizure of white owned farms and the giving of them to people who do not have either the knowledge or the equipment to farm plunged the country's economy into crisis. This is the main reason for the collapse of the health, welfare and social security systems. The deterioration of the welfare system has greatly affected the education system, particularly in the area of special needs where poor parents of children with disabilities relied on the social welfare to feed and educate their children. The present status in Zimbabwe is that parents have to pay for both education and health services and those who cannot afford to do so keep their children at home.

This study is not greatly affected by the system in the sense that when the data was collected, parents were already paying for the services. Economic hardships had already started paralyzing the health, welfare and social services. However, if the same study had been conducted in 2003, the results were likely to be different due to increased hardships in general and educational facilities for children with hearing impairments in particular. The effects of brain drain of qualified personnel in special schools might have had a negative impact on the quality of education given to children and on the counseling parents obtain

from special schools. Given this brief background, the counseling of parents of children with hearing impairments in Zimbabwe will be discussed.

2.7.3 COUNSELING PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS IN ZIMBABWE

According to my experiences as an educator, administrator, lecturer in Special Education and counselor in schools and with a counseling agency in Zimbabwe, most of the counseling of parents who have children with hearing impairments was done in special schools because parents had no idea of what to do with the children thereafter. From 1984 to 1997 I worked as a teacher of children with hearing impairments at one of the schools that belong to the Jairos Jiri Association for people with disabilities. This association caters for blind, deaf, physically disabled and mentally disabled people. The association has branches all over Zimbabwe with centres in all the main towns. They also have primary, secondary and vocational schools to cater for people with disabilities from all regions of the country. I used to move from centre to centre during the school holidays to offer counseling services to parents and students who needed help in that area. I was in charge of counseling parents and students at the school (Naran Centre) where I was stationed.

In 1993 I moved to Harare where I worked at a private school as a specialist teacher and school counselor for students and parents who had children with disabilities. In 1994 I studied a practical counseling course with a non-governmental counseling organization (CONNECT). On this course I had to carry out practical counseling sessions and record them with the clients' consent. The recordings on the tapes were marked and feedback was given. I also lectured at the University of Zimbabwe in the department of Special Education. Counseling is one of the courses I taught. As a lecturer I supervised students on counseling sessions and marked their assignments. CONNECT also engaged me as a trainer and marker for those who were taking counseling courses. These experiences have widened my mental horizon and increased my knowledge in dealing with children, parents and families in counseling.

Specialist teachers who were not formally trained counselors carried out most of the counseling in Special schools. The counseling sessions were a ten to fifteen minute once off. I experienced this during visits to special schools as a university external examiner for

one of the Teachers' Colleges that offered a Special Education course. From my knowledge and experiences during and after training in counseling, the teachers who provided counseling services lacked the necessary skills for them to help parents effectively. This was also indicated by Maluwa-Banda (1998:68) in his study in Malawi. The counseling was not planned and did not involve all the members of the family who were affected by the child's impairment. The views of the parents were not taken into consideration, it was simply telling them what to do. The parents seemed to look forward to the experts' advice and never thought they had anything important to contribute. This happened in all special schools for the hearing impaired in Zimbabwe. The pattern of parents coming back to the schools for advice and help had continued from as far back as 1980 and no one knows when this practice will stop. Some of the parents just "dumped" the children at special schools and only pitched up during the child's final year in either the primary or secondary school. The situation has slightly improved in the sense that from 1996 a few teachers, at least one from every special school for the hearing impaired, have qualified in child counseling. As pointed out by Richards (2000:144) the training given to 'counselors' in Zimbabwe, who work in schools, hospitals and the police, is quite inadequate. She goes on to suggest that, although the time is short, the child-counseling course has intensive practical sessions that are of great help to the trainees. The counseling is either done with individuals or groups of parents.

2.8 COUNSELING ORGANIZATIONS IN ZIMBABWE

Counseling organizations and agents in this piece of research refers to Churches, Special Schools, Hospitals and Counseling Centers. Such organizations provide counseling services to the general population. These organizations offer emergency, education and consultation services. Centers concentrate on common problems in that particular community and universal problems are also accommodated. Some of the agencies include traditional centers such as drop in, and open door, whilst others even offer temporary accommodation. Zimbabwe has six examples of such centers: three in Harare, two in Bulawayo and one in Gweru. Counselors in the centers are used to the culture and beliefs of the people in the community, which makes their services effective (Blatt, 1976:36). Outreach programs are organized by a number of counseling organizations that train counselors. They run short courses in different regions and longer courses for a

qualification. Outreach programs help people who cannot access the services since most organizations and agents are established in towns and big cities. This factor was also emphasized by Charema and Peresuh (1996:76) when they pointed out the need for mobile units in rural areas to support parents of children with disabilities. It would also be a good idea for these agencies to decentralize the services. This would help parents of children with disabilities to access guidance and counseling services within their rural areas. Those parents who cannot make it to big cities due to lack of transport fares would also benefit.

It is understood that counseling organizations and agencies deal with widely diverse populations. This encompasses people of different races and cultural backgrounds. Organizations offer a wide range of services from short-term ordinary family problems to agent ones that need immediate attention. These services include Crisis, Facilitative, Prevention, Developmental, Employment, Correctional, Rehabilitation, Marriage and Family as well as Pastoral counseling. Crisis issues relate to concerns about suicide, drugs or rejection by a loved one (Mbiti, 1990:37 and Locke, 1990:21). In this case the counselor provides individual counseling, personal support and/or referral of the client to appropriate resources. Facilitative issues relate to job placement, career/academic concerns and marital adjustment. Prevention issues involve sex education, self-awareness and career awareness. Developmental issues relate to self-concept, child abuse, sexual abuse, murder and death. Capuzzi and Gross (1999:67) assert that a number of key features must be included in any effective counseling organization and center. This view was supported by Nystul (1999:127) and Wallace (1986:34) when they emphasized that counseling organizations should be situated in places easy to locate and have a clear outline of the services provided. Some of the key features cited by Nystul (1999:132) include:

- Quantitative analysis of the population to be served, so that the number of people to be helped and their specific needs can be determined.

- Case management, to ensure that someone is responsible for coordinating and monitoring necessary services.

- A program of support and rehabilitation to provide services appropriate for each client's age, functional level, and individual needs.

- Centers should be located in a setting that is easy for community members to reach, so that they view it and associate with it as theirs. This differs from having to travel long distances that take time and money.

- Counseling agencies should have a team that includes psychiatrists, counseling psychologists and social workers.

2.9 MARRIAGE AND FAMILY COUNSELING

Although the marriage vows read that married people are only separated by death, the high divorce rate throughout the world (Howard, 1996:18) indicates that thousands of couples have decided they cannot wait that long to split up. Certainly an abundance of statistical empirical evidence indicates that family discord and divorce is continuing to increase (Goldenberg & Goldenberg, 1991:211). We can conclude that the traditional image of the home and family as a cozy nest of love, security, togetherness and never ending happiness has been severely battered in recent generations. The need for counselors who can effectively counsel families in such a way that the family fiber is strengthened is greater than ever before. A family that has a child with disabilities is more likely to experience marital problems due to the demands and change of routines caused by such a child in the family (Cristiani, 1995:66). Therefore there is need for effective counseling to help the family hold together without necessarily blaming one another, as is generally the case. Stewart (1986:110) contend that a family with a child with disabilities should be helped to adapt to the situation, engage in tension-reducing mechanisms and coping methods in order to relieve themselves of tension and anxiety. A professional counselor must use skills, logic, and background knowledge to help parents define the problem and find a solution.

Providing effective counseling assistance to families and couples in today's complex and stressful society is a challenging and difficult task, frequently complicated by cultural traditions, environmental pressures and advice from non-professionals. While individual counseling focuses on the individual person and his or her concerns, family therapy tends to focus on 'the family system.' Even where only one member of the family is being counseled, if the counseling is concerned primarily with the family system, it can be viewed as family counseling. As pointed out by Blocher (2000:248) family therapy focuses

on the communication process, power balances and imbalances, influence process, structure for conflict resolution, and the current function of the family as a system. The goal of family therapy is to effect change not simply in an individual within a family but rather in the structure of the family and the sequencing of behavior among its members. An outgrowth of the increased recognition of the extent and popularity of marital problems has been the development of a specialty area within the field of marriage counseling. A survey carried out by Peltier and Vale (1986:134) and Gladding, Burgraf and Fennell (1987:117) on course offerings in counselor training reported family counseling as the most frequently offered course, especially where a family has a child with disabilities. This need could be attributed to a lack of guidance and/or poor support from family members. Frustration and little knowledge of what to do with a child with disabilities could also necessitate the need for counseling. It is clear that when a family is in such a situation they need counseling.

2.10 PASTORAL COUNSELING

From the standpoint of sheer numbers and geographical coverage, pastoral counseling provides a significant resource. Not only are clergy members generally available to listen to the concerns and personal problems of their church members but also are frequently the first source people turn to when in trouble. Many churches offer extensive counseling on marriage, divorce, widowhood, drug and alcohol abuse and other family problems. It is necessary for pastoral counselors to be trained so that they acquire the necessary skills for counseling. My experiences in my church organization in Zimbabwe are that most of the so-called church counselors are people who are not trained in counseling but have been talked to about counseling. It was only in 1996 that the church started to hire and utilize professional counselors in their youth programs. This is one of the reasons why I explore the qualifications of counselors as one of the tenets in this study. In recognition of the counseling need, many theological training programs include courses in pastoral counseling, related psychology and general counseling subjects. For obvious reasons it is recommended that all church members who are engaged in counseling should be trained and qualified if they are to effectively execute their duties. A study by Maluwa-Banda (1998:76) in Malawi, with 20 school counselors who did not have any formal training or qualifications in counseling indicates that all the participants identified common key problems which compromised their effectiveness. All the counselors concurred that lack of

formal training in counseling, lack of adequate time for guidance and counseling and lack of practical skills in counseling were a hindrance to effective delivery of guidance and counseling in their schools. Although the study was carried out in schools, the situation is likely to be the same in churches, hospitals, welfare organizations and other non-governmental organizations. As indicated in Maluwa-Banda's 1998 study, it is likely that if "counselors" who counseled parents of children with hearing impairments from special schools or counseling organizations were not trained, the service they offered might have been affected by their (counselors) lack of confidence.

2.11 EMPLOYMENT COUNSELING

Employment counseling involves counseling school leavers and people from war situations preparing them to enter the job market. Such counseling includes securing job leads, recording job specifications, referring clients to employers, assessing client level of motivation, assessing client readiness for employment and surveying job opportunities.

2.12 REHABILITATION COUNSELING

Rehabilitation counseling involves counseling the disabled. History reflects the admiration that society has always held for those who have overcome physical disabilities to achieve notable success. The man (Franklin D Roosevelt) who was paralyzed by polio in both legs at the age of 39 later became the president of the United States of America and a wartime world leader. The woman (Helen Keller) who was deaf and blind from the age of two, later became a successful author and lecturer. The deaf musician (Ludwig van Beethoven) and the amputee actress (Sarah Bernhardt) are a few of the people who reached beyond their disability (Muthard & Salomone, 1969:11). The achievements of these and others despite their disabilities were notable, but has history failed to record the tragic loss to humanity of those people whose potential was destroyed by the lack of attention to their disabilities. Since world war two, rehabilitation counseling has expanded into public agencies so that these individuals may receive special counseling assistance in overcoming their disabilities. It is also important to consider rehabilitation counselor placement, affective counseling, group procedures, vocational counseling and medical referral. The counselor should not only be knowledgeable in counseling but also in understanding disabilities and the pressure

it exerts on parents. Hosie, Patterson and Hollingsworth (1989:175) point out that rehabilitation centers are increasingly providing services to individuals with disabilities. Counselors in these centers help clients overcome deficiencies in their skills, which are due to their disabilities. Sometimes they work with a special type of client, such as the deaf, blind, mentally ill or the physically disabled. Vocational rehabilitation counseling seeks to help clients with disabilities prepare for gainful employment and appropriate job placement. They coordinate the effort of community agencies on the clients' behalf and those operating in this role function as resource persons.

2.13 A CRITIQUE OF COUNSELING ORGANIZATIONS

Howard (1996:6) in his book 'Challenges to Counseling and Psychotherapy', points out that professionals in most counseling organizations have not had the time, attention or research lavished on them to develop solid professional frameworks capable of underpinning the escalating demands made on them. In today's society, alienation, loneliness and meaninglessness are rife. This is demonstrated by society's developments in counseling and psychotherapy. Like anybody else riding on a rough tide, parents of children with hearing impairments may benefit from turning to counselors who can support them in managing their day-to-day lives and family relationships. Theories and methods to alleviate parents' worries are many, while critical analysis of these methods, on the part of parents is almost non-existent. Howard (1996:7) further alleges that these care professionals are too busy perfecting and packaging their products, and their clients are too pre-occupied consuming them, to wonder about the justification of all this effort. The emphasis is on income rather than outcome, on survival rather than on rationale. Howard (1996:9) points out that when caring, cash and consumption go hand in hand, the most intensively personal attention inevitably attaches to those who can pay for it. There is so much stress in simply trying to deal with human distress all around that there is little time or energy left to oversee the situation and take stock of it. It is not easy to oversee a situation in which one is deeply involved especially when one requires parents to warn others of the pitfalls and the dangers they are collectively running into. Desperate times sometimes require desperate measures and it is probably true that parents are fairly desperate before they consult a counselor or therapist. Parents are desperate to find solutions to the personal problems they feel surrounded, invaded and overwhelmed by.

They are urgently looking for a way out of the humdrum and difficulties that wear them out. In one way or another they are yearning to find some sense of comfort and meaning in a world that seems increasingly set against them. Counseling and therapy are the last resort for those who experience such agony and anguish.

Faced with the demand for the services and the mushrooming of counseling services in family set ups, churches, job situations and/organizations, I feel the priority is to begin by setting higher standards of training and practice in order to offer effective services. I feel that if groups of individuals or organizations are to offer guidance and counseling to parents of children with hearing impairments, they should have all the necessary modalities in place. These include qualified personnel in counseling, clearly outlined counseling programmes and referral centres for further help. It may be unrealistic to expect the existing counseling organizations that have an obligation to secure their identity, to resonate with this challenging tone. However, with time, on employing new counselors and therapists, organizations would be aware of the heed to have comprehensive training programmes.

2.14 SUMMARY

I have discussed the counseling theories and techniques in relation to counseling parents of children with hearing impairments, by individuals, churches, special schools and counseling organizations. This leads us into the methods that were used to conduct the study.

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3 METHODOLOGY OF THE STUDY

3.1 INTRODUCTION

In this chapter I will italicize all the methodological descriptions that have *already* been explored in chapter 1 of this thesis, in order to provide a link with the discussion of the rationale of these choices and the consequences for the thesis. Following each italicized section then, will be a further section on the rationale and consequence of each choice.

- I will also give an overview of the research design of the study, as well as the methodological decisions.
- Both dependent and independent variables are spelt out.
- The population and the sample are given.
- A further explanation of how the sample was selected is offered.
- The procedure followed in data gathering and the methods used are presented.
- An explanation of how the instrument used was developed, and scored, is offered.
- This is followed by methods of data analysis and ethical considerations in research.

The main focus of this study was on the ways in which parents of children with hearing impairments access guidance and counseling. Stewart (1986:109), Luterman (1990:127) and Locke (1990) strongly support the importance of counseling parents of children with disabilities, from an early age up to the time the parents are able to cope with their children. Early guidance and counseling helps parents to accept, cope and plan for their children. But in order to receive guidance and counseling parents need to access these services – the focus of this study.

3.1.1 RESEARCH DESIGN: SURVEY

This research was conducted by means of surveys and interviews.

PILOT STUDY

PARTICIPANTS (68)	DATA COLLECTION	DATA ANALYSIS
• 40 university students • 20 parents • 8 lectures	• Questionnaire responses • Interviews	• Analyzing responses in relation to positive and negative questions • Analyzing content and language of questionnaire • Analyzing the clarity of questions

MAIN STUDY WITH PARENTS

PARTICIPANTS	DATA COLLECTION	DATA ANALYSIS
• 300 parents, both single parents and couples	• 2 Questionnaires • 206 Interviews • Parents' own views	• Analyzing questionnaire responses • Analyzing reliability, validity and consistency. • Analyzing participants' views qualitatively

MAIN STUDY WITH COUNSELING SERVICE ORGANIZATIONS

PARTICIPANTS	DATA COLLECTION	DATA ANALYSIS
• 28 counseling service organizations	• 1 Questionnaire	• Analyzing participants' responses • Analyzing counselors' qualifications • Analyzing the views of counseling organizations

PRINCIPLES OF RESEARCH DESIGN

RESEARCH DESIGN	**Objectives:** • To find how parents of children with hearing impairments accessed counseling in Zimbabwe • To investigate whether parents who received or did not receive counseling were aware of organizations that offered guidance and counseling • To find parents' perceptions on whether or not counseling helped them to cope with their children • To establish the counselors' qualifications • To explore parents' recommendations on how counseling could be made more accessible
	Paradigm • Positivist
	Techniques • Descriptive statistics supported by qualitative analysis of interview data. • Sampling, data collection, data analysis • Survey Design

3.2 THE SURVEY METHOD

3.2.1 CHOICE AND RATIONALE

I chose the survey method because I found it to be the most appropriate methodology to explore this theme. The study covered the main cities in the country and involved a reasonably large but manageable sample from all over the country. This enabled me to identify attributes of a population from small groups of individuals as presented in Fowler (1988), Babbie (1990), Sudman and Bradburn (1986) and Fink and Kosecoff (1985). The method helped to make estimated assertions about the nature of the total population from which the sample had been selected. It is also possible to generalize from a sample to a population, drawing inferences about some characteristics, attitudes, or behaviors of this population. In depth interviews were used to cross check questionnaire responses. As cited

by Babbie (1990:243), general to all surveys using participants, the use of a survey enabled me to involve in the sample participants from different places within a reasonably short time. Within a reasonable length of time, I was able to collect data from participants in five major cities in the country.

3.2.2 CONSEQUENCES

This method was extremely efficient at providing large amounts of data, at relatively low cost, in a short period of time. It also allowed anonymity, which encouraged frankness where sensitive issues were involved. Direct administration to a group produced a high rate of response, which was close to 100%. I had an opportunity to explain the study and answer questions that the participants asked before they completed the questionnaire. It is important to point out that this method has some disadvantages.

I was not one hundred percent sure whether participants necessarily reported their actual beliefs and attitudes. Because there is likely to be a social desirability response bias, people responding in a way that shows them in a good light. Surveys also do not guarantee future reliability since their main emphasis is what happened in the past. As pointed out by Hanson (1980:68) a lack of relationship between attitudes and behavior also makes it difficult for the researcher to generalize from what people say to what they actually do.

3.3 INTERVIEWS

3.3.1 CHOICE AND RATIONALE

I chose to conduct interviews in an informal way in order to cross check questionnaire responses. I had worked out a set of questions in advance but was free to modify their order based upon my perception of what seemed most appropriate in the context of the conversation. I could also change the way the questions were worded and give explanations where needed. I had the option to leave out particular questions that seemed inappropriate with a particular interviewee. Additional questions could be included as a follow up to obtain required particular information. It took me 15 days to complete interviews with parents of children with hearing impairments, who had volunteered to take part. Most of the

interviews were conducted at the five special schools and only a few were conducted at units were children with hearing impairments were integrated. Face-to-face interviews offered the possibility of modifying one's line of inquiry by following up on interesting responses and investigating underlying motives in a way that self-administered questionnaires cannot. Interviews require careful preparation such as arrangements to visit, securing the necessary permissions, rescheduling and confirming appointments and working out the time for each interview. During the interview process, 'bracketing' was applied, mainly to suspend prejudices and biases in order to approach all interviews openly. 'Horizontalization' was also applied to ensure that all sources of data were treated as equal. I was aware of how preconceived views on certain issues could easily influence behavior and contaminate the data, for example the tone of voice, facial expression and nodding of head of the interviewer. Therefore this was minimized as much as possible.

3.3.2 CONSEQUENCES

I could pick non-verbal cues that provided additional information and gave messages that helped in understanding the verbal responses, possibly changing or even, in extreme cases, reversing the meaning. I also managed to probe and gain access to the information that may be difficult to reach by using other methods. Interviews provided rich and highly illuminating material. Due to person-to-person interaction in the interview the quality of data is likely to have been enhanced. However, one of the shortcomings of interviews is that they are time-consuming and in consequent the process took some time to complete. On analyzing the data, lack of standardization, if the data are not carefully handled, might inevitably raise concerns about reliability and bias. It might not be fair to compare responses when different subjects are asked different follow up questions. Some of the interview data may also be hard to categorize.

3.4 POPULATION

The population comprised of all families that had children with hearing impairments who were receiving primary or secondary education in special schools and units at the time of the study. I chose to involve all such parents in order for the study to include people of different backgrounds and ethnic groups who face more or less similar problems. Through

the schools' administration records the population was established to be 900 families at the time of the study. However, there was no guarantee that all these families were going to take part in the study since involvement was purely voluntary. It is also important to point out that parents whose children were not attending special schools and units during the time of the study are not included in this population. For those included in the population, Masvingo had 194, Harare 197, Gweru 176, Bulawayo 170 and Mutare 163 parents (n = 900). Five major hospitals from the five cities, 30 churches that claimed to have proper counseling services (six from each city) five special schools from the following towns: Bulawayo, Gweru, Masvingo, Mutare and Harare and three counseling agencies, all from Harare, were also to be included.

3.5 SAMPLE (n = 300)

The sample comprised families of children with hearing impairments in special schools and units. I used the sample size formula available in Babbie (1990:69) and Fowler (1988:124). Simple random sampling was used to obtain the required sample. Parents were grouped according to the provinces they came from, Masvingo, Harare, Gweru, Bulawayo and Mutare. A random number table was used to prepare cards that were used to randomly select the required sample. Cards were numbered and put in a box. Five boxes labeled with the names of the five towns were mounted in different places outside the administration block. Each box had cards with valid and invalid numbers and parents were asked to pick a card from the box labeled with the name of the town in their province. All parents who volunteered to take part in the study and picked valid numbers up to 300 were considered in the sample. Invalid numbers had the value of their first three digits bigger than 300. If both a husband and wife took part in the study, they picked up one card and completed one questionnaire. The sampling procedure was conducted in five towns at special schools for children with hearing impairments, where parents were gathered. These five special schools were in the following cities, Bulawayo, Harare, Masvingo, Mutare and Gweru. The sample also included five hospitals, one from each town. All five were included since parents of children with hearing impairments were referred to them for counseling and further help. The only three registered counseling agencies, all in Harare, took part in the study. Fifteen churches, three from each city, were included in the study. These were also sampled through a simple random sampling procedure. Six cards were

made for churches in each city that claimed to run proper counseling sessions. Three of these were numbered. The three churches whose church members picked numbered cards were selected to take part in the study. This was done in all the five cities that took part in the study. Parents from rural and urban areas were also involved in this study.

3.5.1 CHOICE AND RATIONALE

The simple sampling procedure was used in this study in order to give each parent an equal chance of being included. The objective was to include parents from different ethnic and socio-economic backgrounds, rural, semi-urban and urban areas. As stated by Salkind (2000:87) the simple random sampling is the most common type of probability sampling procedure and allows each member of the population an equal and independent chance of being selected to be part of the sample. Undoubtedly the random procedure is most rigorous, enabling one to generalize the findings of a study to the entire population associated with the study (Babbie, 1990:74). In this particular study I have no intention of generalizing the results because different 'counselors' took part in counseling. Their differing skills and qualifications may have had a different impact on clients.

3.5.2 CONSEQUENCES

One result of using a simple stage sampling procedure was that it allowed me direct access to the participants. The procedure used considered that the subjects selected in the sample reflected the true characteristics of the population as a whole, both in physical attributes and socio-economic status (Cohen & Manion, 1989:101). The use of the table of random numbers is a useful innovation, since the basis on which the numbers in the table are generated is totally unbiased. However, one problem associated with this particular sampling method is that a complete list of the biographical details of the entire population is needed and this is not readily available.

3.6 VARIABLES

Independent variables in this research include parents of children with hearing impairments, counselors in Special Schools, Hospitals, Churches and Counseling

Organizations. Dependent variables include the questionnaire data on parents of children with hearing impairments, whether or not they received counseling, and from where, as well as whether they were able to cope with their children after counseling.

The items included and not included in this study are indicated in table 3.6.1.

TABLE 3.6.1 INCLUSIONS AND EXCLUSIONS

INCLUDED IN THIS STUDY	NOT INCLUDED IN THIS STUDY
Counseling theories	Counseling techniques
Counseling in general	Particular type of counseling received by individual parents.
Parents of children with hearing impairments	Children with hearing impairments

3.7 PROCEDURE

Letters were written to heads of special schools asking for permission to conduct research at their schools during open days. All heads of special schools granted permission. Letters to heads of counseling agencies were also written and permission was granted to carry out the study. Permission was also sought from pastors of sampled churches. Information was given to all potential participants explaining the purpose of the study. Those who volunteered to participate in the study granted informed consent.

A structured questionnaire with multiple choice and open-ended questions was administered to 300 families of children with hearing impairments. The participants of this study came from the five major provinces of Zimbabwe. 60 from Harare, 60 from Masvingo, 60 from Mutare, 60 from Gweru and 60 from Bulawayo. Participants were randomly selected as mentioned above (section 3.5). I arranged with heads of special schools to meet parents on open days. Given the time to meet the parents, I explained to the parents the purpose of the study and how they were expected to complete the questionnaires. Parents were given a chance to ask questions on things they did not understand and clarifications were given. I collected the questionnaires as soon as they were completed. Informal interviews were conducted with individuals during the

interval and the lunch break. A different structured questionnaire for service organizations was administered to personnel responsible for counseling at the following general hospitals, Harare, Gweru, Mpilo, Masvingo and Mutare. The same questionnaire was administered to three registered counseling agencies, all in Harare. Members from 15 churches, three from each of the towns, Harare, Gweru, Masvingo, Bulawayo and Mutare also completed the questionnaire.

3.7.1 CHOICE AND RATIONALE

I chose to conduct the study through special schools in order to meet parents at well-known places and at a convenient time as well as to minimize traveling expenses. Letters that were written before gave parents an opportunity to decide whether to participate in the study or not. A meeting with the parents before they completed the questionnaire gave me an opportunity to explain the purpose of the study and also to stress the fact that participation was voluntary. I chose to use questionnaires because it was easy to collect a lot of data from a large sample within a reasonably short time. I could also conduct interviews with parents who volunteered to participate.

3.7.2 CONSEQUENCES

It became easy for me to meet groups of parents in one place and gather data in one day at a particular school in a particular town. It also saved time and money. It was an advantage for me to be able to administer and collect the completed questionnaire on the same day. Interviews took more time than I anticipated. See the map of Zimbabwe in chapter 1, figure 1.14.1, for the location of towns in which the study was conducted.

3.8 INSTRUMENT

I used questionnaires and interviews to gather data. The idea was to gather data in a simple and straightforward way. The questionnaire format made it possible for participants to freely express their opinions and ideas on their experiences in writing. I considered that the anonymity of questionnaires would help elicit more satisfactory information. This claim appears to be corroborated by the assertion of Babbie (1990:198)

when he stated that questionnaires are preferable since they avoid the embarrassment of direct questioning and so enhance the validity of the responses. Structured questionnaires are a universally accepted mode of eliciting information for research purposes. It is therefore probable that the theoretical and practical requirements of the investigation being conducted would be met.

Before setting out to use the research instrument I was aware that the questionnaires would have to be distributed either by hand or by mail. I familiarized myself with the writings of Dawes (1972:152) and Cohen and Manion (1989:108) as to what should constitute a good questionnaire. Writing on what should form the aggregate of an ideal questionnaire, Cohen and Manion declared that it should be simple, clear and workable. This was the basis under which I designed the instrument for this study. The design aimed at minimizing potential errors from participants and coders. Since people's participation in surveys is voluntary, this questionnaire was made in such a way that it would help in engaging their interest, encouraging their co-operation, and eliciting answers as close as possible to the truth.

As pointed out by Fowler (1988:74), questionnaires must be made attractive to the potential respondent, appear simple and not be too time-consuming to complete. The instrument for this study was designed with these criteria in mind. On the proper selection and/ordering of questions, Fishbein (1967:93) maintained that presenting participants with carefully selected ordered questions is the only practical way to elicit the data required to confirm or disconfirm a hypothesis.

The above issues raised by the various authors were taken into consideration in the design of the questionnaires. I designed structured, straightforward questions to obtain the information needed. It was intended that the questionnaires would be easy to understand and complete. The patterns of the questionnaires took the following forms:

- *the fixed alternative format*
- *the multiple choice format*
- *the open-ended or self report format*

3.8.1 CHOICE AND RATIONALE

As stated before, I chose to use questionnaires because they are an easy way of collecting data provided the questions are clear and simple. They allow participants to participate freely. Multiple-choice questions are not time consuming on the part of participants. Open-ended questions allow participants to express their views and even offer suggestions.

3.8.2 CONSEQUENCES

A fairly large amount of data was collected in a short time. I was able to administer the questionnaires personally and collected them soon after completion, which gave me a 100% return. Structured questionnaires do not give participants the freedom to express their views on why they respond positively or negatively. In this sense the data collected may lack depth.

3.9 DESCRIPTION OF THE MEASUREMENT TECHNIQUES

The details of the instrument used were as follows: Two questionnaires were constructed: one for parents of children with hearing impairments and the other for service organizations that offer counseling. A semi-structured interview questionnaire with 15 items was prepared and will be used to cross check parents questionnaire responses. It covers all aspects of the parents' questionnaire. The questionnaire for parents is divided into three parts. Section A has questions on personal information, whether the child was born deaf or not and who counseled the parents. Section B deals with questions that seek to establish:

- *whether or not parents received counseling,*
- *if parents were aware of counseling organizations,*
- *if counseled parents were able to cope with their children.*

Section C has open-ended questions that seek to establish:

- *the difficulties parents faced in raising their child,*

- *the organizations that counseled them,*
- *whether counseling helped them or not,*
- *their views on how counseling could benefit them.*

The questionnaire for parents has six items in section A, 26 items in section B and six items in section C that makes a total of 38 items altogether. The questionnaire for service organizations has two sections. Section A has six items that seek to establish whether organizations have counseled parents of children with hearing impairments and how many, as well as the qualifications of counselors in these organizations. Section B has seven items that seek to find out whether the counseling given to parents of children with hearing impairments helps them cope with their children. The questionnaire has a total of 13 items. The questionnaires used in this study can be found in appendixes D, H, K and L.

This description of the measurement techniques aims to give the reader a clear picture of the structure of the instruments used in the study and what they purport to measure.

3.10 DEVELOPMENT OF THE INSTRUMENT

Despite a thorough survey of all relevant literature, no suitable instrument was found which could be used in this particular study. Some of the key references that were consulted include, Colledge (2002), Nystul (1999), Babbie (1990), Howard (1996; 2000), Satterly (1981), Shepherd (1984), Oppenheim (1966) and Likert (1967). So instruments were made specifically for this study with the help of Babbie (1990:140, 149)'s examples. Some of the items were developed with the use of ideas from Oppenheim (1966:196).

Focusing on the statement of the problem, the instrument for the study was developed from an original pool of 62 items. Section B had 50 items and section C had 12 items. These items were given to staff and students in the Special Education and Counseling Department at the University of Zimbabwe, who were already qualified teachers. The main focus was on:

- *clarity of language*
- *relevance of each question to the information required*

- *equal numbers of positive and negative items*
- *no repetition*
- *items covering counseling from positive to negative extremes.*

In order to have a balanced pool, items in section B were grouped into three different categories as mentioned before:

- *did the parents receive any counseling*
- *who counseled them*
- *what were their perceptions of the counseling they received.*

With the help of experts in counseling at the Special Education Department at the University of Zimbabwe, the wording of certain questions was altered. Changes that were made by students and staff from the Special Education department reduced the items to 40. Section B had 30 items and section C had 10 items. However, before the questions were rewritten, a number of alterations regarding the order, wording, and what the instrument purported to measure were done with the help of professionals in the Special Education and Psychology departments. During this process the number of items dropped to 36. Section B now had 28 items and section C had eight items. Satterly (1981:97) and Shepherd (1984:124)'s response sets were considered. Out of the response sets outlined by Shepherd (1984:124), two of them had relevance to this study. These were the positional set and the category set. With the positional set the respondent repeatedly chooses right hand and left hand responses. This was controlled by randomizing scoring direction. As for category set, the respondent repeatedly chooses one type of response. Balancing positive and negative item responses controls this.

The final process, which was the pilot project, was aimed at the structure of the whole instrument, its relevance to the research questions, repetition of items, terms used in the wording and clarity of items. The pilot project was undertaken with 20 students who were studying for a Bachelor of Education Degree in Counseling, 20 students who were studying for a Bachelor of Education Degree in Special Education (Hearing Impairment) and 40 parents of children with hearing impairments who were not included in the main study, some lived in villages and others in small towns.

I carried out an item analysis to select the best statements for the instrument. As pointed out by Likert (1932:86) ideally the item analysis should take place by correlating each item with some reliable outside criterion of the aspects to be measured, retaining only the items with the highest correlations. However, Likert (1932:90) further asserts that such criteria are almost never available. In my case, the only available measurement was the total pool of items that I had carefully constructed. Purifying the items, so that they became consistent and homogeneous, would enable them to measure the same thing and achieve validity. I simply worked out correlation coefficients for each item with the total score minus the score of the item in question and retained those with the highest correlations. What it means is that for each item in turn, we will have a slightly different set of total scores. Dawes (1972:112) asserts that the subtraction procedure does not often make much difference and therefore many research workers do not bother with it. This serves as an internal-consistency method of item analysis, since no external criterion is available. An example is given where, say, out of 26 items, item 5 is considered for analysis. I have scores of 10 participants on the pool of all items, on item 5, and on the pool of all items minus their score on item 5. See table 3.10.1 adapted from Oppenheim (1996:199).

TABLE 3.10.1 ITEM ANALYSIS

Respondent	Total score	Score on item 5	Total score minus item 5
A	45	5	40
B	42	5	37
C	35	4	31
D	35	4	31
E	20	1	19
F	39	4	35
G	33	3	30
H	40	4	36
I	22	1	21
J	27	2	25

The relationship between item 5 and the total score minus the scores for item 5 was calculated and the relationship was very strong (r = .96). It must be pointed out that in this

study not all items obtained such a high relationship. However, the best 26 were selected on the final instrument. All items carry the same weight.

This further reduced the number of items to the 38 that made up the final questionnaire. After making sure that the questions in section B had an equal balance of positive and negative items, they were scattered and numbered 1-26 for the whole questionnaire. Section A had six items, section B had 26 items and section C had six items.

The questionnaire to Service Organizations (Hospitals, Churches, Special Schools for children with hearing impairments, and Counseling Organizations) was developed along the same lines, following the same stages. The final questionnaire had 16 items. Section A that deals with personal information had six items, section B that focused on parents of children with hearing impairments had six items and section C that dealt with counselors' perceptions of parents of children with hearing impairments had four open-ended questions.

3.10.1 CHOICE AND RATIONALE

It was important that I developed suitable questionnaires to use in this study. I chose to develop these instruments so that I could use them to collect comprehensive and reliable data for this study. The process of starting with a large pool of items, eliminating them to a smaller number through the use of university lecturers and students in different relevant departments until the final questionnaires were obtained, gives credit to the instruments. Carefully constructed questionnaires have good internal consistency and high-test re-test reliability. These instruments were tested through the pilot study and found to be reliable.

3.10.2 CONSEQUENCES

I was able to collect the required data using the instruments referred to above. Most of the participants in the study responded to almost all the multiple-choice questions. This may have been the case because the questionnaire did not require a lot of thinking and was not time consuming. Structured questionnaires are easy to analyze. About one quarter of the participants in the study did not answer open-ended questions. These needed thinking and

writing, and took time to complete. As a whole, comprehensive and reliable data were collected using these instruments.

3.11 SCORING OF THE SCALE

As emphasized by Dawes (1972:16), scoring must be consistent. Thus if it is decided that on a positive statement a high score of 5 is for Strongly Agree, then a score of 1 should be for Strongly Disagree. Negative statements must be scored with a 1 for Strongly Agree and a 5 for Strongly Disagree. It is important to take note of such reversals. On the Likert–type scale constructed for this particular study, responses were graded for each statement, and were expressed in terms of the following five categories, SA; A; U; D and SD. (SA) for Strongly Agree, (A) for Agree, (U) for Undecided, (D) for Disagree and (SD) for Strongly Disagree. The statements were either positive or negative. To score the scale, the responses were credited 5; 4; 3; 2 and 1 from the positive to the negative end or vice-versa. A "Strongly Agree" with a positive statement would receive a score of 5 as would "Strongly Disagree" with a negative statement. The sum of the item credits represented the individual's total score. Scoring keys were made in order to ease the scoring procedure.

3.11.1 CHOICE AND RATIONALE

I chose to score in the above manner in order to try to minimize guesswork. The scoring made it easy to record the data entries for analysis. The use of the positive and negative statements as well as reversals on scoring these statements, helped to indicate unreliable responses.

3.11.2 CONSEQUENCES

The use of the 5-point Likert scale gave the participants a wide choice of options to their responses. Most of the participants' responses matched the positive and negative questions appropriately. The scoring system helped to indicate inappropriate responses. The chief advantage of the Likert scale is that it is based on the respondent's perspectives rather than

on the researcher's construction. Coding and categorizing such data is easy and manageable.

3.12 VALIDITY AND RELIABILITY OF INSTRUMENT

I used my practical experiences of working with parents of and with children with hearing impairments for thirteen years as a teacher and counselor. I also reviewed literature from well-known researchers in the field of counseling: Rogers (1942; 1952; 1959), Howe (1989; 1993; 1996), Davis (1993), McLeod (1994; 1996; 1998; 2000), McCleod (1998), Howard (1996; 2000), Colledge (2002) and many others cited in the study.

Oppenheim (1996:23) maintained that reliability of Likert scales tends to be high, partly because of the greater range of answers permitted to participants. He goes on to say that a reliability coefficient of .85 is often achieved. By using the internal-consistency method of item selection, the scale approaches uni-dimensionality in many cases.

As mentioned above the instrument that was to be used on parents was administered to 20 students studying for a Bachelor's Degree in Counseling, 20 students who were studying for a Bachelor's Degree in Special Education (Hearing Impairment) and 20 parents of children with hearing impairments from small towns and villages, who did not take part in the main study. It was interesting to note that 38 of the students and 19 parents who marked a positive item also marked its direct negative one. Only four cases marked undecided on item 26 on the questionnaire.

The instrument that was to be used on Service Organizations was administered to 20 students studying counseling and also to their lecturers in the Education and Psychology Departments. All 20 students and eight lecturers who marked a positive item also marked its direct negative one. This gave the instruments some credibility in reliability and validity. Adams (1966:47) pointed out that the problem with attitude and perception scales is that they deal with verbalized attitude or perceptions rather than actions. The use of such an instrument does not guarantee future validity. The participants may not complete the questionnaires accurately. Attitudes and perceptions are not easy to measure since the responses depend entirely on the individual's complete honesty and the avoidance of the

tendency to give socially acceptable answers (Cohen & Holliday, 1982:253). As a whole however, the instrument was theoretically sound and its content satisfactory. Experienced staff and students in the Special Education Department, lecturing and studying counseling respectively, checked the content. Above all, an instrument devised for a specific purpose is more suitable than any of the published instruments (Satterly, 1981:87). As evidenced in the review of literature, the instrument to be used in this study will represent a first step in exploring and researching in the field of counseling parents of children with disabilities in Zimbabwe.

In this study I will use some of the guidelines on "Criteria for Evaluating the Validity of Quantitative and Qualitative Research" from Stiles (1993). These are as follows:

- *To ensure that the description of research procedure is clear and comprehensive. This includes sample selection and how the data were collected and analyzed.*

- *To conceptualize the study in its historical, social and cultural location.*

- *To systematically consider the alternative explanations or interpretations of data, so that the findings do not appear to be mere confirmation of one's initial or pre-existing biases.*

- *To give a detailed description of the study in such a way that another researcher would be able to replicate it. The results of the study should have general applicability and relevance to other studies.*

3.12.1 RATIONALE AND CONSEQUENCES

The results of the pilot study indicated consistency in the responses of the participants, which gives credibility to the instruments. The use of the positive and negative items together with the scoring system strengthened the reliability of the instruments. Most participants who marked a negative item also marked its direct positive counterpart. When the instrument that was used on parents was tested for response consistency, only four items out of 26 were not consistent. This is an indication that the instrument is valid and

reliable. The open-ended questionnaire to parents allowed them to express their feelings in terms of what they went through as they raised their children with hearing impairments.

3.13 METHODS OF DATA ANALYSIS

I will present analysis of quantitative data first, followed by qualitative data.

3.13.1 QUANTITATIVE DATA

The quantitative data for this study were analyzed using descriptive statistics. Descriptive statistics provides a method of reducing large data matrices to manageable summaries to permit easy understanding and interpretation. In this study descriptive statistics and the associations among variables summarize single variables. Using descriptive statistics I start with a set of data that is categorized, sorted, recorded and then interpreted. I then attempt to convey the essential characteristics of the data by arranging the data into a more interpretable form, forming frequency distributions and generating graphical displays as well as calculating numerical indexes such as frequencies and percentages. Variables are summarized in a data set, one at a time, and are also examined in how they interrelated (examining correlations). The key factor in descriptive statistics is how to communicate the essential characteristics of the data. One of the most basic ways to describe the data values of a variable is to construct a frequency distribution. A frequency distribution is a systematic arrangement of data values in which the data are rank ordered and the frequency of each unique data value is shown. In this study descriptive statistics is used to establish parents' perceptions of the counseling they received, whether or not they were able to cope with their children after counseling, who counseled them and also the qualifications of the people who counseled them.

3.13.2 RATIONALE AND CONSEQUENCES

I chose to use descriptive statistics due to the nature of the data collected for the study. This method allows for the description of the nature and characteristics of the data collected and how it will be used. Single variables and associations among variables can be

summarized using descriptive statistics. The maximum amount of information is maintained in the simplest summary form.

3.13.3 QUALITATIVE DATA

Qualitative analysis is used to analyze parents and counselors' responses to open-ended questions where they give their views and suggestions. This data will be used to complement the quantitative data and to gain a deeper understanding of the responses of the participants in the study.

3.13.4 RATIONALE AND CONSEQUENCES

I chose to use qualitative analysis on participants' responses to open-ended questions so that the information is brought out in its richest form. The message is contained in the feelings and emotions expressed by the participants as portrayed in their actual statements. Analysis of qualitative data is often complex and time consuming. The process involves categorization, sorting, recording and interpretation. Qualitative data provides an interpretation of people feelings and emotions.

3.13.5 ETHICAL STRATEGIES IN RESEARCH

As stated in chapter 1, informed consent was sought and it was explained to the parents and counseling organizations that participation in the study was voluntary and anyone could withdraw at any time. According to Capuzzi and Gross (1997:94) ethics is the philosophical study of moral value of human conduct and of the rules and principles that ought to govern it, or a code of behavior considered correct especially that of a particular group, profession or individual. It also involves the moral fitness of a decision and course of action taken. McCleod (2000:327) points out the paradox between research and counseling and psychotherapy where the therapy is normally conducted in private between client and counselor. On the other hand research implies making results public. According to Heppner (1992:78) "ethics are expressions of our values and a guide to achieving them". This closely follows the work of Hill, Thompson and Williams (1993:115) on ethics in research where they point out that ethics are central to research. Since

counseling is about privacy between the client and the counselor, whereas research is a public affair, ethics become the guiding principle that ensures the protection of the client as a participant in the research process (Woolfe & Dryden, 1998:57). He suggests that it is in the interest of ethics for the researcher to discuss his/her study limitations, the problems experienced during data collection and how these problems impacted on the quality of conclusions drawn from the results.

In this study parents and counseling organizations were notified verbally and in writing of the purpose of the study and of how the information they contributed was going to be used. They were also assured that they would be informed of the results of the study. Anonymity and confidentiality of individual contributions were upheld. Schools, churches, counseling organizations and hospitals were also informed of confidentiality and anonymity.

Trust is an important cornerstone in the counseling relationship, and central to the development and the maintenance of trust is the principle of confidentiality. The obligation of counselors to maintain confidentiality in their relationships with their clients is not absolute McCLeod (2000:3). However, counselors need to be aware of both the ethical and legal guidelines that apply. In distinguishing between "confidentiality" and "privileged communication," (Miles & Huberman, 1994:10), in a research context, it is important to keep in mind that confidentiality is an ethical concept, whereas privileged communication is a legal concept (Tesch, 1990:85). Confidentiality is defined as an ethical responsibility and a professional duty, which demands that information learned in private interaction with a client not be revealed to others. Professional ethical standards mandate this behavior except when the counselor's commitment to uphold client confidences must be set aside due to special or compelling circumstances or legal mandate (Arthur & Swanson, 1993:3). For example when a client is a danger to self or others. The law places physical safety above considerations of confidentiality or the right of privacy. Protection of the person takes precedence and includes the duty to warn. In this research anonymity is maintained within these boundaries.

In chapter 4, I will present and provide an analysis of the results of this study.

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4 PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS ACCESSING COUNSELLING SERVICES: RESEARCH RESULTS

4.1 INTRODUCTION

In this chapter I will present the research results from the questionnaire to parents and the interviews that were conducted. I will do this by first presenting the results by means of tables and graphical representations (e.g. bar charts and pie charts) and then by discussing each one of these findings. Results from the questionnaire to counseling organizations will also be presented. I will also present results from parents' views on how they thought counseling could be made more accessible. This chapter will only serve the purpose of presenting the results. In the next chapter I will discuss the research results from this study with the broader available literature and also by integrating it with the theoretical framework that has been discussed in chapter 2 of this thesis.

4.2 PRESENTATION AND INTERPRETATION OF RESULTS – AN OVERVIEW

Three hundred (300) parents of children with hearing impairments from the five main cities of the country, namely Harare, Bulawayo, Gweru, Masvingo and Mutare, completed three hundred questionnaires. Interviews were also conducted with the same parents to cross check the questionnaire responses. Two hundred and eighty two (282) parents responded to the open-ended questionnaire. In addition to 300 parents, a total number of 28 organizations took part in this study. Five special schools, five hospitals, three counseling organizations and 15 churches completed 28 questionnaires prepared for counseling service organizations. All 28 organizations responded to the open-ended questionnaire.

There was a 100% response rate mainly because the questionnaires were self administered and collected on the same day. It is possible that parents expected the study to bring quick solutions to their problems and so everybody wanted their contributions to be put forward. It could also have been due to the fact that it was emphasized to parents that if they wanted

to leave early, they could either put the questionnaires in the box from which they took them or hand them to me directly. Most parents spent the day with their families supporting their child with a hearing impairment and only left at the required time, half past four in the afternoon. The questionnaire response rate was exceptional although not all the questions were fully completed.

Throughout this study, graphical representations and tables are identified by the relevant chapter number, which is used as a prefix, followed by the sequence number in which they appear in the chapter.

4.3 QUANTITATIVE ANALYSIS ON THE QUESTIONNAIRE TO PARENTS

The word "parents" refers to representatives of the families that took part in the study, in the form of a wife or husband/or both. If both parents took part in the study, they completed one questionnaire and were considered as one parent (a couple). Participants in this study refer to parents and therefore the terms parents and participants or parent-participants will be used alternatively to avoid monotony. Although frequencies of results are shown in both raw scores and percentages, I will use percentages to report the results in the graphic representations. Before I present the results, I will provide biographical details of children with hearing impairments and of their parents.

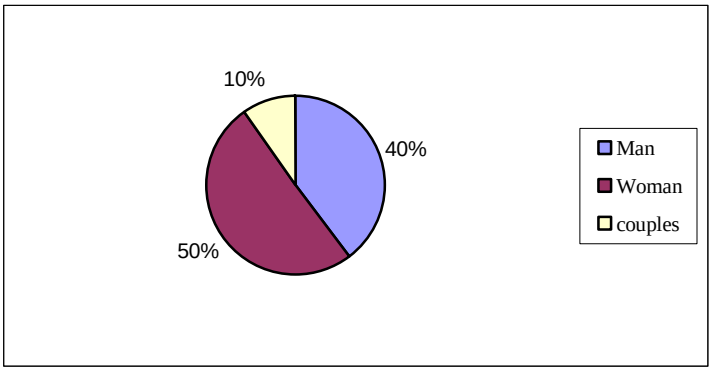
4.3.1 BIOGRAPHICAL DETAILS OF PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS AND OF THEIR CHILDREN

Items 'i' to 'v' on the questionnaire are represented by tables 4.3.1.1 to 4.3.1.5 that contain biographical details of parents of children with hearing impairments and that of their children.

FIGURE 4.3.1.1 (ITEM I) GENDERS OF PARTICIPANTS IN THE STUDY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Men	*119*	*39.7*	*39.7*	*39.7*

		Frequency	Percent	Valid Percent	Cumulative Percent
	Women	*152*	*50.7*	*50.7*	*90.3*
	Couples	*29*	*9.7*	*9.7*	*100.0*
	Total	*300*	*100.0*	*100.0*	

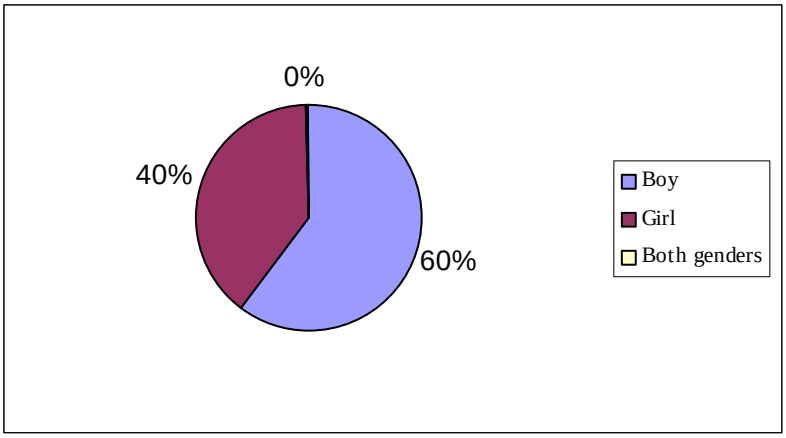


Of the 300 parents who responded to item (i), 40% were men, 50% were women and 10% were couples. It is interesting to note that there is such a high number of men in this sample, because usually mothers are much more involved with a child with disability. However, it can also be explained that the parents' main reason for coming was not the study but to spend a day with the family, interacting and sharing ideas with other parents, which has always been the tradition. It is also at such meetings that parents discuss the future of their children with the school authorities and have to make a commitment by signing documents for secondary or vocational education, especially for those children completing primary education. This could have necessitated the attendance of a large number of fathers. Studies by Bristol and Gallagher (1986:92) and Kazak and Marvin (1984:69), point out that fathers of children with disabilities play a peripheral parental role when compared to mothers. Seligman and Darling (1989:153) assert that through their attitude towards their wives and families, fathers affect the way in which mothers interact with a child with hearing impairments. Moores (1996:31) points out that traditionally, fathers have not played a large role in continuous relationships with professionals such as counselors, specialist teachers, speech therapists and psychologists. In most cases fathers would not take the responsibility of attending counseling, parental or consultation meetings (Moores & Meadow-Orlans, 1990:306). However, in their study, Cartwright, Cartwright and Ward (1995:398) noted that fathers have also only recently become a source of study in

the families of children with disabilities. In this study, the high percentage of participants who were fathers, will contribute to this emerging body of knowledge.

FIGURE 4.3.1.2: (ITEM II) GENDER OF CHILDREN OF PARTICIPANTS IN THE STUDY

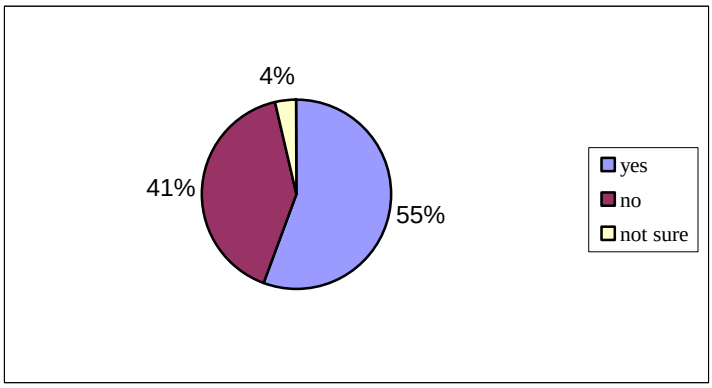
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Boy	*180*	*60.0*	*60.0*	*60.0*
	Girl	*119*	*39.7*	*39.7*	*99.7*
	Both	*1*	*.3*	*.3*	*100.0*
	Total	*300*	*100.0*	*100.0*	



Out of 300 participants, 60% of the parents' children were boys, 40% of the parents' children were girls and .3% of the parents had a girl and a boy with a hearing impairment. However, in the graph percentages are rounded off to the nearest ten and so .3% is indicated as zero percent. According to Cartwright, Cartwright and Ward (1995:271); Meadow (1996:86) and Moores and Meadow (1990:347), deafness is more prevalent in boys than in girls although the difference is not significant. A study by Vernon and Andrews (1990:158) indicates that after screening a pool of children, out of 566 children who were confirmed to be having hearing impairments, (286) 51% were boys and (280) 49% were girls.

FIGURE 4.3.1.3 (ITEM III) MY CHILD WAS BORN DEAF

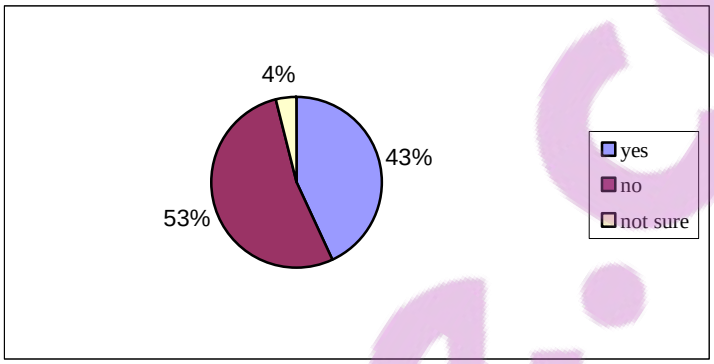
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	*165*	*55.0*	*55.0*	*55.0*
	No	*123*	*41.0*	*41.0*	*96.0*
	Not sure	*12*	*4.0*	*4.0*	*100.0*
	Total	*300*	*100.0*	*100.0*	



Out of 300 parents who responded to item (iii), 55% of the parents' indicated that their children were born deaf, 41% of the parents indicated that their children became deaf later, and 4% of the parents did not know whether their children were born deaf or whether they acquired deafness later. A study carried out by Moores and Meadow (1990:123), indicates that out of data presented on 200 children with hearing impairments, 55% were born deaf, 43% acquired deafness later in life through diseases and accidents and 2% were not known. The two acknowledged that it was sometimes impossible to ascertain when and how a child became deaf. In another study by Moores (1996:85), where he carried out an analysis on 619 children with hearing impairments, he established that (290) 47% were born deaf, (252) 41% acquired deafness through other means and (77) 12% were deaf through unknown causes. It seems therefore that there is a high correlation between the etiological factors for the children of the participants in this study, and that of other studies that relate to children with hearing impairments.

FIGURE 4.3.1.4 (ITEM IV) MY CHILD BECAME DEAF LATER

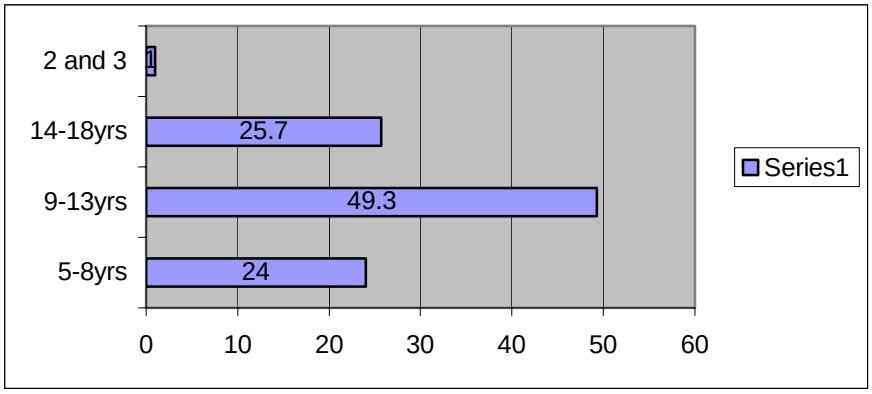
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	*129*	*43.0*	*43.0*	*43.0*
	No	*159*	*53.0*	*53.0*	*53.0*
	Not sure	*12*	*4.0*	*4.0*	*100.0*
	Total	*300*	*100.0*	*100.0*	



Out of 300 parents who responded to item (iv), 53% indicated that their children did not become deaf later, while 43% of the parents indicated that their children became deaf later and 4% of the parents indicated that they did not know whether their children were born deaf or they acquired deafness later. It is interesting to note the inconsistency in responses to question (iii) and question (iv) When the statement was given as "My child was born deaf" 55% indicated "yes" and when it was stated "My child became deaf later" 53% indicated "no" instead of 55%. The same with children who are said to have become deaf later, in (ii) they are indicated as 41% and here they are indicated as 43%. This may mean that some parents were not quite sure as to whether their children were born deaf or acquired deafness later, as pointed out earlier on by Moores and Meadow (1990:123). It is interesting to note that parents can remain hesitant as attributing the causes of hearing impairment in their child.

FIGURE 4.3.1.5 (ITEM V) HOW OLD IS YOUR CHILD?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	5-8yrs	*72*	*24.0*	*24.0*	*24.0*
	9-13yrs	*148*	*49.3*	*49.3*	*73.3*
	14-18yrs	*77*	*25.7*	*25.7*	*99.0*
	2 and 3	*3*	*1.0*	*1.0*	*100.0*
	Total	*300*	*100.0*	*100.0*	



(2 & 3) refers to parents with more than one child with hearing impairments in the age groups 14-18 years and also 9-13 years respectively.

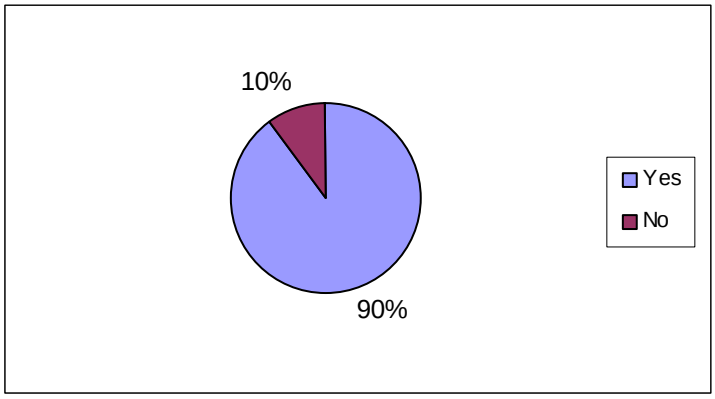
Out of 300 parents who responded to item (v), 24% had children between the ages of five and eight, 49% had their children between the ages of nine and 13, 26% had children between the ages of 14 and 18 and 1% of the parents had children between nine and 13 and also between 14 and 18. In developing countries screening methods are very poor due to inadequate equipment and lack of qualified personnel (Nolan & Tucker, 1981:49 and Moores & Meadow, 1990:114). Most children with hearing impairments are identified at a late stage and therefore are enrolled late as well at the ages of nine or 10. This is further confirmed by the findings of Chimedza (1986) when he carried out a study in Zimbabwe in special schools for children with hearing impairments. Some children are hidden due to superstitious beliefs while others are hidden due to feelings of inadequacy and/or ignorance (Baine, 1988:16 and UNESCO 1981:48). Such children are sometimes discovered at a late age and put in a special school in standard one at the age of 10 years. This may explain

why 49% of the parents have children between nine and 13 years and 25% have children between the ages of 14 and 18 years. From my own experiences as a teacher of children with hearing impairments for 23 years, it is very likely that parents of some of these children come from rural areas where they have limited resources in terms of transport and even lack of knowledge of special schools and the procedure of enrolling a child in a special school. They may also take time to acquire the required boarding or and tuition fees for the child. By the time the necessary funds are secured, the child will have lost a considerable amount of schooling time.

4.3.2 QUANTITATIVE RESULTS ON COUNSELING

FIGURE 4.3.2.1 (ITEM VI) DID YOU RECEIVE ANY COUNSELING AT ALL?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	*270*	*90.0*	*90.0*	*90.0*
	No	*30*	*10.0*	*10.0*	*100.0*
	Total	*300*	*100.0*	*100.0*	

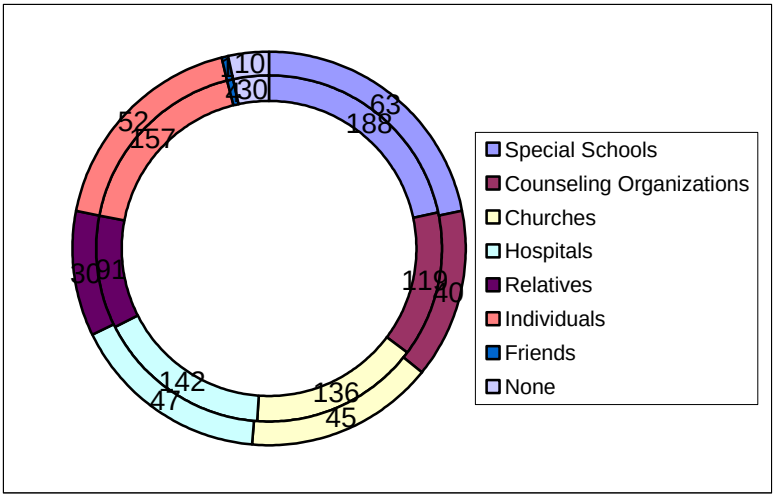


Out of 300 parents who responded to item (vi), 90% said they received counseling and 10% said they did not receive counseling. Nystul (1999) and Kirk, Gallagher and Anastasiow (1997) point out that most parents of children with hearing impairments go through counseling in one way or another. According to Moores (1996) most parents receive counseling from professional counselors, individuals, members of the extended family, specialist teachers, and psychologists or from churches. On the definition of counseling

Howard (1992:37), points out that counseling has always existed and will continue to exist and therefore almost everyone has a chance to receive counseling. Hallahan and Kauffman (1994:498) assert that some parents confuse counseling with advice. They further point out that sometimes parents are given both and may find it difficult to distinguish the one from the other. For the purposes of this study, I assume that the use of the term "counseling" in the formulation of the question may also include advice giving for the participants in the study.

FIGURE 4.3.2.2 PARTICIPANTS' SOURCES OF COUNSELING

Sources of Counseling	Count	Column%
Special Schools	*188*	*63.1*
Counseling Organization	*119*	*39.9*
Churches	*136*	*45.3*
Hospitals	*142*	*47.3*
Relatives	*91*	*30.3*
Individuals	*157*	*52.0*
Friends	*4*	*1.3*
None	*30*	*10.0*



All 300 parents responded to sources of counseling indicating where they were counseled. The results indicate that (188) 63% of the parents got counseling from special schools, (119) 40% from registered counseling organizations, (136) 45% from churches, (142) 47%

from hospitals, (91) 30% from relatives, (157) 52% from individuals, (4) 1% from friends and (30) 10% did not get any counseling at all. Moores and Meadow (1990:137) pose it that the child with hearing impairments presents the family with specific problems that may result in shock, shame, guilt, anger, sadness, denial and finally failure to adjust (Featherstone, 1980:498). Many move through a grieving process as though the child had died (Turnbull & Turnbull, 1990:24). With all these terrifying feelings going through the parents' minds, counseling is needed to help parents work through their emotions and come to terms with their problems. Many parents approach various professionals for counseling, advice and treatment of the child. According to Hallahan (1992:522) parents of children with hearing impairments visit doctors, counseling clinics, school counselors in special schools as well as registered counseling organizations. Hallahan and Kauffman (1994:489) further point out that some parents turn to other parents who have children with hearing impairments and share experiences. As noted by Featherstone (1980:496) many parents have found parents' support groups to be effective in both sharing experiences and offering emotional support. While families obtain a lot of support from friends, relatives and members of the extended family, they prefer to get counseling from professional counselors in counseling organizations and special schools as well as from churches (Vernon & Andrews, 1990:141). In their research in which they interviewed 120 parents, Hardman, Drew, Egan and Wolf (1993:295), indicate that most parents do not bother much about the source of counseling as long as they get help for their children. Considering all the above factors, it is clear that parents do not have hard and fast rules as to who to approach for counseling as long as they obtain professional help for their children.

4.3.3 NEGATIVELY PHRASED ITEMS

Table 4.3.2.1(a) indicates results of participants to the negatively phrased items. I present these results by indicating the cumulative sum for all the responses on each of the scale points. I also present it as percentage of the total number of responses for a given question.

TABLE 4.3.3.1(a) NEGATIVELY PHRASED ITEMS

Questions	Strongly Agree		Agree		Undecided		Disagree		Strongly Disagree		Total	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
1. Parents of children with hearing impairments do not need.	*8*	*2.7*	*8*	*2.7*	*2*	*.7*	*112*	*37.3*	*170*	*56.7*	*300*	*100.0*
2.Counseling is totally different from advice.	*34*	*11.4*	*93*	*31.2*	*15*	*5.0*	*106*	*35.6*	*50*	*16.8*	*298*	*99.3*
4. Counseling did not help us to understand the needs of our child.	*14*	*4.8*	*21*	*7.2*	*17*	*5.8*	*154*	*52.9*	*85*	*29.2*	*291*	*97.0*
5. Counseling does not help parents to accept the idea of having a hearing impaired child in the family.	*13*	*4.4*	*35*	*11.9*	*15*	*5.1*	*141*	*48.0*	*90*	*30.6*	*294*	*98.0*
6. Children who are hearing impaired should be looked after by the Social Welfare.	*15*	*5.1*	*53*	*18.1*	*12*	*4.1*	*163*	*55.6*	*50*	*17.1*	*293*	*97.6*
8. We do not allow our child to play with other children in our community because they may not treat him well.	*19*	*6.4*	*37*	*12.5*	*10*	*3.4*	*121*	*40.9*	*109*	*36.8*	*296*	*98.6*
9. My child does not relate well and interact effectively with other members of the family.	*19*	*6.3*	*88*	*29.3*	*14*	*4.7*	*124*	*41.3*	*55*	*18.3*	*300*	*100.0*
10. Most people, who counseled us, told us what to do.	*34*	*11.8*	*147*	*50.9*	*18*	*6.2*	*69*	*23.9*	*21*	*7.3*	*289*	*96.3*
12. The counseling we received did not help us to cope with the child at all.	*6*	*2.0*	*59*	*20.1*	*17*	*5.8*	*152*	*51.9*	*59*	*20.1*	*293*	*97.6*

Questions	Strongly Agree		Agree		Undecided		Disagree		Strongly Disagree		Total	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
15. It is almost impossible to plan the future of a child who is hearing impaired.	*82*	*27.8*	*141*	*47.8*	*20*	*6.8*	*40*	*13.6*	*12*	*4.1*	*295*	*983*
16. People who counseled us did not give us guidance at all.	*28*	*10.0*	*47*	*16.8*	*63*	*22.5*	*104*	*37.1*	*38*	*13.6*	*280*	*93.3*
21. Parents can equally do well for their child without guidance and counseling.	*19*	*6.5*	*81*	*27.8*	*43*	*14.8*	*105*	*36.1*	*43*	*14.8*	*291*	*97.0*

TABLE 4.3.3.1(b) POSITIVELY PHRASED ITEMS

Questions	Strongly Agree		Agree		Undecided		Disagree		Strongly Disagree		Total	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
7. Counseling helped me to plan the future of my child.	*25*	*8.4*	*62*	*20.9*	*18*	*6.1*	*131*	*44.1*	*61*	*20.5*	*297*	*99.0*
11. Counseling is a must for parents of children with hearing impairments.	*8*	*2.7*	*14*	*4.7*	*16*	*5.3*	*144*	*48.0*	*116*	*38.7*	*300*	*100.0*
13. I am aware of organizations that offer I in Zimbabwe.	*42*	*14.2*	*78*	*26.4*	*16*	*5.4*	*100*	*33.9*	*59*	*20.0*	*295*	*98.3*
14. My child fits well and interacts effectively with family members.	*14*	*4.7*	*60*	*20.0*	*10*	*3.3*	*158*	*52.7*	*58*	*19.3*	*300*	*100.0*
17. Without counseling one cannot fully accept having a child with hearing impairment in the family.	*19*	*6.4*	*41*	*13.9*	*11*	*3.7*	*137*	*46.3*	*88*	*29.7*	*296*	*98.6*

Questions	Strongly Agree		Agree		Undecided		Disagree		Strongly Disagree		Total	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
18. With or without help from other organizations, it is parents' responsibility to fully cater for their children who are hearing impaired.	*15*	*5.1*	*48*	*16.3*	*7*	*2.4*	*146*	*49.5*	*79*	*26.8*	*295*	*98.3*
19. We allow our child to make friends and play with other children in our neighborhood.	*8*	*1.7*	*19*	*6.4*	*11*	*3.7*	*193*	*65.2*	*65*	*22.0*	*296*	*98.6*
20. The problem with counseling is that one is not provided with answers.	*28*	*9.9*	*108*	*38.2*	*52*	*18.4*	*81*	*28.6*	*14*	*4.9*	*283*	*94.3*
22. Counseling really helped us to understand the child.	*8*	*2.7*	*16*	*5.4*	*16*	*5.4*	*156*	*52.9*	*99*	*33.6*	*295*	*98.3*
23. Counselors also referred me to other professionals for further help.	*36*	*12.4*	*74*	*25.5*	*22*	*7.6*	*110*	*37.9*	*48*	*16.6*	*290*	*96.6*
24.Counseling helped us to cope with our child who is hearing impaired.	*3*	*1.0*	*27*	*9.1*	*16*	*5.4*	*166*	*56.1*	*84*	*28.4*	*296*	*98.6*
25. Guidance and counseling are important for both parents and the child.	*26*	*8.8*	*71*	*24.1*	*12*	*4.1*	*114*	*38.6*	*72*	*24.4*	*295*	*98.3*
26. It is difficult to separate counseling from advice.	*39*	*13.3*	*97*	*33.1*	*33*	*11.3*	*97*	*33.1*	*27*	*9.2*	*293*	*97.6*

Table 4.3.3.1(b) above indicates results of participants to the positively phrased items. Again I present these results by indicating the cumulative sum for all these responses on

each of the scale points. I also present it as a percentage of the total number of responses for a given question.

Tables 4.3.8.1 to 4.3.8.26 are a further analysis of parents' responses to the whole questionnaire, item by item.

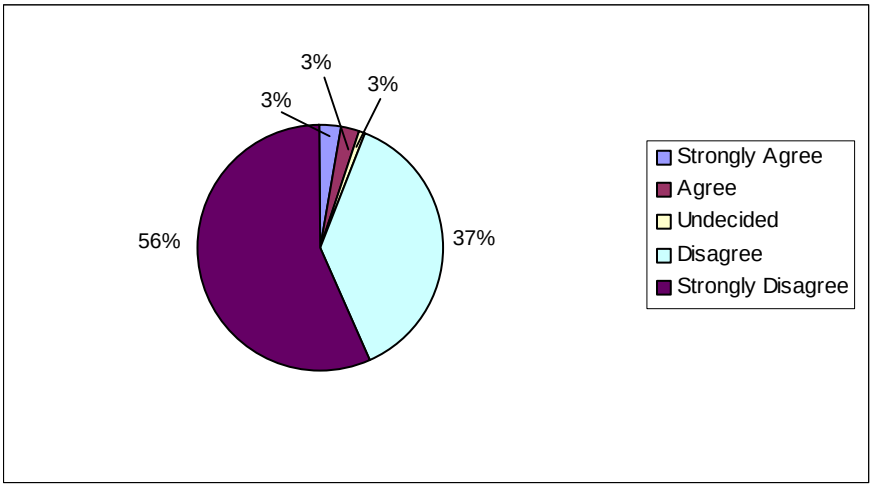
All 300 parents responded to items 1, 3, 9 and 14. Two hundred and ninety eight (298) responded to items 2 and 11. Two hundred and ninety seven (297) responded to item 7. Two hundred and ninety six (296) responded to items 8, 17, 19 and 24 and 295 responded to items 13, 15, 18, 22 and 25. Two hundred and ninety four (294) responded to item 5 while 293 responded to items 6, 12 and 26. Two hundred and ninety one (291) parents responded to items 4 and 21. Two hundred and ninety (290) responded to item 23. Two hundred and eighty nine (289) responded to item 10. Two hundred and eighty three (283) parents responded to item 20 and 280 responded to item 16. Results are indicated in the respective tables and summaries of results.

In the next section I will present the results to each of the items graphically, to give a visual representation of the results per item. I will use both graphs and tables for this purpose, mainly to give a vivid clear picture of the results. In the short synopsis that follows each graph and table, I will combine the results on each side of the response scale in order to form three categories for responses: Agree, Disagree and Undecided. The graphic representation will therefore give a slightly more nuanced version of the results, whereas the syntactical description will delineate the results by simplifying the continuum of these responses.

FIGURE 4.3.8.1 (ITEM 1) PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS DO NOT NEED COUNSELING

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*8*	*2.7*	*2.7*	*2.7*
	Agree	*8*	*2.7*	*2.7*	*5.3*
	Undecided	*2*	*.7*	*.7*	*6.0*
	Disagree	*112*	*37.3*	*37.3*	*43.3*

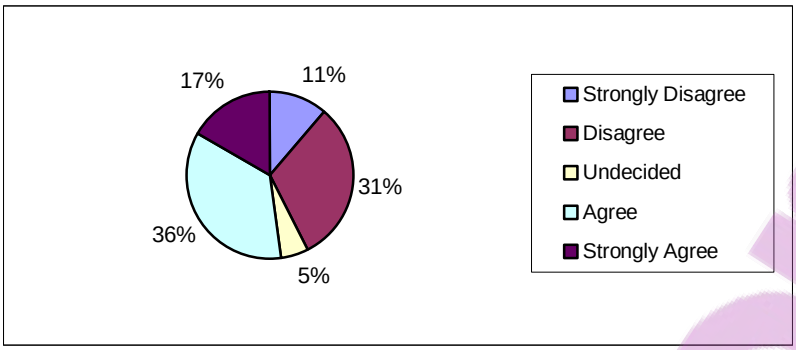
		Frequency	Percent	Valid Percent	Cumulative Percent
	Strongly Disagree	*170*	*56.7*	*56.7*	*100.0*
	Total	*300*	*100.0*	*100.0*	



Of 300 parents who responded to item 1, 6% agreed with the statement, 93% disagreed and 1% was undecided.

Table 4.3.8.2 (Item 2) Counseling is totally different from advice

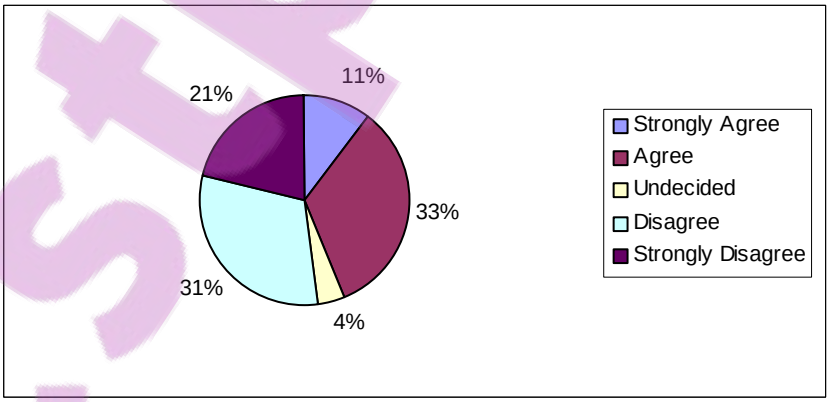
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*34*	*11.3*	*11.4*	*11.4*
	Disagree	*93*	*31.0*	*31.2*	*42.6*
	Undecided	*15*	*5.0*	*5.0*	*47.7*
	Agree	*106*	*35.3*	*35.6*	*83.2*
	Strongly Agree	*50*	*16.7*	*16.8*	*100.0*
	Total	*298*	*99.3*	*100.0*	
Missing	System	*2*	*.7*		
Total		*300*	*100.0*		



Of the 298 parents who responded to item 2, 53% agreed with the statement, 42% disagreed and 5% were undecided.

FIGURE 4.3.8.3 (ITEM 3) I AM NOT AWARE OF ANY ORGANIZATION THAT OFFERS COUNSELING IN ZIMBABWE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*32*	*10.7*	*10.7*	*10.7*
	Agree	*99*	*33.0*	*33.0*	*43.7*
	Undecided	*12*	*4.0*	*4.0*	*47.7*
	Disagree	*93*	*31.0*	*31.0*	*78.7*
	Strongly Disagree	*64*	*21.3*	*21.3*	*100.0*
	Total	*300*	*100.0*	*100.0*	

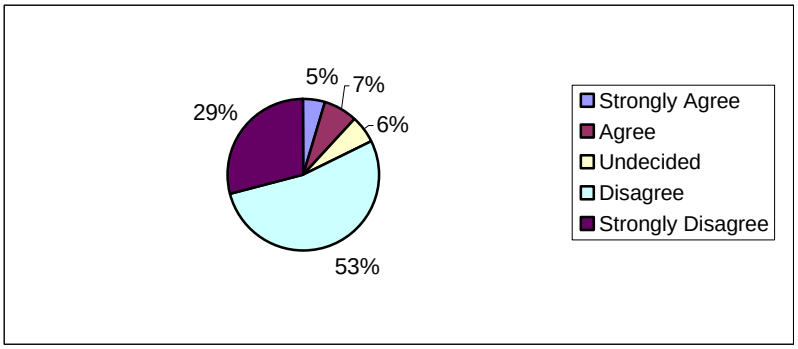


Of the 300 parents who responded to item 3, 44% agreed with the statement, 52% disagreed and 4% were undecided. It is interesting to note that the groups of parents who are aware

and those who are not aware of counseling organizations are almost equal. The indication is that there are almost as many people in this group of participants who are not aware of counseling organizations as those who are aware, with the latter being a slightly larger group.

FIGURE 4.3.8.4 (ITEM 4) COUNSELING DID NOT HELP US TO UNDERSTAND THE NEEDS OF OUR CHILD

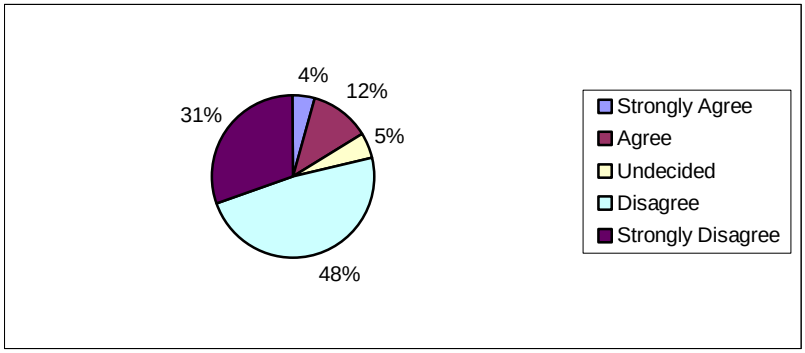
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*14*	*4.7*	*4.8*	*4.8*
	Agree	*21*	*7.0*	*7.2*	*12.0*
	Undecided	*17*	*5.7*	*5.8*	*17.9*
	Disagree	*154*	*51.3*	*52.9*	*70.8*
	Strongly Disagree	*85*	*28.3*	*29.2*	*100.0*
	Total	*291*	*97.0*	*100.0*	
Missing	System	*9*	*3.0*		
Total		*300*	*100.0*		



Of the 291 parents that responded to item 4, 12% agreed with the statement, 82% disagreed and 6% were undecided. It appears that most parents were of the opinion that they benefited from counseling in understanding the needs of their child.

FIGURE 4.3.8.5 (ITEM 5) COUNSELING DOES NOT HELP PARENTS TO ACCEPT THE IDEA OF HAVING A HEARING IMPAIRED CHILD IN THE FAMILY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*13*	*4.3*	*4.4*	*4.4*
	Agree	*35*	*11.7*	*11.9*	*16.3*
	Undecided	*15*	*5.0*	*5.1*	*21.4*
	Disagree	*141*	*47.0*	*48.0*	*69.4*
	Strongly Disagree	*90*	*30.0*	*30.6*	*100.0*
	Total	*294*	*98.0*	*100.0*	
Missing	System	*6*	*2.0*		
Total		*300*	*100.0*		

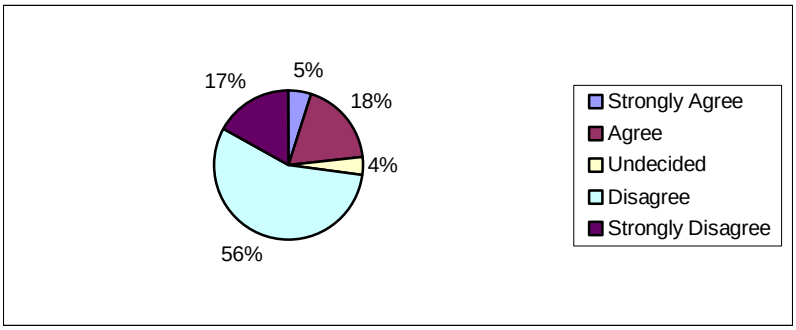


Of the 294 parents who responded to item 5, 16% agreed with the statement, 79% disagreed and 5% were undecided. It would appear that parents believe counseling helps them to accept and integrate the child with hearing impairments into the family. Studies carried out by Cartwright, Cartwright and Ward (1990:398) and Hallahan and Kauffman (1994:496), indicate that counseling did not only help parents of children with hearing impairment to accept their children, but further increased their bonding and family integration.

FIGURE 4.3.8.6 (ITEM 6) CHILDREN WHO ARE HEARING IMPAIRED SHOULD BE LOOKED AFTER BY THE SOCIAL WELFARE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*15*	*5.0*	*5.1*	*5.1*

		Frequency	Percent	Valid Percent	Cumulative Percent
	Agree	*53*	*17.7*	*18.1*	*23.2*
	Undecided	*12*	*4.0*	*4.1*	*27.3*
	Disagree	*163*	*54.3*	*55.6*	*82.9*
	Strongly Disagree	*50*	*16.7*	*17.1*	*100.0*
	Total	*293*	*97.7*	*100.0*	
Missing	System	*7*	*2.3*		
Total		*300*	*100.0*		



Of the 293 parents who responded to item 6, 23% agreed with the statement, 73% disagreed and 4% were undecided. A number of authorities, Tucker and Nolan (1984:115); Kirk, Gallagher and Anastasiow (1997:380); Seligman and Darling (1989:225) contend that although parents go through shock, anger, guilt and denial, they own total responsibility for their children with hearing impairments. A study by Turnbull and Turnbull (1990:187), in which they interviewed 250 parents, indicated that all parents expressed feelings of love and responsibility for their children.

FIGURE 4.3.8.7 (ITEM 7) COUNSELING HELPED ME TO PLAN THE FUTURE OF MY CHILD

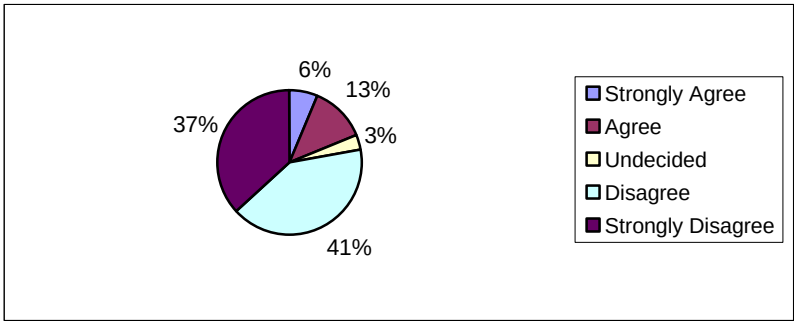
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*25*	*8.3*	*8.4*	*8.4*
	Disagree	*62*	*20.7*	*20.9*	*29.3*
	Undecided	*18*	*6.0*	*6.1*	*35.4*
	Agree	*131*	*43.7*	*44.1*	*79.5*
	Strongly Agree	*61*	*20.3*	*20.5*	*100.0*
	Total	*297*	*99.0*	*100.0*	

Missing	System	*3*	*1.0*		
Total		*300*	*100.0*		

Of the 297 parents who responded to item 7, 65% agreed with the statement, 29% disagreed and 6% were undecided.

FIGURE 4.3.8.8 (ITEM 8) WE DO NOT ALLOW OUR CHILD TO PLAY WITH OTHER CHILDREN IN OUR COMMUNITY BECAUSE THEY MAY NOT TREAT HIM WELL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*19*	*6.3*	*6.4*	*6.4*
	Agree	*37*	*12.3*	*12.5*	*18.9*
	Undecided	*10*	*3.3*	*3.4*	*22.3*
	Disagree	*121*	*40.3*	*40.9*	*63.2*
	Strongly Disagree	*109*	*36.3*	*36.8*	*100.0*
	Total	*296*	*98.7*	*100.0*	
Missing	System	*4*	*1.3*		
Total		*300*	*100.0*		

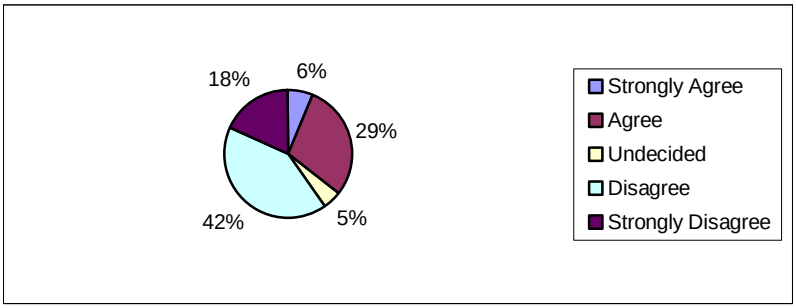


Of the 296 parents who responded to item 8, 19% agreed with the statement, 78% disagreed and 3% were undecided. This question was included in the questionnaire mainly to find out if parents had been given adequate guidance in terms of how they should facilitate the socialization process of their child with hearing impairments. Tucker and Nolan (1984:113) contend that, when counseling parents of children with hearing impairments, there should be proper guidance given in terms of how parents

should handle other siblings and the importance of interaction between the child in question and his/her siblings as well as other children of the same age. This process is important for the social, psychological and language development of the child with hearing impairments. Therefore I wanted to establish whether parents were made aware of this important aspect concerning their child with hearing impairments. Not allowing the child to interact with other children would deprive him/her quality time of socialization with children of the same age.

FIGURE 4.3.8.9 (ITEM 9) MY CHILD DOES NOT RELATE WELL AND INTERACT EFFECTIVELY WITH OTHER MEMBERS OF THE FAMILY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*19*	*6.3*	*6.3*	*6.3*
	Agree	*88*	*29.3*	*29.3*	*35.7*
	Undecided	*14*	*4.7*	*4.7*	*40.3*
	Disagree	*124*	*41.3*	*41.3*	*81.7*
	Strongly Disagree	*55*	*18.3*	*18.3*	*100.0*
	Total	*300*	*100.0*	*100.0*	

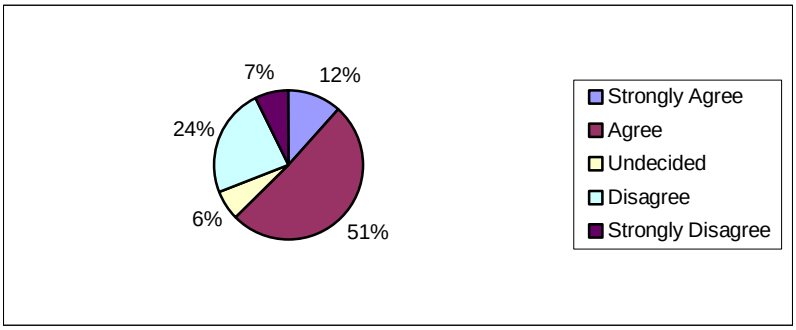


Of the 300 parents who responded to item 9, 35% agreed with the statement, 60% disagreed and 5% were undecided. This question is significant in terms of how the child with hearing impairments relates to his/her siblings. According to Hallahan and Kauffman (1994:499) although a large body of literature pertains to parental reactions, recent studies indicate that siblings frequently experience the same emotions of shock, fear, anger and guilt. Parents have an important role to play ensuring that there is effective interaction amongst all the children. Guidance and counseling has a part to play in order to help parents promote

family harmony. Parents need proper guidance and counseling to facilitate and promote understanding among their hearing children and the child with a hearing impairment. Another study by Moores (1996:263) indicates that if parents are not counseled and guided they may pay almost all their attention to the child with hearing impairment and neglect other children. This may create feelings of not being loved in other children.

FIGURE 4.3.8.10 (ITEM 10) MOST PEOPLE WHO COUNSELED US TOLD US WHAT TO DO

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*34*	*11.3*	*11.8*	*11.8*
	Agree	*147*	*49.0*	*50.9*	*62.6*
	Undecided	*18*	*6.0*	*6.2*	*68.9*
	Disagree	*69*	*23.0*	*23.9*	*92.7*
	Strongly Disagree	*21*	*7.0*	*7.3*	*100.0*
	Total	*289*	*96.3*	*100.0*	
Missing	System	*11*	*3.7*		
Total		*300*	*100.0*		

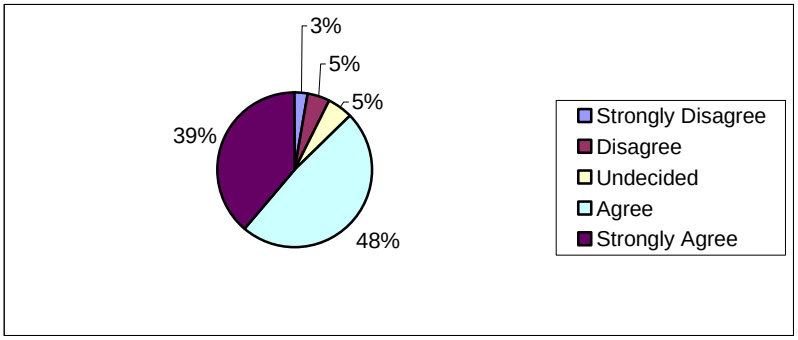


Of the 289 parents who responded to item 10, 63% agreed with the statement, 31% disagreed and 6% were undecided. Different counselors employ different basic counseling techniques depending on the needs of the clients. Most western counseling techniques are non-directive while most traditional techniques are directive. Counseling techniques are vitally important in establishing counseling relationships, empathy, listening skills and creating a conducive environment for the clients to work through their emotions and think rationally in order to find possible solutions to their problems (Nystul, 1999:193 and Hallahan & Kauffman, 1994:498). In this case the counselor facilitates the conversation

and gives the client an opportunity to look at his/her problem from a positive standpoint. Whereas traditional counseling is directive and involves advice giving (Mbiti, 1990:15). This is mainly carried out by elders in the church, community and members of the extended family (Richards, 2000:149). However, it must be pointed out that in both western and traditional approaches, there are non-directive and directive counseling.

FIGURE 4.3.8.11 (ITEM 11) COUNSELING IS ESSENTIAL FOR PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS

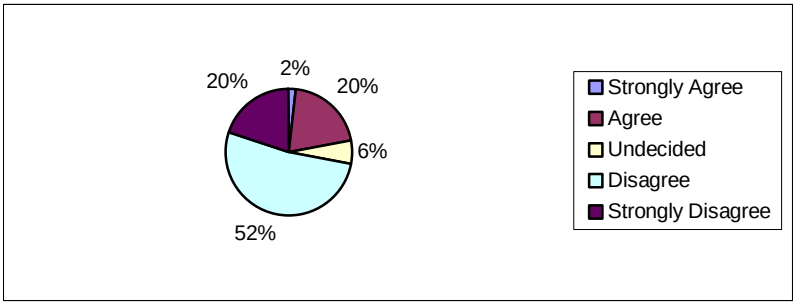
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*8*	*2.7*	*2.7*	*2.7*
	Disagree	*14*	*4.7*	*4.7*	*7.3*
	Undecided	*16*	*5.3*	*5.3*	*12.7*
	Agree	*144*	*48.0*	*48.0*	*60.7*
	Strongly Agree	*116*	*38.7*	*38.7*	*99.3*
	Missing	*2*	*.7*	*.7*	*100.0*
	Total	*300*	*100.0*	*100.0*	



Of the 298 parents who responded to item 11, 87% agreed with the statement, 8% disagreed and 5% were undecided. These results clearly complement the literature that validates the counseling need of parents of children with hearing impairments (Luterman, 1991:316; Martin & Clark, 1996:193 and McConkey & Templer, 1986:68). As pointed out by Moores (1996:374), the question is not whether parents need counseling or not but whether they are able to access the counseling services they desperately require.

FIGURE 4.3.8.12 (ITEM 12) THE COUNSELING WE RECEIVED DID NOT HELP US TO COPE WITH THE CHILD AT ALL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*6*	*2.0*	*2.0*	*2.0*
	Agree	*59*	*19.7*	*20.1*	*22.2*
	Undecided	*17*	*5.7*	*5.8*	*28.0*
	Disagree	*152*	*50.7*	*51.9*	*79.9*
	Strongly Disagree	*59*	*19.7*	*20.1*	*100.0*
	Total	293	*98.8*	*100.0*	
Missing	System	*7*	*2.3*		
Total		*300*	*100.0*		

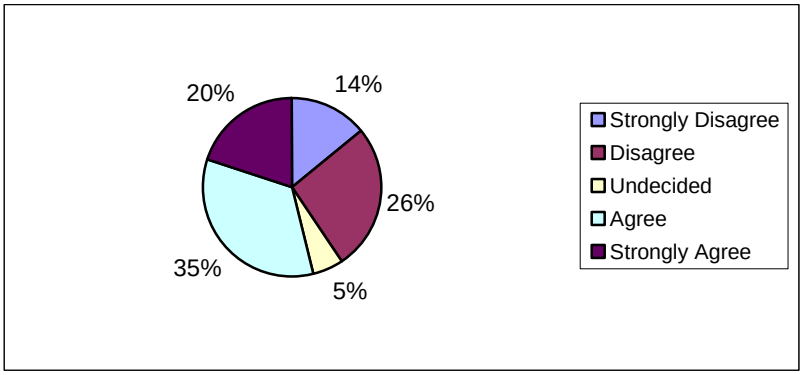


Of the 293 parents who responded to item 12, 22% agreed with the statement, 72% disagreed and 6% were undecided. These results indicate that counseling helped most of the parents to cope with their children with hearing impairments. A study by Hardman, Drew, Egan and Wolf (1993:279) indicates that most parents of children with hearing impairments who received counseling and were interviewed, reported that they were able to cope although they continued to experience communication and behavior challenges from time to time.

FIGURE 4.3.8.13 (ITEM 13) I AM AWARE OF ORGANIZATIONS THAT OFFER COUNSELING IN ZIMBABWE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*42*	*14.0*	*14.2*	*14.2*
	Disagree	*78*	*26.0*	*26.4*	*40.7*

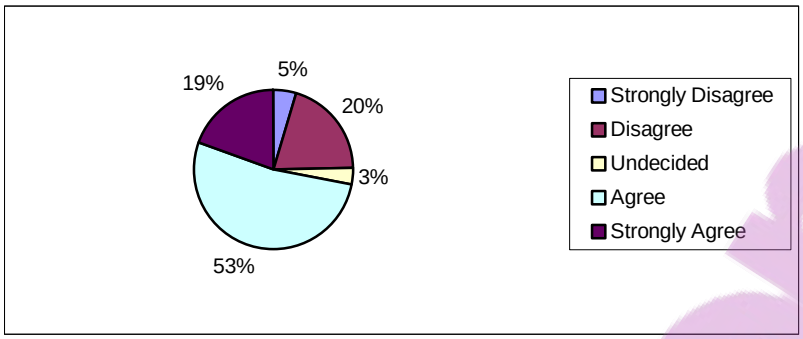
		Frequency	Percent	Valid Percent	Cumulative Percent
	Undecided	*16*	*5.3*	*5.4*	*46.1*
	Agree	*100*	*33.3*	*33.9*	*80.0*
	Strongly Agree	*59*	*19.7*	*20.0*	*100.0*
	Total	*295*	*98.3*	*100.0*	
Missing	System	*5*	*1.7*		
Total		*300*	*100.0*		



Of the 295 parents who responded to item 13, 55% agreed with the statement, 40% disagreed and 5% were undecided. As indicated in figure 4.3.8.3, parents who were aware of counseling organizations are in the majority by only 13.3%.

FIGURE 4.3.8.14 (ITEM 14) MY CHILD FITS WELL AND INTERACTS EFFECTIVELY WITH FAMILY MEMBERS

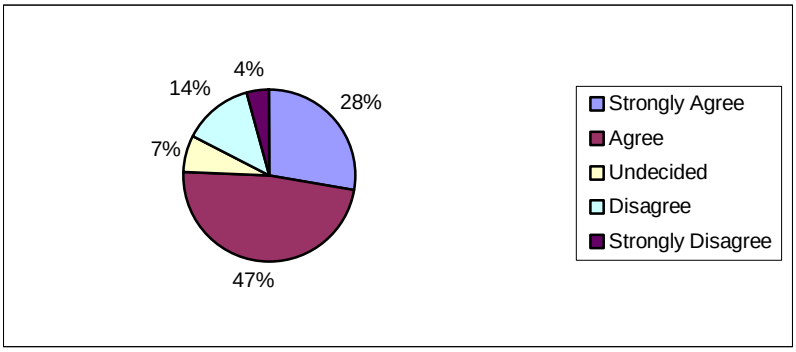
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*14*	*4.7*	*4.7*	*4.7*
	Disagree	*60*	*20.0*	*20.0*	*24.7*
	Undecided	*10*	*3.3*	*3.3*	*28.0*
	Agree	*158*	*52.7*	*52.7*	*80.7*
	Strongly Agree	*58*	*19.3*	*19.3*	*100.0*
	Total	*300*	*100.0*	*100.0*	



Of the 300 parents who responded to item 14, 72% agreed with the statement, 25% disagreed and 3% were undecided. As indicated in figure 4.2.8.9, siblings are an important component of a family structure. Parents are affected by the presence of a child with hearing impairments amongst his/her hearing siblings. Therefore counselors who deal with parents of children with hearing impairments, (Kirk, Gallagher & Anastasiow, 1997:374), have to include the subject of siblings since they are part of the family network and they complete the family cycle. In their study, Moores and Meadow (1990:140) established that if parents are not properly guided about how to strike a balance in terms of sharing resources, love and attention between the child with a hearing impairment and the hearing children, the latter might be frustrated and in turn frustrate the former together with the parents.

FIGURE 4.3.8.15 (ITEM 15) IT IS ALMOST IMPOSSIBLE TO PLAN THE FUTURE OF A CHILD WHO IS HEARING IMPAIRED

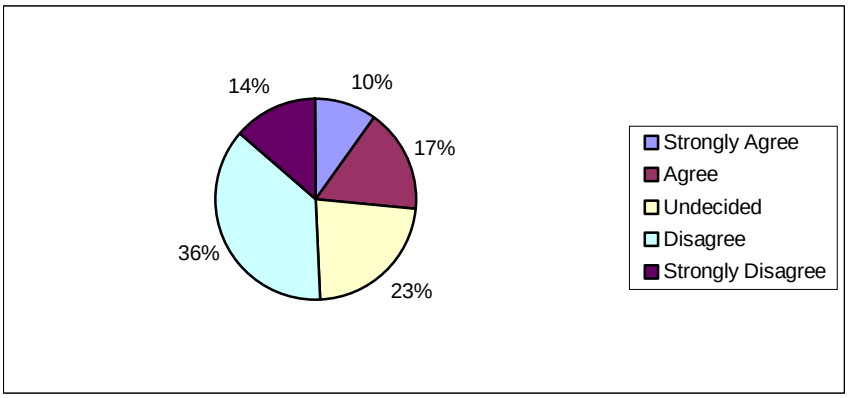
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*82*	*27.3*	*27.8*	*27.8*
	Agree	*141*	*47.0*	*47.8*	*75.6*
	Undecided	*20*	*6.7*	*6.8*	*82.4*
	Disagree	*40*	*13.3*	*13.6*	*95.9*
	Strongly Disagree	*12*	*4.0*	*4.1*	*100.0*
	Total	*295*	*98.3*	*100.0*	
Missing	System	*5*	*1.7*		
Total		*300*	*100.0*		



Of the 295 parents who responded to item 15, 75% agreed with the statement, 18% disagreed and 7% were undecided. Throughout the literature there is an indication (Hallahan & Kauffman, 1994:510; Cartwright, Cartwright & Ward, 1995:118 and Neel, *et al*., 1988:211) that children with a hearing impairment, when offered a job, will do it well. However, in reality there is a huge problem in them being able to secure employment. In fact, as pointed out by Edgar (1987:558), most of them drop out of school before they complete secondary education. Studies of what happens to such students during and after their high school years suggest that a high percentage of them have difficulty in making transition from high school to work. Many drop out of school, experience great difficulty in finding and holding a job, do not find work suited to their capabilities and do not receive further training and education, thus becoming dependent on their families (Edgar, 1987:559; Neel, Meadows, Levine & Edgar, 1988 and Rusch, Szymanski, & Chadsey-Rusch, 1992:13). It seems that these factors may be impacting on the views the parents hold for planning for the future of their children with hearing impairments.

FIGURE 4.3.8.16 (ITEM 16) MOST COUNSELORS DID NOT GIVE US ANY GUIDANCE AT ALL

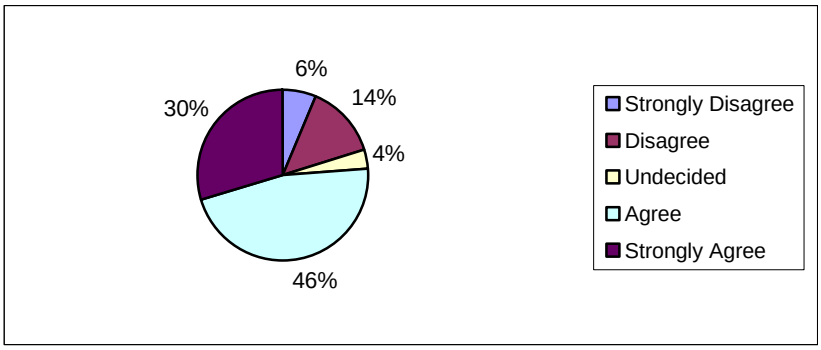
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*28*	*9.3*	*10.0*	*10.0*
	Agree	*47*	*15.7*	*16.8*	*26.8*
	Undecided	*63*	*21.0*	*22.5*	*49.3*
	Disagree	*104*	*34.7*	*37.1*	*86.4*
	Strongly Disagree	*38*	*12.7*	*13.6*	*100.0*
	Total	*280*	*93.3*	*100.0*	
Missing	System	*20*	*6.7*		
Total		*300*	*100.0*		



Of the 280 parents who responded to item 16, 27% agreed with the statement, 50% disagreed and 23% were undecided. These results indicate that most parents were counseled, guided to approach other professionals, and directed to suitable schools to have their child enrolled. Hendrick, MacMillan and Barlow (1989:77) and Wolman, Bruininks and Thurlow (1989:104) contend that effective counseling should include guidance and referrals. It would appear that most professional counselors inform and provide their clients with information pertaining to available services and resources.

FIGURE 4.3.8.17 (ITEM 17) WITHOUT COUNSELING ONE CANNOT FULLY ACCEPT HAVING A CHILD WITH HEARING IMPAIRMENT IN THE FAMILY

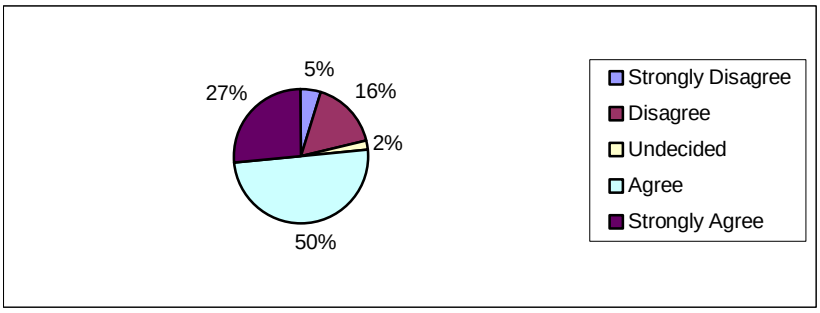
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*19*	*6.3*	*6.4*	*6.4*
	Disagree	*41*	*13.7*	*13.9*	*20.3*
	Undecided	*11*	*3.7*	*3.7*	*24.0*
	Agree	*137*	*45.7*	*46.3*	*70.3*
	Strongly Agree	*88*	*29.3*	*29.7*	*100.0*
	Total	*296*	*98.7*	*100.0*	
Missing	System	*4*	*1.3*		
Total		*300*	*100.0*		



Of the 296 parents who responded to item 17, 76% agreed with the statement, 20% disagreed and 4% were undecided. These results confirm the findings of Turnbull and Turnbull (1990:496) who point out that although all the parents of children with hearing impairments they interviewed expressed that they experienced shock, denial, sadness, anger, fear and anxiety, they eventually accepted their positions after a lot of consultation and counseling. As indicated in figure 4.3.8.5, Cartwright, Cartwright and Ward (1995:400) assert that engaging parents in guidance and counseling from an early stage helps them to gradually accept their children with hearing impairments and participate actively in their educational programmes.

FIGURE 4.3.8.18 (ITEM 18) WITH OR WITHOUT HELP FROM OTHER ORGANIZATIONS, IT IS PARENTS' RESPONSIBILITY TO FULLY CATER FOR THEIR CHILDREN WHO ARE HEARING IMPAIRED

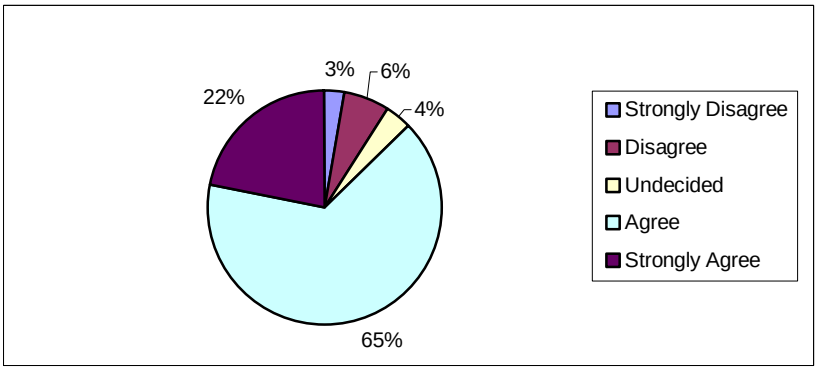
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*15*	*5.0*	*5.1*	*5.1*
	Disagree	*48*	*16.0*	*16.3*	*21.4*
	Undecided	*7*	*2.3*	*2.4*	*23.7*
	Agree	*146*	*48.7*	*49.5*	*73.2*
	Strongly Agree	*79*	*26.3*	*26.8*	*100.0*
	Total	*295*	*98.3*	*100.0*	
Missing	System	*5*	*1.7*		
Total		*300*	*100.0*		



Of the 295 parents who responded to item 18, 77% agreed with the statement, 21% disagreed and 2% were undecided. As indicated in figure 4.3.8.6, despite the difficulties parents go through, there is overwhelming evidence that they (parents) eventually accept, and take full responsibility for their children (Gartner, Lipsky & Turnbull, 1991:324 and Fear & Woolfe, 1996:371).

FIGURE 4.3.8.19 (ITEM 19) WE ALLOW OUR CHILD TO MAKE FRIENDS AND PLAY WITH OTHER CHILDREN IN OUR NEIGHBORHOOD

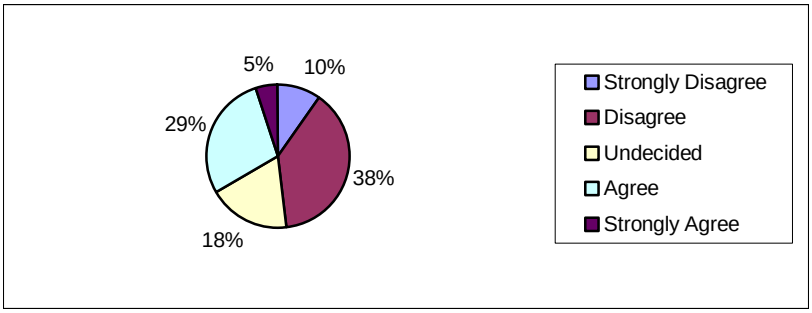
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*8*	*2.7*	*2.7*	*2.7*
	Disagree	*19*	*6.3*	*6.4*	*9.1*
	Undecided	*11*	*3.7*	*3.7*	*12.8*
	Agree	*193*	*64.3*	*65.2*	*78.0*
	Strongly Agree	*65*	*21.7*	*22.0*	*100.0*
	Total	*296*	*98.7*	*100.0*	
Missing	System	*4*	*1.3*		
Total		*300*	*100.0*		



Of the 296 parents who responded to item 19, 87% agreed with the statement, 9% disagreed and 4% were undecided. These results corroborate what is indicated in figure 4.3.8.8. It appears parents have been made aware of the importance of child interaction and its benefits. As pointed out by Moores and Meadow (1990:125), children with hearing impairments should be integrated into the community from an early age if they are to enhance their social, psychological, and cognitive development.

FIGURE 4.3.8.20 (ITEM 20) THE PROBLEM WITH COUNSELING IS THAT ONE IS NOT PROVIDED WITH ANSWERS

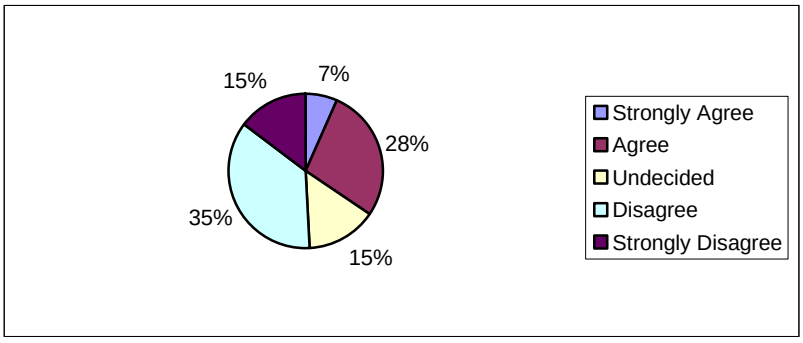
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*28*	*9.3*	*9.9*	*9.9*
	Disagree	*108*	*36.0*	*38.2*	*48.1*
	Undecided	*52*	*17.3*	*18.4*	*66.5*
	Agree	*81*	*27.0*	*28.6*	*95.1*
	Strongly Agree	*14*	*4.7*	*4.9*	*100.0*
	Total	*283*	*94.3*	*100.0*	
Missing	System	*17*	*5.7*		
Total		*300*	*100.0*		



Of the 283 parents who responded to item 20, 34% agreed with the statement, 48% disagreed and 18% were undecided.

FIGURE 4.3.8.21 (ITEM 21) PARENTS CAN DO EQUALLY WELL FOR THEIR CHILD WITHOUT GUIDANCE AND COUNSELING

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	*19*	*6.3*	*6.5*	*6.5*
	Agree	*81*	*27.0*	*27.8*	*34.4*
	Undecided	*43*	*14.3*	*14.8*	*49.1*
	Disagree	*105*	*35.0*	*36.1*	*85.2*
	Strongly Disagree	*43*	*14.3*	*14.8*	*100.0*
	Total	*291*	*97.0*	*100.0*	
Missing	System	*9*	*3.0*		
Total		*300*	*100.0*		

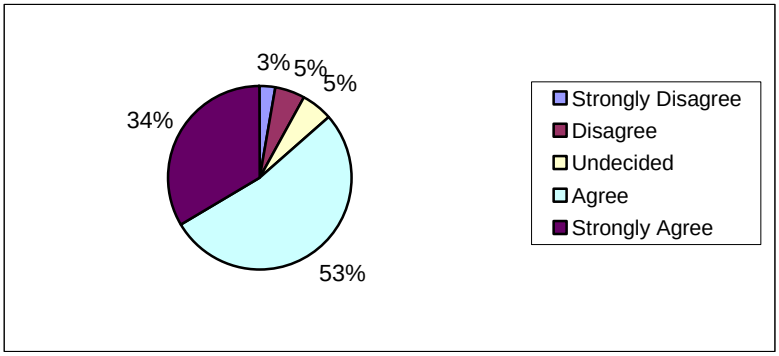


Of the 291 parents who responded to item 21, 35% agreed with the statement, 50% disagreed and 15 were undecided. Although 50% is not a resounding majority, this result indicates the perceived need for counseling by the participants in this study. These results corroborate the findings indicated in figure 4.3.8.11. Most authorities concur that counseling is invaluable to parents of children with disabilities (Tucker & Nolan, 1984:110; Blocher, 2000:38; Bell, 1996:341).

Figure 4.3.8.22 (Item 22) Counseling really helped us to understand the child

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*8*	*2.7*	*2.7*	*2.7*
	Disagree	*16*	*5.3*	*5.4*	*8.1*
	Undecided	*16*	*5.3*	*5.4*	*13.6*

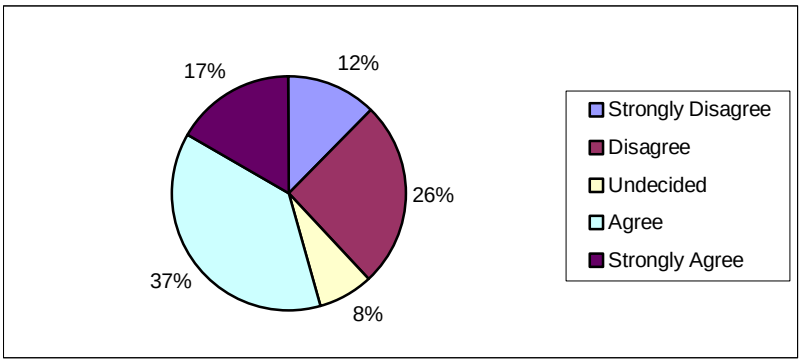
	Agree	*156*	*52.0*	*52.9*	*66.4*
	Strongly Agree	*99*	*33.0*	*33.6*	*100.0*
	Total	*295*	*98.3*	*100.0*	
Missing	System	*5*	*1.7*		
Total		*300*	*100.0*		



Of the 295 parents who responded to item 22, 87% agreed with the statement, 8% disagreed and 5% were undecided. These results endorse the findings of Burnett and Van Dorssen (2000:248), Dale (1984:206) and Moores (1996:352) who assert that most parents that were counseled and interviewed perceived that the counseling process helped them to understand the emotional, sociological and psychological needs of their children. These results are also confirmed in figure 4.3.8.4.

FIGURE 4.3.8.23 (ITEM 23) COUNSELORS ALSO REFERRED ME TO OTHER PROFESSIONALS FOR FURTHER HELP

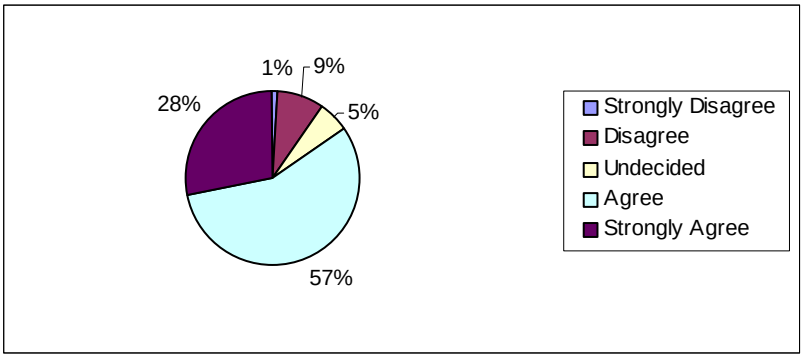
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*36*	*12.0*	*12.4*	*12.4*
	Disagree	*74*	*24.7*	*25.5*	*37.9*
	Undecided	*22*	*7.3*	*7.6*	*45.5*
	Agree	*110*	*36.7*	*37.9*	*83.4*
	Strongly Agree	*48*	*16.0*	*16.6*	*100.0*
	Total	*290*	*96.7*	*100.0*	
Missing	System	*10*	*3.3*		
Total		*300*	*100.0*		



Of the 290 parents who responded to item 23, 54% agreed with the statement, 38% disagreed and 8% were undecided. Referral in Zimbabwe is done through Schools Psychological Services (SPS) and used to be very effective, particularly during the time of the study. At present the system is still the same but due to economic hardships and limited resources, it has been hard hit by the brain drain and the withdrawal of donor funds. As pointed out by Mutasa (2000:34) the abolition of the department of screening and testing for hearing loss by the Ministry of Education has caused a draw back for both children with hearing impairments and their parents. Screening of hearing impairment is now done in special schools and hospitals as it used to be in the initial stages of special education. According to these results, it would appear that more participants were referred to other professionals for further help than those who were not referred.

FIGURE 4.3.8.24 (ITEM 24) COUNSELING HELPED US TO COPE WITH OUR CHILD WHO IS HEARING IMPAIRED

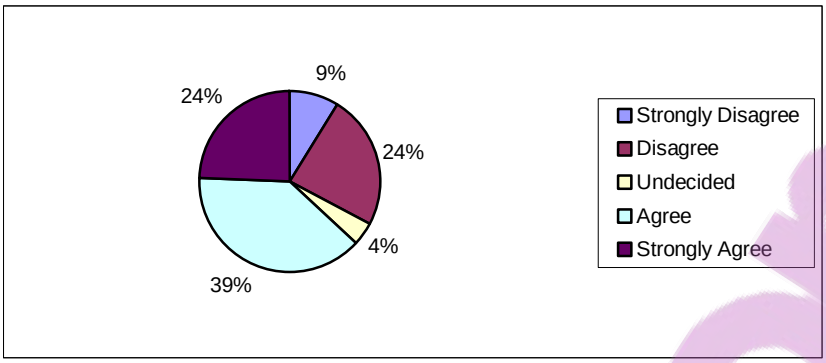
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*3*	*1.0*	*1.0*	*1.0*
	Disagree	*27*	*9.0*	*9.1*	*10.1*
	Undecided	*16*	*5.3*	*5.4*	*15.5*
	Agree	*166*	*55.3*	*56.1*	*71.6*
	Strongly Agree	*84*	*28.0*	*28.4*	*100.0*
	Total	*296*	*98.7*	*100.0*	
Missing	System	*4*	*1.3*		
Total		*300*	*100.0*		



Of the 296 parents who responded to item 24, 85% agreed with the statement, 10% disagreed and 5% were undecided. As indicated in figure 4.3.8.12 the participants confirmed that counseling helped them to cope with their children with hearing impairments. These results are supported by the findings of Webster and Ellwood (1985:94); Luterman (1991:156) and Kauffman (1992:304), who contend that counseled families that have children with disabilities tend to accept and cope with the upbringing of their children irrespective of the difficulties they go through.

FIGURE 4.3.8.25 (ITEM 25) GUIDANCE AND COUNSELING ARE IMPORTANT FOR BOTH PARENTS AND THE CHILD

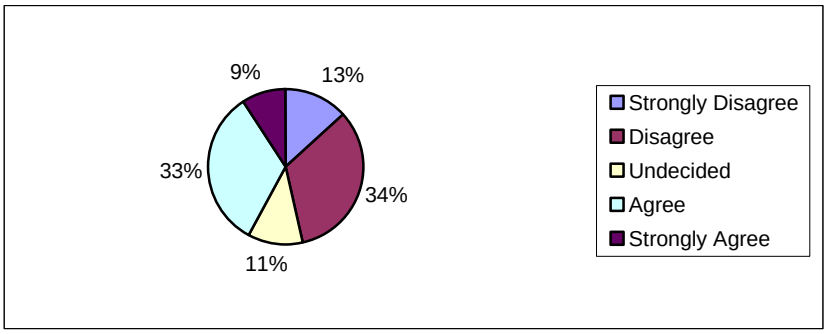
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*26*	*8.7*	*8.8*	*8.8*
	Disagree	*71*	*23.7*	*24.1*	*32.9*
	Undecided	*12*	*4.0*	*4.1*	*36.9*
	Agree	*114*	*38.0*	*38.6*	*75.6*
	Strongly Agree	*72*	*24.0*	*24.4*	*100.0*
Total	Total	*295*	*98.3*	*100.0*	
Missing	System	*5*	*1.7*		
Total		*300*	*100.0*		



Of the 295 parents who responded to item 25, 63% agreed with the statement, 33% disagreed and 4% were undecided. Studies were carried out by Lobato (1990:183) where he compared families that had children with disabilities. In some only parents were counseled, in some both the parents and the child with disabilities was counseled, while in others parents, the child with disabilities and other siblings were counseled. The most socially, psychologically and emotionally healthy families that seemed to have been progressing well were families that had all their members counseled. Similar findings were reported by Moores and Meadow (1990:127) and Vernon and Andrews (1990:145). It is therefore apparent that counseling is important for all members of the family in which a child with disabilities is born.

FIGURE 4.3.8.26 (ITEM 26) IT IS DIFFICULT TO SEPARATE COUNSELING FROM ADVICE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	*39*	*13.0*	*13.3*	*13.3*
	Disagree	*97*	*32.3*	*33.1*	*46.4*
	Undecided	*33*	*11.0*	*11.3*	*57.7*
	Agree	*97*	*32.3*	*33.1*	*90.8*
	Strongly Agree	*27*	*9.0*	*9.2*	*100.0*
	Total	*293*	*97.7*	*100.0*	
Missing	System	*7*	*2.3*		
Total		*300*	*100.0*		



Of the 293 parents who responded to item 26, 42% agreed with the statement, 47% disagreed and 11% were undecided. As indicated in figure 4.3.8.10 some counseling techniques are directive. The counselor guides and leads the client into a situation where he/she can view the problem is more rational and positive way (Burnard, 1992:93). Some words of advice may be used in a subtle manner to enable the client gain a more view of his/her problem. Some of the participants may not have been very clear about the distinction between counseling and advice. This question was mainly to find whether participants had in their minds a clear distinction between counseling and advice.

Having analyzed all items one at a time, the next aspect would be to establish the correlations between different variables. These include gender of parents versus their sources of counseling, what they say about coping with their children, gender of children and what parents say about coping as well as age of children and what parents say about coping.

4.4 CORRELATION BETWEEN THE GENDER OF PARENTS AND WHERE THEY OBTAINED COUNSELING, WHAT THEY SAY ABOUT COPING WITH THE CHILD WITH A HEARING IMPAIRMENT, AGE OF CHILDREN AND WHAT PARENTS SAY ABOUT COPING

It is important to note that when the percentage of cells in the table that ‘have expected countless than 5’ is high, especially 20% or more, chi-squared is not reliable. Also when the sign value in the table of the chi-squared along the ‘Pearson Chi-Square’ row or ‘Likelihood Ratio’ row is bigger than (0.05) there is no association or relationship. When it is 0.05 or less then the row and column factors are correlated or there is a relationship.

When the sources of counseling where analyzed one at a time, some of the sources had too few frequencies; therefore sources were combined in order to obtain reliable results.

As pointed out above, in order to obtain a more reliable result, I combined some of the categories with small frequencies to get three sources of counseling, namely:

- Special Schools
- Counseling organizations, Churches, Hospitals
- Relatives, Individuals, Friends

Table 4.4.1 First source of counseling – A1 Gender of parents cross tabulation

			A1 Gender of Parents		Total
			Male	Female	
A1 First Source of Counseling	Special Schools	Count	*76*	*93*	*169*
		% within A1 Gender of Parents	*68.5%*	*69.4%*	*69.0%*
	Counseling organizations, Churches, Hospitals	Count	*31*	*24*	*55*
		% within A1 Gender of Parents	*27.9%*	*17.9%*	*22.4%*
	Relatives, Individuals & Friends	Count	*4*	*17*	*21*
		% within A1 Gender of Parents	*3.6%*	*12.7%*	*8.6%*
Total		Count	*111*	*134*	*245*
		% within A1 Gender of Parents	*100.0%*	*100.0%*	*100.0%*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	*8.565(a)*	*2*	*.014*
Likelihood Ratio	*9.106*	*2*	*.011*
Linear-by-Linear Association	*.978*	*1*	*.323*
N of Valid Cases	*245*		

Zero cells (.0%) have expected count less than 5. The minimum expected count is 9.51.

Now all expected frequencies of counseling sources are larger than 5, so results are quite reliable. Basing on the Sign (p) value of 0.014, we can conclude that there is a fairly strong association between First Source of counseling information and gender of parents. The percentages indicate that about the same proportion of males (68.5%) and females (69.4%) use special schools for counseling. The significant differences arises from the fact that relatively more male parents (27.9%) use Counseling organizations, Churches and/or Hospitals, compared to female parents (17.9%), while fewer male parents (3.6%) turn to Relatives, Individuals and Friends compared to female parents (12.7%).

Table 4.4.2 Second source of counseling – A2 Gender of parents

			A2 Gender of Parents		Total
			Male	Female	
A2 Second Source of Counseling	Counseling Organizations	Count	*39*	*52*	*91*
		% within A2 Gender of Parents	*41.9%*	*51.0%*	*46.7%*
	Churches	Count	*17*	*15*	*32*
		% within A2 Gender of Parents	*18.3%*	*14.7%*	*16.4%*
	Hospitals	Count	*24*	*13*	*37*
		% within A2 Gender of Parents	*25.8%*	*12.7%*	*19.0%*
	Relatives	Count	*7*	*6*	*13*
		% within A2 Gender of Parents	*7.5%*	*5.9%*	*6.7%*
	Individuals	Count	*6*	*16*	*22*
		% within A2 Gender of Parents	*6.5%*	*15.7%*	*11.3%*
Total		Count	*93*	*102*	*195*
		% within A2 Gender of Parents	*100.0%*	*100.0%*	*100.0%*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	*9.480(a)*	*4*	*.050*
Likelihood Ratio	*9.687*	*4*	*.046*
Linear-by-Linear Association	*.014*	*1*	*.907*
McNemar Test			
N of Valid Cases	*195*		

Zero cells (.0%) have expected count less than 5. The minimum expected count is 6.20.

With respect to the second source of Information, there is a moderate association (p = 0.050) between second source of information and the gender of the participants in the study. The main sources of differences appear to be in use of Counseling organizations, Hospitals and Individuals. Relatively more males use hospitals (25.8%) than females (12.7%), while more females use Counseling organizations (51.0%) and turn to individuals (15.7%) than males (41.9% and 6.5% respectively). The results are reliable since all expected frequencies are greater than 5.

TABLE 4.4.3 THIRD SOURCE OF COUNSELING – A3 GENDER OF PARENTS

			A3 Gender of Parents		Total
			Male	Female	
A3 Third Source of Counseling	Churches	Count	*27*	*34*	*61*
		% within A3 Gender of Parents	*38.0%*	*39.5%*	*38.9%*
	Hospitals	Count	*14*	*26*	*40*
		% within A3 Gender of Parents	*19.7%*	*30.2%*	*25.5%*
	Relatives	Count	*17*	*6*	*23*
		% within A3 Gender of Parents	*23.9%*	*7.0%*	*14.6%*
	Individuals	Count	*13*	*20*	*33*
		% within A3 Gender of Parents	*18.3%*	*23.3%*	*21.0%*
Total		Count	*71*	*86*	*157*
		% within A3 Gender of Parents	*100.0%*	*100.0%*	*100.0%*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	*9.805(a)*	*3*	*.020*
Likelihood Ratio	*10.004*	*3*	*.019*
Linear-by-Linear Association	*.212*	*1*	*.645*
N of Valid Cases	*157*		

Zero cells (.0%) have expected count less than 5. The minimum expected count is 10.40.

Again, the relationship between gender and the third source of counseling information is fairly strong (p = 0.020). Relatively more males turn to Relatives while relatively more females turn to Hospitals. Proportions turning to Churches and Individuals do not appear to differ much between genders.

Table 4.4.4 (Item 1) Although we received guidance and counseling, we still cannot cope with the child – A5 Gender of parents

			A4 Gender of Parents		Total
			Male	Female	
A4 1. Although we received guidance and I, we still cannot cope with the child.	Agree/Strongly Agree	Count	*61*	*54*	*115*
		% within A4 Gender of Parents	*51.3%*	*36.0%*	*42.8%*
	Neutral	Count	*4*	*5*	*9*
		% within A4 Gender of Parents	*3.4%*	*3.3%*	*3.3%*
	Disagree/Strongly Disagree	Count	*54*	*91*	*145*
		% within A4 Gender of Parents	*45.4%*	*60.7%*	*53.9%*
Total		Count	*119*	*150*	*269*
		% within A4 Gender of Parents	*100.0%*	*100.0%*	*100.0%*

CHI-SQUARE TESTS

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	*6.492(a)*	*2*	*.039*
Likelihood Ratio	*6.504*	*2*	*.039*
Linear-by-Linear Association	*6.466*	*1*	*.011*
McNemar Test			
N of Valid Cases	*269*		

a.1 cells (16.7%) have expected count less than 5. The minimum expected count is 3.98.

There is a fairly strong association (p = 0.039) observed between gender and agreement or disagreement with the comment that "Although we received guidance and counseling, we still cannot cope with the child". Relatively more males (51.3%) agree compared to females (36.0%) while more females disagree (60.7%) compared with males (45.4%)

TABLE 4.4.5 (ITEM 2) COUNSELING HELPED US TO COPE WITH OUT CHILD WHO IS HEARING IMPAIRED – A5 GENDER OF CHILDREN

			A5 Gender of Children			Total
			Boy	Girl	Both	
A5. Counseling helped us to cope with our child who is hearing impaired.	Strongly Disagree	Count	*2*	*1*	*0*	*3*
		% within A5 Gender of Children	*1.2%*	*1.0%*	*.0%*	*1.1%*
	Disagree	Count	*20*	*7*	*0*	*27*
		% within A5 Gender of Children	*12.4%*	*6.7%*	*.0%*	*10.1%*
	Undecided	Count	*4*	*10*	*0*	*14*
		% within A5 Gender of Children	*2.5%*	*9.5%*	*.0%*	*5.2%*
	Agree	Count	*92*	*55*	*0*	*147*
		% within A5 Gender of Children	*57.1%*	*52.4%*	*.0%*	*55.1%*

	Strongly Agree	Count	*43*	*32*	*1*	*76*
		% within A5 Gender of Children	*26.7%*	*30.5%*	*100.0%*	*28.5%*
Total		Count	*161*	*105*	*1*	*267*
		% within A5 Gender of Children	*100.0%*	*100.0%*	*100.0%*	*100.0%*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	*11.237(a)*	*8*	*.189*
Likelihood Ratio	*11.201*	*8*	*.191*
Linear-by-Linear Association	*1.818*	*1*	*.178*
McNemar Test			
N of Valid Cases	*267*		

a. 7 cells (46.7%) have expected count less than 5. The minimum expected count is .01.

The results in the chi-squared tests table (above) suggest that there is no relationship between coping/not coping after receiving counseling and gender of child, basing on Sign (p) value of (0.189). However, test results in this instance is not reliable since seven cells (46.7%) have expected count less than 5 as indicated under the table. When the percentage exceeds 20%, the chi-squared result becomes unreliable.

TABLE 4.4.6 (ITEM 3) THE COUNSELING WE RECEIVED DID NOT HELP US TO COPE WITH THE CHILD AT ALL – A6 AGE OF CHILDREN

			A6 Age of Children				Total
			5-8yrs	9-13yrs	14-18yrs	9-13 and 14-18	
6. The counseling we received did not help us to cope with the child at all.	Agree/ Strongly Agree	Count	*14*	*25*	*20*	*0*	*59*

			A6 Age of Children				Total
			5-8yrs	9-13yrs	14-18yrs	9-13 and 14-18	
		% within A6 Age of Children	*22.6%*	*18.7%*	*30.8%*	*.0%*	*22.3%*
	Neutral	Count	*5*	*9*	*3*	*0*	*17*
		% within A6 Age of Children	*8.1%*	*6.7%*	*4.6%*	*.0%*	*6.4%*
	Disagree/ Strongly Disagree	Count	*43*	*100*	*42*	*3*	*188*
		% within A6 Age of Children	*69.4%*	*74.6%*	*64.6%*	*100.0 %*	*71.2%*
Total		Count	*62*	*134*	*65*	*3*	*264*
		% within A6 Age of Children	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	*5.347(a)*	*6*	*.500*
Likelihood Ratio	*6.028*	*6*	*.420*
Linear-by-Linear Association	*.563*	*1*	*.453*
McNemar Test			
N of Valid Cases	*264*		

a. 5 cells (41.7%) have expected count less than 5. The minimum expected count is .19.

The results in the chi-squared tests table (above) suggest that there is no relationship between coping after receiving counseling and the age of child, basing on Sign (p) value of (0.500). Also test result is not reliable since five cells (41.7%) have expected count less than 5 as indicated under the table. When the percentage exceeds 20%, the chi-squared result becomes unreliable.

I can therefore conclude that analysis of both male and female responses indicates that there was no relationship between age of child and inability or ability to cope with the child even

after receiving guidance and counseling. Similarly there was no relationship between gender of child and coping or failing to cope with child after receiving counseling. The next part of the study sought to establish the reliability and validity of the instrument as a whole analyzing positive items versus their negative counterparts.

4.5 DEGREE OF CONSISTENCY BETWEEN POSITIVE AND NEGATIVELY PHRASED ITEMS

The instrument used in this study has 13 positive items and their 13 direct negative items. The next part of presentation and analysis of results is mainly to cross check the degree of consistency by participants in terms of how they responded to positive and negative items. I would like to establish if for instance participants who marked "Strongly Agree" or "Agree" on item 11 also marked "Strongly Disagree" or "Disagree " on item 1, which is its negative counterpart. This to a certain extent will establish the validity and reliability of the instrument. As stated by Cohen and Manion (1989:111), it is important to have a valid and reliable instrument that produces reliable data.

In tables 4.3.2.1a and 4.3.3.1b summarizing the raw scores on each item will indicate degrees of consistency/inconsistency. This will be followed by item analysis that shows consistency/inconsistency in terms of percentages per item. Results are indicated in the respective tables.

TABLE 4.5.1 DEGREE OF CONSISTENCY BETWEEN POSITIVE AND NEGATIVELY PHRASED ITEMS

Pair of Items and Attribute	Consistent	Slightly Inconsistent	Moderately Inconsistent	Very Inconsistent	Extremely Inconsistent	Total
1-11. The need for Counseling of Parents of children with hearing impairments.	*172*	*108*	*12*	*2*	*6*	*300*
2-26. Utility of the counseling received.	*116*	*51*	*80*	*40*	*9*	*296*
3-13. Awareness of any organization that offers counseling in Zimbabwe.	*222*	*42*	*26*	*3*	*2*	*295*

Pair of Items and Attribute	Consistent	Slightly Inconsistent	Moderately Inconsistent	Very Inconsistent	Extremely Inconsistent	Total
4-22. Counseling and understanding the needs of our child.	*240*	*37*	*6*	*4*	*2*	*289*
5-17. Counseling and Acceptance of the idea of having a hearing impaired child in the family.	*244*	*40*	*4*	*4*		*292*
6-18. Who should look after children who are impaired.	*236*	*39*	*11*	*3*	*4*	*293*
7-15. Counseling in planning for the future of my child.	*70*	*55*	*87*	*59*	*24*	*295*
8-19. Allowing child to play with other children in our community.	*130*	*98*	*34*	*24*	*8*	*294*
9-14. Child's relation and interaction with other members of the family.	*157*	*65*	*57*	*15*	*6*	*300*
10-20. Most people who counseled us told us what to do.	*177*	*49*	*48*	*2*	*5*	*281*
12-24. Coping with child after receiving guidance and counseling.	*184*	*55*	*22*	*23*	*5*	*289*
16-23. Assistance vs. Referral to other professionals for further help.	*183*	*58*	*23*	*11*	*3*	*278*
21-25. Importance of Guidance and counseling to Parents.	*185*	*73*	*28*	*2*	*3*	*291*

TABLE 4.5.2 DEGREE OF CONSISTENCY BETWEEN POSITIVE AND NEGATIVELY PHRASED ITEMS PERCENTAGE

Pair of Items and Attribute	Consistent	Slightly Inconsistent	Moderately Inconsistent	Very Inconsistent	Extremely Inconsistent	Total
1-11. The need for Counseling of Parents of children with hearing impairments.	*57.3*	*36.0*	*4.0*	*.7*	*2.0*	*100.0*
2-26 Utility of the counseling received.	*39.1*	*17.3*	*27.0*	*13.5*	*3.1*	*100.0*
3-13. Awareness of any organization that offers counseling in Zimbabwe.	*75.3*	*14.2*	*8.8*	*1.0*	*.7*	*100.0*
4-22. Counseling and understanding the needs of our child.	*83.0*	*12.8*	*2.1*	*1.4*	*.7*	*100.0*

Pair of Items and Attribute	Consistent	Slightly Inconsistent	Moderately Inconsistent	Very Inconsistent	Extremely Inconsistent	Total
5-17. Counseling and Acceptance of the idea of having a hearing impaired child in the family.	*83.6*	*13.7*	*1.4*	*1.4*		*100.0*
6-18. Who should look after children who are impaired.	*80.5*	*13.3*	*3.8*	*1.0*	*1.4*	*100.0*
7-15. Counseling in planning for the future of my child.	*23.7*	*18.6*	*29.5*	*20.0*	*8.1*	*100.0*
8-19. Allowing child to play with other children in our community.	*44.2*	*33.3*	*11.6*	*8.2*	*2.7*	*100.0*
9-14. Child's relation and interaction with other members of the family.	*52.3*	*21.7*	*19.0*	*5.0*	*2.0*	*100.0*
10-20. Most people who counseled us told us what to do.	*63.0*	*17.4*	*17.1*	*.7*	*1.8*	*100.0*
12-24 Coping with child after receiving guidance and counseling.	*63.9*	*19.2*	*7.8*	*7.9*	*1.8*	*100.0*
16-23. Assistance vs. Referral to other professionals for further help.	*65.8*	*20.9*	*8.3*	*4.0*	*1.1*	*100.0*
21-25. Importance of Guidance and counseling to Parents.	*63.6*	*25.1*	*9.6*	*.7*	*1.0*	*100.0*

TABLE 4.5.3 (ITEM 1-11) THE NEED FOR COUNSELING OF PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*172*	*57.3*	*57.3*	*57.3*
	Slightly Inconsistent	*108*	*36.0*	*36.0*	*93.3*
	Moderately Inconsistent	*12*	*4.0*	*4.0*	*97.3*
	Very Inconsistent	*2*	*.7*	*.7*	*98.0*
	Extremely Inconsistent	*6*	*2.0*	*2.0*	*100.0*
	Total	*300*	*100.0*	*100.0*	

TABLE 4.5.4 (ITEM 2-26) COUNSELING IS TOTALLY DIFFERENT FROM ADVICE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*117*	*39.1*	*39.1*	*39.1*
	Slightly Inconsistent	*52*	*17.3*	*17.3*	*56.4*
	Moderately Inconsistent	*81*	*27.0*	*27.0*	*83.4*
	Very Inconsistent	*41*	*13.5*	*13.5*	*96.9*
	Extremely Inconsistent	*9*	*3.1*	*3.1*	*100.0*
	Total	*300*	*100.0*	*100.0*	

TABLE 4.5.5 (ITEM 3-13) AWARENESS OF ANY ORGANIZATION THAT OFFERS COUNSELING IN ZIMBABWE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*222*	*74.0*	*75.3*	*75.3*
	Slightly Inconsistent	*42*	*14.0*	*14.2*	*89.5*
	Moderately Inconsistent	*26*	*8.7*	*8.8*	*98.3*
	Very Inconsistent	*3*	*1.0*	*1.0*	*99.3*
	Extremely Inconsistent	*2*	*.7*	*.7*	*100.0*
	Total	*295*	*98.3*	*100.0*	
Missing	System	*5*	*1.7*		

TABLE 4.5.6 (ITEM 4-22) COUNSELING AND UNDERSTANDING THE NEEDS OF OUR CHILD

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*240*	*80.0*	*83.0*	*83.0*
	Slightly Inconsistent	*37*	*12.3*	*12.8*	*95.8*
	Moderately Inconsistent	*6*	*2.0*	*2.1*	*97.9*
	Very Inconsistent	*4*	*1.3*	*1.4*	*99.3*

	Extremely Inconsistent	*2*	*.7*	*.7*	*100.0*
	Total	*289*	*96.3*	*100.0*	
Missing	System	*11*	*3.7*		
Total		*300*	*100.0*		

TABLE 4.5.7 (ITEM 5-17) COUNSELING AND ACCEPTANCE OF THE IDEA OF HAVING A HEARING IMPAIRED CHILD IN THE FAMILY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*244*	*81.3*	*83.6*	*83.6*
	Slightly Inconsistent	*40*	*13.3*	*13.7*	*97.3*
	Moderately Inconsistent	*4*	*1.3*	*1.4*	*98.6*
	Very Inconsistent	*4*	*1.3*	*1.4*	*100.0*
	Total	*292*	*97.3*	*100.0*	
Missing	System	*8*	*2.7*		
Total		*300*	*100.0*		

TABLE 4.5.8 (ITEM 6-18) WHO SHOULD LOOK AFTER CHILDREN WHO ARE IMPAIRED?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*236*	*78.7*	*80.5*	*80.5*
	Slightly Inconsistent	*39*	*13.0*	*13.3*	*93.9*
`	Moderately Inconsistent	*11*	*3.7*	*3.8*	*97.6*
	Very Inconsistent	*3*	*1.0*	*1.0*	*98.6*
	Extremely Inconsistent	*4*	*1.3*	*1.4*	*100.0*
	Total	*293*	*97.7*	*100.0*	
Missing	System	*7*	*2.3*		
Total		*300*	*100.0*		

TABLE 4.5.9 (ITEM 7-15) PLANNING FOR THE FUTURE OF MY CHILD

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*70*	*23.3*	*23.7*	*23.7*
	Slightly Inconsistent	*55*	*18.3*	*18.6*	*42.4*
	Moderately Inconsistent	*87*	*29.0*	*29.5*	*71.9*
	Very Inconsistent	*59*	*19.7*	*20.0*	*91.9*
	Extremely Inconsistent	*24*	*8.0*	*8.1*	*100.0*
	Total	*295*	*98.3*	*100.0*	

TABLE 4.5.10 (ITEM 8-19) ALLOWING MY CHILD TO PLAY WITH OTHER CHILDREN IN OUR COMMUNITY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*236*	*78.7*	*80.5*	*80.5*
	Slightly Inconsistent	*39*	*13.0*	*13.3*	*93.9*
	Moderately Inconsistent	*11*	*3.7*	*3.8*	*97.6*
	Very Inconsistent	*3*	*1.0*	*1.0*	*98.6*
	Extremely Inconsistent	*4*	*1.3*	*1.4*	*100.0*
	Total	*293*	*97.7*	*100.0*	
Missing	System	*7*	*2.3*		
Total	*300*	*100.0*			

TABLE 4.5.11 (ITEM 9-14) CHILD'S RELATION AND INTERACTION WITH OTHER MEMBERS OF THE FAMILY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*157*	*52.3*	*52.3*	*52.3*
	Slightly Inconsistent	*65*	*21.7*	*21.7*	*74.0*
	Moderately Inconsistent	*57*	*19.0*	*19.0*	*93.0*
	Very Inconsistent	*15*	*5.0*	*5.0*	*98.0*

		Frequency	Percent	Valid Percent	Cumulative Percent
	Extremely Inconsistent	*6*	*2.0*	*2.0*	*100.0*
	Total	*300*	*100.0*	*100.0*	

TABLE 4.4.12 (ITEM 10-20) MOST PEOPLE WHO COUNSELED US TOLD US WHAT TO DO

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*177*	*59.0*	*63.0*	*63.0*
	Slightly Inconsistent	*49*	*16.3*	*17.4*	*80.4*
	Moderately Inconsistent	*48*	*16.0*	*17.1*	*97.5*
	Very Inconsistent	*2*	*.7*	*.7*	*98.2*
	Extremely Inconsistent	*5*	*1.7*	*1.8*	*100.0*
	Total	*281*	*93.7*	*100.0*	
Missing	System	*19*	*6.3*		
Total		*300*	*100.0*		

TABLE 4.5.13 (ITEM 12-26) UTILITY OF THE COUNSELING RECEIVED

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*113*	*37.7*	*39.1*	*39.1*
	Slightly Inconsistent	*50*	*16.7*	*17.3*	*56.4*
	Moderately Inconsistent	*78*	*26.0*	*27.0*	*83.4*
	Very Inconsistent	*39*	*13.0*	*13.5*	*96.9*
	Extremely Inconsistent	*9*	*3.0*	*3.1*	*100.0*
	Total	*289*	*96.3*	*100.0*	
Missing	System	*11*	*3.7*		
Total		*300*	*100.0*		

TABLE 4.5.14 (ITEM 16-23) ASSISTANCE *VS.* REFERRAL TO OTHER PROFESSIONALS FOR FURTHER HELP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*183*	*61.0*	*65.8*	*65.8*
	Slightly Inconsistent	*58*	*19.3*	*20.9*	*86.7*
	Moderately Inconsistent	*23*	*7.7*	*8.3*	*95.0*
	Very Inconsistent	*11*	*3.7*	*4.0*	*98.9*
	Extremely Inconsistent	*3*	*1.0*	*1.1*	*100.0*
	Total	*278*	*92.7*	*100.0*	
Missing	System	*22*	*7.3*		
Total		*300*	*100.0*		

TABLE 4.5.15 (ITEM 21-25) IMPORTANCE OF GUIDANCE AND COUNSELING TO PARENTS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Consistent	*185*	*61.7*	*63.6*	*63.6*
	Slightly Inconsistent	*73*	*24.3*	*25.1*	*88.7*
	Moderately Inconsistent	*28*	*9.3*	*9.6*	*98.3*
	Very Inconsistent	*2*	*.7*	*.7*	*99.0*
	Extremely Inconsistent	*3*	*1.0*	*1.0*	*100.0*
	Total	*291*	*97.0*	*100.0*	
Missing	System	*9*	*3.0*		
Total	*300*	*100.0*			

TABLE 4.5.16 SUMMARY OF ITEM CONSISTENCY BY PERCENTAGE

Negative to positive items	Consistent	Inconsistent	Neutral	Total
1-11	*93.3*	*2.7*	*4.0*	*100.0*
2-26	*56.4*	*16.6*	*27.0*	*100.0*
3-13	*89.5*	*1.7*	*8.8*	*100.0*

4-22	*95.8*	*2.1*	*2.1*	*100.0*
5-17	*97.3*	*1.4*	*1.4*	*100.0*
6-18	*93.8*	*2.4*	*3.8*	*100.0*
7-15	*42.3*	*28.1*	*29.5*	*100.0*
8-19	*77.5*	*10.9*	*11.6*	*100.0*
9-14	*74.0*	*10.0*	*19.0*	*100.0*
10-20	*80.4*	*2.5*	*17.1*	*100.0*
12-24	*82.5*	*7.8*	*9.6*	*100.0*
16-23	*86.7*	*5.1*	*8.3*	*100.0*
21-25	*88.7*	*1,7*	*9.6*	*100.0*

Participants' responses were highly consistent on 22 of the 26 items, the exceptions being items 2-26, and 7-15. It may imply that these items were poorly phrased, not clear or were not specific enough. As a whole the instrument used in this study produced highly consistent responses. For example responses to items eight versus 19 and nine *versus* 14 have a degree of consistency above 70%. Items 10 *versus* 20, 12 *versus* 24, 16 *versus* 23 and 21 *versus* 25 have degrees of consistency from 80% to 89% respectively. Items 1 *versus* 11 and 6 *versus* 18 were very consistent with 93% degree of consistency. These items can be said to be very reliable. It may mean that they were clear and measured what they purported to measure. It may also be a clear indication that response and positional bias were successfully controlled for and hence objectivity and internal validity were achieved. This further enhances the reliability of the research results. Babbie and Mouton (2001:27) point out that validity and reliability of a research is largely dependent on the method and instrument used to collect data. The results of this study will be discussed in detail in the next chapter.

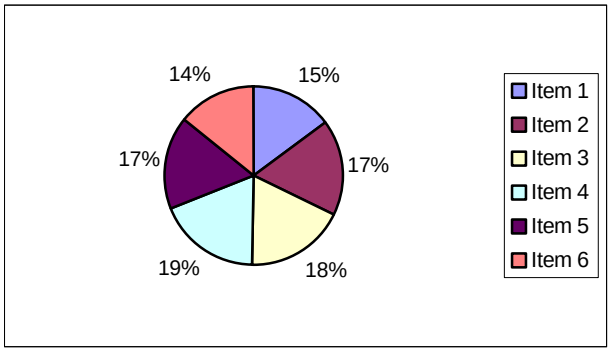
4.6 QUALITATIVE ANALYSIS ON THE OPEN-ENDED QUESTIONNAIRE TO PARENTS

Qualitative analysis was used on items one to six on the open-ended questionnaire to parents. The first item was on five major difficulties parents experienced in raising their children with hearing impairments, the second was on organizations and individuals that counseled them, the third one was on whether the counseling they received helped them or not, that is if they received any counseling at all. The fourth one was on whether they

thought counseling helped them (parents) to cope with their children or not. The fifth one sought their views on what they thought could be done in order to make counseling more accessible to parents, and the sixth was on how guidance and counseling could help them more. The results are presented in the form of charts and tables. The analysis of these responses was made in the following way: a comprehensive overview of the data was gained by reading through all the results of the qualitative part of the questionnaires. The results were then considered item by item by reading the results across items. Key aspects and/or themes that were mentioned by a majority of the participants in their responses to each item were written down. Then the data was checked again and simple counting methods were used to count the number of participants whose responses indicated a particular theme/key aspect.

In the next section these quantified results will be presented by indicating the number of participants that presented a particular theme in the results. This will be followed by a section where examples from the raw data will be shared, to indicate the qualitative dimensions in the responses from the participants.

FIGURE 4.6.1: NUMBER OF PARENTS WHO RESPONDED TO ITEMS 1-6



Each item is presented in a table numbered with a chapter number point item number. For example item 1 is numbered table 4.2.1, item 6 is numbered table 4.2.6, etc. Percentages used in these results have been rounded up or down to the nearest whole number. One hundred and eighty two (182) parents, (15%) responded to item 1, 208 parents (17%) responded to item 2, 218 parents (18%) responded to item 3, 226 parents (19%) responded to item 4, 206 parents (17%) responded to item 5 and 172 parents (14%) responded to item 6.

TABLE 4.6.2 FIVE MAJOR DIFFICULTIES PARENTS EXPERIENCED IN RAISING THEIR CHILDREN WITH HEARING IMPAIRMENTS

Community negative attitude towards the child	68	24%
Teaching the child basic living skills	122	43%
Communication	146	52%
Money for fees and hearing aids	130	46%
Transporting the child to school and hospital	42	15%

One hundred and eighty two (182) parents responded to item 1 and the results were as indicated. Communication seems to be the biggest problem, followed by shortage of financial resources to pay fees and purchase hearing aids for the child. This is followed by teaching the child basic living skills, then societal negative attitude towards the child and finally lack of means to transport the child to school and visit the hospital.

TABLE 4.6.3 ORGANIZATIONS AND/OR INDIVIDUALS THAT COUNSELED THE PARENTS

Parents counseled by church counselors	25	12%
Parents counseled by hospital counselors	62	30%
Parents counseled by counselors in special schools	46	22%
Parents counseled by relatives and friends	75	36%

Two hundred and eight (208) parents responded to item 2, and the results were as indicated. Twelve percent of the parents obtained counseling from churches, 30% from hospitals, 22% from special schools and 36% from relatives and friends. Participants are not very keen to spend a lot of time answering taxing questions, this may explain why only 208 parents responded to this item.

TABLE 4.6.4 WHETHER OR NOT PARENTS RECEIVED COUNSELING AND HOW IT HELPED THEM IF THEY RECEIVED IT

Yes	212	97%
No	6	3%
Helped me to fully accept the child	152	54%

Two hundred and eighteen (218) parent-participants responded to item 3, and the results were as indicated. Ninety seven percent (97%) of the participants agreed that they received counseling. This percentage relates to the one on quantitative data, item (vi) where 90% agreed that they received counseling, 54% agreed that counseling helped them to accept their children with hearing impairments, which also correlates to the earlier findings on table 4.3.8.5. It is interesting to note that 3% of the participants indicated that they did not receive counseling, while 10% indicated so when 300 participants responded, as shown in table 4.3.2.1.

TABLE 4.6.5 **WHETHER OR NOT PARENTS THOUGHT THE COUNSELING THEY RECEIVED HELPED THEM TO COPE WITH THEIR CHILD. IF THEY THOUGHT IT HELPED, THEIR VIEWS ON HOW IT HELPED WERE SOUGHT**

Yes	196	70%
No	27	10%
Helped me to cope with the child	162	57%

Two hundred and twenty six (226) parents responded to item 4, and the results were as indicated. Seventy percent (70%) agreed that the counseling they received helped the to cope with their children with hearing impairment, 10% indicated that counseling did not help them to cope with their children and 57% indicated that they were able to cope with the child after counseling.

TABLE 4.6.6 **PARENTS' VIEWS ON WHAT COULD BE DONE TO MAKE COUNSELING MORE ACCESSIBLE TO PARENTS**

Awareness campaigns using the media, posters and advertisements	100	35%
Seminars and workshops	214	76%
Parents support groups where parents meet share problems and possible solutions	106	38%

Two hundred and six (206) parents responded to item 5, and the results were as indicated. Seventy six percent (76%) of the participants suggested that seminars and workshops would inform more people of the available counseling services, 38% suggested that parents

support groups would help especially when parents who have similar problems share possible solutions to their problems and 35% suggested awareness campaigns using the media, posters, and advertisements over the radio and/or on television.

TABLE 4.6.7 HOW PARENTS COULD BE HELPED MORE THROUGH GUIDANCE AND COUNSELING

Counseling the hearing impaired child	46	16%
Help parents to cope and to integrate the child into the family	86	30%
Help parents to plan the future of the child	70	25%

One hundred and seventy two (172) parents responded to item 6, and the results were as indicated. Thirty percent (30%) of the parents who responded suggested that guidance and counseling should equip them with strategies that will enable them to cope with their children and further integrate them into the family. Twenty five percent (25%) suggested that guidance and counseling should help parents plan the future of their children and 16% suggested that children with hearing impairments should receive guidance and counseling.

4.7 INTERPRETATION OF QUALITATIVE RESULTS ON THE OPEN-ENDED QUESTIONNAIRE TO PARENTS

Parents of children with hearing impairments have an important contribution to make towards the counseling of other parents and students with disabilities. However, very little attention is paid to understanding them in terms of their opinions and knowledge about counseling, their views on how parents can have easy access to counseling and how counseling can be improved (Tucker & Nolan, 1984:112). In answer to the question 'What five major difficulties did you meet in raising your child with a hearing impairment?' Out of 300 parents, 182 responded to this question. Several different responses were given but of these five were stood out. Sixty eight (68) participants, (24%) of the parents indicated negative attitude from the community towards the child with hearing impairments. Some of the comments were as follows, **"Amazement attitude from the community as they gaze at you till you are out of sight as if there is something terribly wrong with you and your child"**, **"Some people watch you as you communicate with the child and**

laugh as if they are watching an interesting film", 122 participants, (43%) indicated a difficulty in teaching the child basic living skills. Some of the comments expressed were; **"It was a nightmare to teach her toilet and eating habits, as well as general cleanliness without a language"**, **"Teaching her how to eat, dress, use the toilet and clean herself was difficult and embarrassing if you had visitors"**, 146 participants, (52%) indicated communication problems. Some of the direct comments; **"It was frustrating in failing to communicate with my child", "I felt frustrated to communicate with the child signing without understanding each other, especially where there was a group of people"**, 130 participants, (46%) indicated financial difficulties. Some of the parents' comments, **"Taking the child to the hospital for interviews and treatment was a problem due to shortage of money. This made her go to school at 11 years"**, **"I sold 5 oxen to visit witch doctors and private doctors till all the money was finished before the child started school",** 42 participants, (15%), indicated transport problems. Some of the comments expressed were; **"It was difficult to carry the child on one's back from the village to the bus stop in order to take him to the hospital. Sometimes I did not have money for bus fare so I did not go to the hospital", "Taking the child to the audiologist, ENT and special school was difficult without a car. Sometimes I would run out of money. My relatives were not eager to help."**

In answering the question 'Which individuals or organizations counseled you?' Two hundred and eight (208) parents out of 300 responded to this question. Forty six (46) participants, (16%) indicated that churches counseled them. Comments from some of the participants**, "Our church, Roman Catholic, counseled me and gave me some money to pay for the child's treatment"**, **"Our pastor counseled me and prayed for the child. Ladies from our church brought money for bus fare to take the child to hospital"**, 112 participants, (40%) indicated hospitals. Some of the direct comments, **"Doctor Powell from the hospital counseled me and treated the child"**, **"Harare rehabilitation centre and doctors there counseled me and advised me where to take the child"**, 82 participants, (29%) indicated special schools. Comments from some of the participants were as follows; **"Special school counseled me and gave the child a hearing aid"**, **"One special teacher counseled us and took the child to the boarding",** 130 participants, (46%) indicated relatives and friends. Direct comments from participants, **"My relatives counseled us and did not want us to tell many people about our child"**, **"Relatives and**

friends counseled us and supported my family during the difficult times." In answering the question 'Did the counseling you receive help you?' 218 parents out of 300 responded to this question. Two hundred and twelve (212) participants, (75%) indicated 'yes' and 49 (17%) indicated 'no'. Comments from participants, **"Yes, in a sense I had to accept him as he is"**, **"Yes, it helped me to accept my child as he is but it was not easy"**, **"No, there was nothing I got from the counselors"**, **"No, they did not tell us who caused it."** To the follow up question 'Why?' 152 participants, (54%) indicated that it helped them to fully accept their child. Comments to the why question are included in the responses above.

In answering the question 'Do you think counseling helps parents to cope with their children?' 226 out of 300 parents responded to this question. One hundred and ninety six (196) participants (70%) indicated 'yes' and 27 (10%) indicated 'no'. To the follow up question, which asked for a reason, 162 participants (54%) indicated that it helps parents to cope with the child. Direct comments from participants**, "Yes, knowing what your child can and cannot do is important"**, **"Yes, it helped me to know that my child can lead a normal life"**, **"No, because they do not give you money to buy hearing aids and pay school fees"**, **"No, because they will not be there when you are with your child in your home."**

In answering the question 'What do you think should be done to make guidance and counseling accessible to parents?' 206 out of 300 parents responded to this question. A number of suggestions were given but there were three outstanding ones. One hundred (100) participants, (35%) suggested awareness campaigns through the media, posters in public places and advertisements. Some direct comments from participants, **"Must have programmes on television, put posters in public places and advertise counseling organizations over the radio and on television"**, **"Counseling organizations must come in the open and publicize themselves"**, 214 participants, (76%) suggested seminars and workshops run by counseling organizations and special schools. Some comments from the participants, **"Hospitals, counseling organizations and special schools must run workshops for parents"**, **"Advertise counseling organizations through the television, seminars and workshops"**, 106 participants, (38%) suggested parents counseling groups, where parents meet, support one another sharing experiences, problems and possible solutions. Some direct comments from the participants, **"Parents support groups can be**

formed and run in all major cities of the country", **"Parents workshops with qualified counselors advising them about counseling services."** In answering the question 'How can guidance and counseling help you more as parents?' 172 out of 300 parents responded to this question. Again a number of suggestions were given, with three outstanding ones. Forty six (46) participants, (16%) suggested counseling the child who is hearing impaired. Direct comments from participants were as follows; **"Our deaf children also need counseling because some of them do not do what you ask them to do"**, **"Children with hearing impairments also need counseling because some of them do not know what they are able to do"**, 86 participants, (30%) suggested guiding parents to cope with the situation and to be able to integrate the child into the family. Direct comments from participants, **"Help parents cope and treat the child together with others, not making him special"**, **"Frequent meetings to discuss problems and solutions on how parents can cope and involve the child in family activities"**, 70 participants, (25%) suggested guiding parents to plan the future of their hearing impaired child. Direct comments from participants were as follows, **"We need proper guidance in order to plan the future of these children so that they do not remain a burden"**, **"We should be made aware of what these children can do such as sewing, cooking, art and typing so that we can plan for their future."** The next part of this chapter deals with quantitative data analysis on the questionnaire to service organizations.

4.8 QUANTITATIVE DATA ON THE QUESTIONNAIRE TO SERVICE ORGANIZATIONS

TABLE 4.8.1 COUNSELING SERVICE ORGANIZATIONS

	N	
	Valid	Missing
Type of Service Organization	*28*	*0*
Have Counseled Parents of Children with Disability	*28*	*0*
Have Counseled Parents of deaf Children	*28*	*0*
Parent counseled	*28*	*0*
Have qualified counselors	*28*	*0*
No. of Uncertified Counselors	*28*	*0*
No. of Counselors with Certificate level	*28*	*0*

No. of Counselors with Diploma level	*8*	*20*
No. of Counselors with Degree level	*1*	*27*
No of Parents Counseled per Year	*28*	*0*

All 28 organizations responded to the first seven items and the last one. Eight organizations responded to the qualification of Diploma level and one responded to the qualification of Degree level.

TABLE 4.8.2 TYPE OF SERVICE ORGANIZATION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Special School	*5*	*17.9*	*17.9*	*17.9*
	Hospital	*5*	*17.9*	*17.9*	*35.7*
	Church	*15*	*53.6*	*53.6*	*89.3*
	Counseling Organization	*3*	*10.7*	*10.7*	*100.0*
	Total	*28*	*100.0*	*100.0*	

Table 4.8.2 indicates the type and number of organizations that took part in the study. Eight percent (18%) were special schools, 18% hospitals, 54% were churches and 11% were registered counseling organizations.

TABLE 4.8.3 HAVE YOU COUNSELED PARENTS OF CHILDREN WITH DISABILITIES?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	*28*	*100.0*	*100.0*	*100.0*

All organizations indicated that they have counseled parents of children with disabilities.

TABLE 4.8.4 HAVE YOU COUNSELED PARENTS OF DEAF CHILDREN?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	*28*	*100.0*	*100.0*	*100.0*

All organizations indicated that they have counseled parents of deaf children**.**

TABLE 4.8.5 PARENTS COUNSELED

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Mother	*9*	*32.1*	*32.1*	*32.1*
	Both	*19*	*67.9*	*67.9*	*100.0*
	Total	*28*	*100.0*	*100.0*	

Of the 28 organizations that responded to item 5, 32% of them counseled women only and 68% counseled couples. It is interesting to note that no man has been counseled on his own.

TABLE 4.8.6 HAVE YOU QUALIFIED COUNSELORS?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	*28*	*100.0*	*100.0*	*100.0*

Of the 28 organizations that responded to item 6, all 28 indicated that they have qualified counselors.

TABLE 4.8.7 NO. OF UNCERTIFIED I

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	*1*	*3.6*	*3.6*	*3.6*
	4	*3*	*10.7*	*10.7*	*14.3*
	5	*6*	*21.4*	*21.4*	*35.7*
	6	*3*	*10.7*	*10.7*	*46.4*
	8	*4*	*14.3*	*14.3*	*60.7*
	10	*2*	*7.1*	*7.1*	*67.9*
	12	*1*	*3.6*	*3.6*	*71.4*
	14	*1*	*3.6*	*3.6*	*75.0*
	15	*3*	*10.7*	*10.7*	*85.7*
	16	*3*	*10.7*	*10.7*	*96.4*
	17	*1*	*3.6*	*3.6*	*100.0*
	Total	*28*	*100.0*	*100.0*	

Of the 28 organizations that responded to item 7, on the number of uncertified counselors, 4% thus four separate organizations, each indicated that they had two, 12, 14 and 17 respectively. Another four groups of three separate organizations thus 11% indicated 4, 6, 15, and 16 respectively. Four organizations, thus 14% indicated that they had eight uncertified counselors, while six thus 21% indicated that they had five. All the 28 organizations had a total of 109 uncertified counselors.

TABLE 4.8.8 NO. OF COUNSELORS WITH CERTIFICATE LEVEL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	*15*	*53.6*	*53.6*	*53.6*
	2	*8*	*28.6*	*28.6*	*82.1*
	3	*4*	*14.3*	*14.3*	*96.4*
	4	*1*	*3.6*	*3.6*	*100.0*
	Total	*28*	*100.0*	*100.0*	

Of the 28 organizations that responded to item 8, 54% had one counselor qualified at certificate level, 29% had two, 14% had three and 4% had four.

TABLE 4.8.9 NO. OF COUNSELORS WITH DIPLOMA LEVEL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	*6*	*21.4*	*75.0*	*75.0*
	2	*1*	*3.6*	*12.5*	*87.5*
	3	*1*	*3.6*	*12.5*	*100.0*
	Total	*8*	*28.6*	*100.0*	
Missing	System	*20*	*71.4*		
Total		*28*	*100.0*		

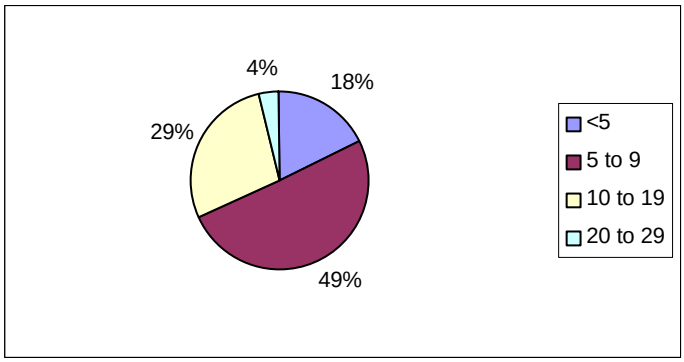
Of the 28 organizations, only eight responded to item 9. From those eight, 75% had one counselor qualified at diploma level, 13% had two and another 13% had three. All the eight organizations that responded had a total of six counselors qualified at diploma level.

TABLE 4.8.10 NO. OF COUNSELORS WITH DEGREE LEVEL

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	*1*	*3.6*	*100.0*	*100.0*
Missing	System	*27*	*96.4*		
Total		*28*	*100.0*		

Only one organization out of 28 responded to this item. The organization indicated that they had one counselor qualified at degree level.

FIGURE 4.8.11 NO. OF PARENTS COUNSELED PER YEAR



Again all 28 organizations responded to the question on the number of parents they counseled per year. Eighteen percent (18%) of the organizations indicated that they counsel less than five parents per year. Fifty percent (50%) indicated that they counsel five to nine parents, 29% indicated that they counsel 10 to 19 parents while 4% indicated that they counsel 20 to 29 parents per year.

Responses of organizations to six questions on the questionnaire to counseling service organizations were analyzed item by item and the results are indicated in table 4.8.12.

TABLE 4.8.12 RESPONSES OF ORGANIZATIONS

		SA	A	U	D	SD	Total
Count	Most parents counseled are able to cope	*5*	*11*	*3*	*7*	*2*	*28*

		SA	A	U	D	SD	Total
	Counselors are well equipped	*9*	*10*	*1*	*7*	*1*	*28*
	Not all counselors know difference between counseling and advice	*2*	*17*	*4*	*5*		*28*
	Most parents counseled keep coming back	*5*	*16*	*1*	*6*		*28*
	Counselors are not comfortable to deal with parents of children with disabilities.	*5*	*16*	*1*	*5*	*1*	*28*
	Qualified Counselors perform better than unqualified counselors	*1*	*5*	*1*	*16*	*5*	*28*
Percent	Most parents counseled are able to cope	*17.9*	*39.3*	*10.7*	*25.0*	*7.1*	*100.0*
	Counselors are well equipped	*32.1*	*35.7*	*3.6*	*25.0*	*3.6*	*100.0*
	Not all counselors know difference between counseling and advice	*7.1*	*60.7*	*14.3*	*17.9*		*100.0*
	Most parents counseled keep coming back	*17.9*	*57.1*	*3.6*	*21.4*		*100.0*
	Counselors are not comfortable to deal with parents of children with disabilities.	*17.9*	*57.1*	*3.6*	*17.9*	*3.6*	*100.0*
	Qualified Counselors perform better than unqualified counselors	*3.6*	*17.9*	*3.6*	*57.1*	*17.9*	*100.0*

SUMMARY OF RESULTS

Item	Agree	Disagree	Undecided	Total
1	*57.2*	*32.1*	*10.7*	*100,0*
2	*67.8*	*28.6*	*3.6*	*100.0*
3	*67.8*	*17.9*	*14.3*	*100.0*
4	*75.0*	*21.4*	*3.6*	*100.0*
5	*75.0*	*21.5*	*3.6*	*100.0*
6	*21.5*	*75.0*	*3.6*	*100.0*

On item 1: Most parents counseled are able to cope with their children, 16 organizations (57%) agreed with the statement and nine participants (32%) disagreed while three participants (11%) were undecided. On item 2: Counselors in our organization are well equipped, 19 participants (68%) agreed, while eight (29%) disagreed and one (4%) was

undecided. On item 3: Not all counselors know the difference between counseling and advice, 19 participants (68%) agreed with the statement, five (18%) disagreed and four (14%) were undecided. On item 4: Most parents who were counseled kept on coming back for more help, 21 participants (75%) agreed with the statement, six (21%) disagreed and one (4%) was undecided. On item 5: Counselors are not comfortable to work with parents of children with disabilities, 21 (75%) agreed, while six (22%) disagreed and one (4%) was undecided. On item 6: Qualified counselors perform better than unqualified counselors, six participants (21%) agreed with the statement, while 21 (75%) disagreed and one (4%) was undecided. The next part of the study looks at the qualitative analysis on the open-ended questionnaire to service organizations.

4.9 QUALITATIVE ANALYSIS ON THE OPEN-ENDED QUESTIONNAIRE TO SERVICE ORGANIZATIONS

All 28 organizations responded to the open-ended questionnaire. Out of the 28, 26 responded to item 13, 28 responded to item 14, 19 responded to item 15 and 24 responded to item 16.

The analysis of these results was performed in a similar way to the qualitative analysis from the data that was obtained from the parent participants in the study. It will be presented in a similar fashion.

TABLE 4.9.1 WHAT ORGANIZATIONS CONSIDERED BEING THE MAJOR PROBLEMS OF PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS

Accepting the child	24	86%
Communication	28	100%

Twenty six (26) organizations responded to item 13, the results were as indicated. Eighty six percent (86%) considered accepting the child as one of parents' major problems while 100% considered communication as one of the major problems.

TABLE 4.9.2 WHAT ORGANIZATIONS THOUGHT WOULD BE THE MOST EFFECTIVE WAY OF HELPING PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS

Counseling	23	82%
Prayer	15	54%
Financial assistance	25	89%

Twenty eight (28) organizations responded to item 14 and the results were as indicated. 86% considered counseling to be one of the most effective ways of helping parents of children with hearing impairments, 54% suggested prayer as one of the most effective ways of helping the parents in question and 89% considered financial assistance as one of the most effective ways of helping parents.

TABLE 4.9.3 WHETHER PARENTS WHO WERE COUNSELED BY ORGANIZATIONS WERE ABLE TO COPE WITH THEIR CHILDREN OR NOT

Yes	12	43%
Were able to cope with the child	10	38%
No	9	32%
Were not able to cope with the child	4	14%

Nineteen (19) organizations responded to item 15, and the results were as indicated. Forty three percent (43%) indicated that they received counseling, while 38% of those counseled confirmed that they were able to cope with their children. Thirty two percent (32%) indicated that they were not counseled and out of these and 14% indicated that they could not cope with their children.

TABLE 4.9.4 COMMON PROBLEMS OFTEN PRESENTED BY PARENTS OF CHILDREN WITH HEARING IMPAIRMENTS

Community negative attitude towards the child	22	79%
Failing to cope with the child	18	64%

Twenty four (24) organizations responded to item 16, and the results were as indicated. Seventy nine percent (79%) of the participants indicated community negative attitude towards the child as one of the common problems often presented by parents of children with hearing impairments while 64% indicated failing to cope with the children as one of the common problems presented by the parents in question.

4.10 SYNOPSIS ON THE RESULTS FROM THE SERVICE ORGANIZATIONS

As pointed out by McLeod (1996:312) counseling organizations play an integral part in counseling parents of children with disabilities. Therefore their contributions are of paramount importance if parents are to receive a quality counseling service. Twenty eight (28) organizations responded to the open-ended questionnaire that had four items.

In answering the question 'What do you consider to be the major problem of parents of children with hearing impairments?' 26 organizations out of 28 responded to this question. Twenty four (24) organizations 86% indicated accepting the child as one of the major problems. Directs comments were as follows, **"What we have found here is that most parents find it difficult to accept the child and the situation as a whole"**, **"Parents feel that having a child who has a hearing impairment means there is something inadequate in them."** Twenty eight (28) participants, (100%) indicated communication as a major problem. Some of the comments from participating organizations were, **"Parents get frustrated when they fail to communicate with their own children"**, **"It is a devastating experience for parents and the hearing siblings when they see their child, or brother or sister fail to put across his/her demands or requirements."**

In answering the question 'What do you think would be the most effective way of helping parents of children with a hearing impairment?' all the 28 organizations responded to this question. Twenty three (23) participants (82%) indicated counseling. Comments were as follows; **"Counseling should be the first thing before anything else"**, **"Parents in such a situation need counseling before the family break apart"**, 15 participants (54%) indicated prayer. Comments given were**, "There is nothing impossible with God therefore prayer is the answer to these parents' problems"**, **"Through prayer God can heal their children if he forgives them.**" Twenty five (25) participants (89%) indicated

financial assistance. Direct comments were**, "These parents need financial assistance to pay for medical bills, school fees and transport"**, **"Having a child who is disabled in a family is like a curse because it is financially draining and therefore these parents need money to have the child tested and treated."**

In answering the question 'Were the parents counseled by your organization able to cope with their children?' 19 out of 28 organizations responded to this question. Twelve (12) participants (43%) indicated 'yes' and 10 (38%) of these gave the reason that they were able to cope. Their actual comments were, **"Yes, many of the parents were so happy because they understood their children's problems better"**, **"Yes, some of them came back to register their feelings of joy and to thank us."** Nine (9) participants (32%) indicated 'no' and four (14%) of these gave the reason that they were not able to cope. Their actual comments were, **"It is not easy to counsel parents of children with disabilities when you do not know much about what should be done with the child"**, **"It is frustrating to see how these parents suffer, no matter what you tell them the problems remain as long as the child is in the family."**

In answering the question 'What common problems have parents of children with hearing impairments often presented?' 24 out of 28 organizations responded to this question. Two outstanding problems were indicated. Twenty two (22) participants (79%) indicated negative attitude from the community. Direct comments were, **"Parents always complain about their neighbours, relatives and members of the community who withdraw their children from playing with the child with hearing impairments"**, **"Getting into a shop or bus with the child draws everyone's attention and they all give you the way."** Eighteen (18) participants (64%) indicated failing to cope with the child as one of the problems. Actual comments from the counseling organizations were, **"Sometimes you hear parents say: can't you find me a boarding school where I can put him, since they know how to communicate with him"**, **"I have stopped working and I have to be home all the time to make sure that he is safe."** A number of challenging comments that cannot be accommodated here have been expressed, the ones given here are only a few selected ones.

4.11 SUMMARY OF THE CHAPTER

In this chapter results concerning the demographic information on parents and children have been presented and analyzed. Sources of counseling, parents' experiences, views and perceptions on counseling have been looked at. Contributions of counseling organizations in terms of counseling parents of children with hearing impairment, qualifications of their employees and their experiences in dealing with parents of children with disabilities have been tapped into. Although results have been presented and analyzed, there is need to discuss all the results in detail in order to make them more meaningful. Chapter 5 gives a detailed discussion of the results and their implications for parents of children with hearing impairments and their children. In the next chapter I will discuss the research findings in relation to the existing body of knowledge.

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5 DISCUSSION OF RESULTS

5.1 INTRODUCTION

In this chapter I will discuss the results of the research findings in relation to the ways parents of children with hearing impairments accessed counseling in Zimbabwe during the period 1999 to 2000. I will start with a discussion of the biographical details of the participants in the study in order to frame the results that follow it. The difficulties that parents experienced in raising their children with hearing impairments, that further motivated some of them to seek counseling services will be looked into. Details of where parents obtained counseling, their perceptions of the counseling they received and the relationship between counseling and accepting and coping with their children with hearing impairments are also discussed. Quantitative results will be discussed first, followed by qualitative results, all obtained from data generated from parents of children with hearing impairments. Results from counseling organizations, both of quantitative and qualitative data will also be discussed. All results reveal a number of important issues pertaining to the counseling of parents of children with hearing impairments and the accessibility of counseling services.

5.2 GENDERS OF PARTICIPANTS IN THE STUDY

Results indicate that out of 300 participants who responded to the item on gender, 120 (40%) were men, 150 (50%) were women and 30 (10%) were couples. The high number of participants who were fathers is encouraging, because fathers are often under-represented in studies on the parents of children with disabilities. The high percentage can probably be explained by the fact that the data was gathered during enrolment days at schools, when fathers are often present. A number of studies (Moores, 1987:257, Meadow, 1980:384, Kauffman, 1992:169 and Heward & Orlansky, 1988:643), indicate that fathers of children with disabilities show less interest in and commitment to their children than their counterparts with non-disabled children. However, a study by Hallahan and Kauffman

(1994:498) with fathers and mothers of children with disabilities indicated that while mothers are more involved than fathers, there is a gradual increase in the number of men who are taking an active role in the life of a child with disabilities. As pointed out by Dale (1984:69) this could be caused by the general wide spread knowledge on disability and its causes that is gained through the media, literature and televised educational programmes. The number of father-participants in this study is also indicative of this trend.

5.3 GENDER OF PARTICIPANTS' CHILDREN

Out of 300 parents who responded to the item on gender of children, 180 (60%) of the parents' children were boys and 120 (40%) of the parents' children were girls. Only one parent (0.3%) had a boy and a girl but this incidence became insignificantly small as the larger pool of the data was analyzed. As indicated in figure 4.3.1.2, this biographical detail confirms that of other literature concurring the prevalence of hearing disabilities in children. Cartwright, Cartwright and Ward (1995:271) and Moores and Meadow (1990:347), precisely point out that deafness is more prevalent in boys than in girls, although the difference is not always significant. The fact that one parent had a boy and a girl with a hearing impairment, may imply that the causes were hereditary.

5.4 NATURE OF HEARING LOSS

Out of 300 parents who responded to the question of whether their children were born deaf or became deaf later, 55% of the parents indicated that their children were born deaf while 41% indicated that their children became deaf later while 4% indicated that they did not know whether their children were born deaf or they became deaf later. The results of a study by Moores and Meadow (1990:123) as indicated in figure 4.3.1.3 show a high correlation with the findings of this study. A small inconsistency appears in parents' responses to the same questions asked the other way. For example the statement "My child was born deaf" 55% indicated that they agreed with the statement. When the opposite statement was given, "My child became deaf later", 53% of the parents indicated "no" instead of 55%. As pointed out earlier on in figure 4.3.1.4, the implication may be that some parents are not quite sure whether the child was born deaf or became deaf later, especially if the child's hearing impairment was discovered at a very late stage. Hunt and

Marshall (1994:364) assert that it is difficult to be certain whether the child was born deaf or became deaf later, if the screening system is not implemented at birth or is not effective.

5.5 AGES OF PARTICIPANTS' CHILDREN

Of the 300 parents who responded to the question on children's ages, 24% indicated that they had children between the ages of five and eight years, 49.3% indicated that they had children between the ages of nine and 13 years, 25.7% indicated that they had children between the ages of 14 and 18 years, while 1% indicated that they had children between nine and 13 years and also other children between the ages of 14 and 18 years. The high percentage of children in the age groups nine to 13 and 14 to 18 is likely to be caused by late discovery of hearing impairment. Heward and Orlansky (1988:582) in their study carried out in America specify that late identification of hearing impairment delays correct placement and causes loss of time on the part of the child. Children whose hearing impairments is discovered late lose out on early intervention programmes that help the formation of speech patterns, listening skills, speech and lip reading as well as correct concept formation (Martin & Clark, 1996:192 and McCormick, 1988:270). It is encouraging to note that 24% of the parents indicated that their children were between five and eight years, this being the most appropriate age for speech development and auditory training (Webster, 1986:153).

5.6 PARTICIPANTS WHO RECEIVED AND THOSE WHO DID NOT RECEIVE COUNSELING

Out of 300 participants who responded to whether they received counseling or not, 270 (90%) indicated that they received counseling while 30 (10%) indicated that they did not receive counseling. As pointed out earlier on by Howard (1992:37) in figure 4.3.2.2, people obtain counseling from different sources: from professionals, non-professionals, members of the extended family, individuals and sometimes from relatives. Howe (1993:87) and Howard (2000:94) assert that some counseling sessions are unstructured, taking place in natural conversation where the counselor may not say anything but just listens attentively and empathizes with the client as he/she relates his/her story. Ivey and Ivey (1993:128) asserts that some clients may not interpret this as counseling due to their

expectations of what should come out of a counseling session. These factors may explain why 10% of the parents perceived that they did not receive counseling. It is, of course, possible that they did indeed receive no counseling.

5.7 PARTICIPANTS' SOURCES OF COUNSELING

Participants in this study reported that they obtained counseling from different sources. Out of 270 participants who received counseling, 63% indicated that they received counseling from special schools, 40% from registered counseling organizations, 45% from churches, 47% from hospitals, 30% from relatives, 52% from individuals and 1% from friends. In developing countries, particularly in sub-Saharan Africa (Roffey, 2001:48 and Baine, 1988:56) parents of children with disabilities mainly rely on teachers of special education for professional counseling and expert advice. This is so because these are the professionals they come to know and work with, as they seek to enroll their child in a school. This is endorsed by Werner (1987:204) when he pointed out that parents and the community regard special schools as their savior regarding children with disabilities. To them, special schools have everything for both children with disabilities and their parents. According to Werner, parents' assumptions are that in special schools, all their needs are met, problems solved and the children are fully catered for. However, in reality, special schools have a lot of gaps that other professionals such as psychologists, speech therapists, audiologists and social workers must fill in order for the school to provide a comprehensive service. Most special schools in developing countries cannot afford to employ these professionals full time in schools, though some have them on part-time basis (Meese, 2001:15). The other factor is that developing countries have a shortage of qualified personnel in all the above-mentioned professions (UNESCO, 2001:2). Considering Werner, Roffey and Baine's explanations, it would seem logical to assume that most participants were counseled in special schools simply because they (special schools) were a more readily available source, possibly with a free service. Studies carried out by Gartner, Lipsky and Turnbull (1991:261) indicate that in developed countries, where resources, qualified personnel and registered counseling organizations are readily available, by the time parents of children with hearing impairments visit special schools, most of them would have already received counseling and/or advice from different professionals and/or organizations.

The fact that only 40% of the participants received counseling from registered counseling organizations may be due to the fact that not many parents were aware of counseling organizations, as indicated in figures 4.3.8.3 and 4.3.8.13. Although there is a slightly higher percentage of participants who were aware of counseling organizations (53.9%), it is possible that means of transport, traveling expenses and financial constraints could have prevented them from visiting the counseling organizations all of which are situated in towns. These factors are apparent in table 4.6.2 where participants cited lack of transportation and financial constraints as some of the difficulties they faced in taking children to special schools and hospitals. Lea and Clarke (1991:159) carried out a study and found that 11 families that had requested help from health professionals failed to attend the appointments. Possible reasons given were that they might have failed due to difficulties traveling to specialized centres, lack of funds, lack of knowledge of what the services offered and where the services could be located, as well as fear of stigmatization.

It is interesting to note that 45% of the participants received counseling from churches. Most studies in special education, particularly in developing countries, target children, teachers and to a lesser extent parents (Kisanji, 1992:263; Makoni, 1996:8; Baine, 1988:49 and United Nations, 1997:1). Most of these studies are conducted in a school and/or home environment, but this study included churches, and church environments. In his research article, 'Spiritual issues in counseling' Fukuyama (1997:237), indicates that there are a number of studies in general spiritual counseling that involve families, teachers and students, but a lot more is still to be done in the area of special education. Fukuyama (1997:241) points out that churches play an important role in counseling as long as counselors are well trained and offer spiritual support. It was clear from the literature review in a study carried out by Howe (1996:127) that church counselors who continuously gave their clients moral, social and physical support achieved better counseling results than other counselors who quickly disengaged. According to the above studies there seems to be some indication that churches are an effective source of counseling that could be encouraged to continue to play a major role in counseling parents of children with disabilities.

Only 47% of the participants indicated that they received counseling from hospitals. If the screening procedure were to be effective from birth, this figure would have been much

higher. McCormick (1988:372) and Tucker and Nolan (1984:2) declare that work in guidance and counseling should be co-ordinated by educational audiologists. In the United Kingdom one of the major roles of audiologists is to train the health visitors who carry out the initial screening procedures in hospitals and other health related centres. Part of this training involves counseling parents since audiologists and health visitors are the first to discover hearing impairment in children. They are therefore the ones called upon to break the news to the parents. Audiologists, nurses and health visitors who work in audiological centres and clinics have a counseling background and many parents get their initial counseling soon after the child is confirmed to be having a hearing impairment (Martin & Clark, 1996:78). In Zimbabwe there is a shortage of qualified audiologists and counselors with the result that only isolated cases of hearing impairment are discovered at an early stage. Such children are found merely by chance. The percentage of parents counseled in hospitals has only started increasing from 1999 due to rehabilitation units set up in hospitals. There are serviced by trained specialist teachers for the hearing impaired. A number of nurses are also being trained in counseling by a non-governmental counseling organization that has qualified counselors. Parents in rural areas may not have sufficient money to travel to big hospitals where specialists are stationed. All these factors contribute to the low percentage of parents counseled in hospitals.

Participants who indicated that they received counseling from relatives amount to 91 out of 300 (30%). Those who indicated counseling by individuals constitute 157 out of 300 (52%) while those who indicated that they were counseled by friends, only constitute four out of 300 (1%). According to the literature, in the African traditional counseling, Shumba (1995:37), Sue and Sue (1990:327) and Baine (1988:84) in one way or another, all point out that relatives and members of the extended family were considered as counselors of a family. There is also a growing trend of families moving away from the traditional extended family to the single-parent family and/or the modern nuclear family (Blocher, 2000:247). This is encouraged by the limited facilities in towns that do not allow for big families. A high percentage of the participants in this study, who indicated that they received counseling from individuals, might have obtained it from professionals, or counselors in their individual capacities or church members or family doctors or any other individuals. Throughout the literature, professional counselors who operate as individuals do offer counseling to many who approach them either for payment or for free (Howard,

1996, 28; Howe, 1996:369 and Ivey, 1980:14). It is interesting to note that friends do not seem to be the best people to approach for counseling. It is possible that they are so close to the family with a child with hearing impairment that they become part of the family that needs counseling. As pointed out by Peltier and Vale (1986:315) a family with a child with disabilities will need counseling together with friends and members of the extended family in order for them to offer appropriate moral and emotional support to one another.

5.8 THE NEED FOR COUNSELING AND ITS EFFECT ON PARENTS ACCEPTING AND COPING WITH THEIR CHILDREN WHO HAVE HEARING IMPAIRMENTS

Out of 300 participants that responded to the statement, "Parents of children with hearing impairment do not need counseling", 93% disagreed with the statement, 6% agreed and 1% were undecided. In response the opposite question, "Counseling is a must for parents of children with hearing impairments", out of 260 participants who responded, 87% agreed with the statement, 7% disagreed and 5% were undecided. The high percentages are a clear indication that counseling is regarded as necessary for parents of children with hearing impairment. These results are confirmed in the literature. A study by Thomas (1989:110) examined the social and emotional adjustment of 84 families of children with hearing impairments. His study indicates that parents who had received counseling developed positive attitudes towards their children and that these further produced emotional and social stability in both children and parents, with a higher correlation in older children. The role of counseling cannot be underestimated. Gartner, *et al*. (1991:36) in their article "Changing views of family participation", indicate the needs of parents for counseling by presenting direct quotations from the data: "As families of children with hearing impairments, we require guidance and counseling and support, preferably from families that have gone through a similar experience and have successfully integrated into the community." This is further complemented by Harry (1997:153) when he pointed out that the process of going through anger, guilt, shock and denial requires guidance and counseling to help parents and siblings work through their emotions in such a way that they as a family accept the child.

Analyzed data on participants accepting the child with hearing impairments indicate that counseling in general helped parents to accept their children with hearing impairments. Out of 294 participants who responded to the statement, "Counseling does not help parents accept the idea of having a hearing impaired child in the family", 16% agreed with the statement, 79% disagreed and 5% were undecided. In response to the direct opposite statement, "Without counseling one cannot fully accept having a child with a hearing impairment in the family", out of 296 participants who responded, 76% agreed with the statement, 20% disagreed and 4% were undecided. Again this clearly confirms what is in the literature. Cartwright, Cartwright and Ward (1995:398) assert that parents of children with hearing impairments gradually accept their child as part of the family, after a lot of consultations and counseling sessions. However, they point out that not only is the study of families of individuals with disabilities difficult because of the complexity of the interactions that take place, but it is further complicated by the fact that studies rely so much on subjective impressions. One is then dealing with parents' feelings towards the child, and the siblings and parents' feelings towards the society's reactions towards the child. Moores (1996:87) points out that many parents accept their children with hearing impairments after receiving counseling and interacting with other parents who went through a similar situation. Moores and Meadow (1990:140) indicate that parent support groups are more powerful in helping parents of children with hearing impairments accept their children than counselors who have never had children with disabilities.

With regard to parents coping with their children after counseling, in response to the statement, "The counseling we received did not help us to cope with the child at all". Out of 293 participants, 22% agreed with the statement, 72% disagreed and 6% were undecided. The response to its direct opposite, "Counseling helped us to cope with our child who is hearing impaired". Out of 296 participants who responded to this statement, 85% agreed, 10% disagreed and 5% were undecided. There was a clear indication that parents of children with hearing impairments were more able to cope with their children after receiving counseling. This result concurs with similar results in the literature. A study by Kirk, Gallagher and Anastasiow (1997:403) indicates that while parents go through difficult times in which they experience, fear, shock, guilt, frustration and grief, eventually with the help of professionals in the field of hearing impairment and counselors, the whole picture normally changes into loving, accepting and coping with the child. In their study

with 24 families that each had a child with a hearing impairment and had received counseling, Meese (2001:93) interviewed parents and siblings to find out if they had accepted and were able to cope with the child. All families indicated that they loved their children and were coping although it was not always easy. One family said, "It is like the world has rejected you, but with counseling and numerous consultations it is rewarding at the end". Hunt and Marshall (1994:358) assert that even after counseling, parents who have only one child, their first born, who happens to be hearing impaired, take longer to accept and to cope with the children. Such parents are shattered, they do not understand why it happened to them, and in some instances they might not even want to try having another child.

5.9 UNDERSTANDING COUNSELING, THE NEEDS OF THE CHILD, TAKING RESPONSIBILITY AND PLANNING THE FUTURE OF THE CHILD

In this study counseling was considered in all its different forms, either one to one between the counselor and the counselee or in-group form, sometimes with more than one counselor. We have also looked at counsel and guidance in the African culture where the elderly counsel the young. Participants understood counseling in different ways and all these were considered. The data collected on the difference between receiving counseling and receiving advice indicate that most participants are aware of the differences but at the same time subscribe to the view that in counseling there is also advice giving. Data collected from the statement, "Counseling is totally different from advice", yielded the following results; out of 298 participants who responded to this statement, 52% agreed with it, 43% disagreed and 5% were undecided. In response to the direct opposite statement, "It is difficult to separate counseling from advice", 42% of the participants agreed with the statement, 46% disagreed and 11% were undecided. It is clear that most participants were aware of the relationship between the two. Different counselors apply different counseling techniques. Howard (2000:43), Ivey and Ivey (1993:174) and Nystul (1999:328) all point out that counselors may use a variety of skills depending on the nature and problems of the client. Some clients do well with directive methods while others succeed with non-directive methods. On understanding the needs of the child, data collected indicate that over 80% of the participants agreed that counseling helped them to understand the child

and his/her needs. This result confirms the findings in a study by Hallahan and Kauffman (1994:495) that indicate that after three to four counseling sessions, parents gained confidence in dealing with their children's needs and demands. Parents also made an effort to read and understand more about hearing impairment and the challenges faced by parents of children with hearing impairments. Cartwright, Cartwright and Ward (1995:134) point out that most parents prefer to get advice from, and share information with parents who have children with hearing impairments and have managed to integrate them into their families. Hunt and Marshall (1994:375) assert that 76% of the parents they interviewed indicated that through counseling, parents were encouraged and challenged to acquire more information on the effects of hearing impairment on social and emotional development. This helped them to value child/child interaction and the benefits their children derive from playing with other children in the community.

Turnbull and Turnbull (1990:189) emphasized the importance of stressing to parents the value of child/child interaction and its benefits. Most parents express feelings of shock, anger, guilt, denial fear, anxiety and inadequacy about their child's hearing impairment. According to Kirk, Gallagher and Anastasiow (1997:380) parents do take full responsibility of their own children and counseling usually supports this process. In this study results indicate that over 70% of the parents were of the opinion that their children are their responsibility whether the government helps them or not in terms of their child's hearing impairment. Moores (1987:97) contend that through the use of guidance and counseling parents may shift from one extreme (denial) to the other end providing love and protection. In giving love and protection parents take full responsibility for their children.

Throughout the literature, (Edgar, 1987:559, Meadows, 1980:75, Neel, *et al*., 1988:211, and Hossie, Patterson & Hollingworth, 1989:174) indicate that there is a growing concern in the education of children with disabilities, about poor transition from primary to secondary education, from secondary to tertiary institutions and then in securing employment. There is a problem in either the education system or the planning by parents and/or educational authorities. Edgar (1987:557) points out that children with disabilities will continue to depend on their families until a system that sets them free is put in place. A system that will enable them to be employable and lead an independent life. In the first chapter of this study, the statement of the problem clearly indicates that parents continue to

come back to the special schools where their children learnt for advice on what to do with the children. Hunt and Marshall (1994:362) confirm that planning the future of students with disabilities remains an area of concern.

In this study, parents acknowledge that it is not easy to plan the future of children with hearing impairments. The problem may be compounded by education systems the world over, particularly in developing countries where unemployment figures are high (Backenroth, 2001:25). People with disabilities seem to struggle more to secure employment and other basic necessities of life such as accommodation (Heward & Orlansky (1988:246). While equal opportunities as advocated by Public Law (PL92-142) in the United States of America, the Education of All Handicapped Children Act (1975) (USA) and the Individuals with Disability Education Act (IDEA, (1986) also in the United States of America, have been accepted world-wide, the reality of the job market is that people with disabilities are still marginalized (Colledge, 2002:78). This is extensively supported by results of the multi-site study carried out by the United Nations (1997:5-7) in Malaysia, Nepal, Pakistan, the Philippines, Korea, Sri Lanka, Thailand and Bangladesh. The results of this study indicate that parents are not confident in planning the future of their children with hearing impairments, probably due to the prevailing unfavorable conditions the world over, regarding the employment of people with disabilities. It is important to review secondary and tertiary education programmes for individuals/students with disabilities so that they become more relevant and realistic to what people with disabilities can do and what industry demands. Blackorby and Wagner (1996:405), in their longitudinal study with post secondary school youth with disabilities, indicate that the majority of students with disabilities do not complete their education, they either drop out of school in secondary education or when doing college work. The study also shows that most of them are not employed and that the few who get jobs are poorly paid.

5.10 CORRELATION OF RESULTS BY GENDER OF PARENTS

In the comparison of counseling, (special schools, counseling organizations, churches, hospitals, relatives, individuals and friends), in relation to the gender of participants, Chi-squared results indicate that about the same proportion of males and females use special schools for counseling. Relatively more male parents use counseling organizations,

churches, and hospitals compared to female parents. Fewer male parents turn to relatives, individuals and friends compared to female parents. It is interesting to note that when I considered only five sources of counseling: counseling organizations, churches, hospitals, relatives and individuals, as sources used by both men and women, the main differences appear to be in use of counseling organizations, hospitals and individuals. In this analysis, more males then use hospitals than females while more females use counseling organizations and turn to individuals than males (respectively). When participants were compared in relation to only four sources of counseling, churches, hospitals, relatives and individuals, more males turn to relatives while relatively more females turn to hospitals. Proportions turning to churches and individuals do not appear to differ by much. There is an indication that the number of counseling sources affects both male and female choices and these choices change when certain sources are taken away.

In trying to establish the position of not being able to cope with the child with hearing impairment, after receiving counseling, males agreed that even after receiving counseling, they could not cope compared to females who relatively tend to disagree. The data established that there was no relationship between male and female participant responses in terms of being able to and not being able to cope with regard to the particular gender or the age of their children after receiving counseling. However, one of the paradoxes in traditional cultures is the fact that generally men *talk* about the importance of counseling, family cohesion and the nurturance of children while women are largely left unassisted to do something about it (Blocher, 2000:254). The tendency to blame mothers for the social and psychological problems of children is a well documented and readily apparent phenomenon in popular perceptions, public policy pronouncements, and even in the social scientific literature (Phares, 1992:658). It is befitting that men join hands with their wives or partners in parenting their children with disabilities. Studies indicate that fathers and mothers provide the same warmth and love to children if they give their time (Neukrug, 1999:66). The next part of this study deals with questionnaire response consistency.

5.11 QUESTIONNAIRE RESPONSE CONSISTENCY

In this section of the study I will indicate the strength of the instrument in terms of validity and reliability. The measure for consistency was administered mainly to check the validity and reliability of the instrument. Hill, Thompson and Williams (1997:537) point out that the validity and reliability of the instrument used, as well as the environment in which the study is conducted determine the quality of data collected. In this study, participants constantly acknowledged the value of counseling in both questionnaire responses and interview notes, particularly for parents of children with hearing impairments. On 22 out of 26 items, participants' responses were very consistent. Items 8 *versus* 19 and 9 *versus* 14 had degrees of consistency above 70%. Items 10 *versus* 20, 12 *versus* 24, 16 *versus* 23 and 21 *versus* 25 have degrees of consistency from 80% to 88.7% respectively. Items 1 *versus* 11 and 6 *versus* 18 were very consistent with 93% degree of consistency. These items can be said to be very reliable. It may mean that they were clear and measured what they purported to measure. It may also be a clear indication that response and positional bias were successfully controlled and hence objectivity and internal validity were achieved. This further enhances the reliability of the research results. Babbie and Mouton (2001:27) point out that validity and reliability of a research study is largely dependent on the method and instrument used to collect data. The levels of consistency in the instrument in this study are a clear indication that the instrument measured what it was intended to measure and that it turned out to be reliable. It would therefore stand to reason that the data collected in this study is reliable and valid, which contributes towards the credibility of the study. Inconsistency was only registered on four items: items 2 *versus* 26 and 7 *versus* 15. These items could have been poorly phrased, or not clear or specific. However, as a whole the instrument used in this study produced highly consistent responses.

5.12 QUALITATIVE RESULTS OF PARENTS

Results of qualitative data are discussed in the sequence in which they are presented in chapter 4, item 4.6.2. In these results the first item contains the participants' contributions towards the five major difficulties parents experienced in raising their child with hearing impairments. One hundred and eighty two (182) parents responded to this item. Of the five difficulties given, communication is at the top of the list. One hundred and forty six

(146) parents (52%) indicated that communication was a big problem. According to Cartwright, Cartwright and Ward (1995:147), Hallahan and Kauffman (1994:322) and Hunt and Marshall (1994:361) both parents and children get frustrated when they fail to engage in a meaningful conversation for basic needs and requirements. As social beings, communication is one of our most important means of survival. Without it, the potential of an individual in communicating needs and wants is severely restricted, and yet the ability to carry out a conversation with another person is one of the unique characteristics of human beings. Communication is important to every one to such an extent that lack of it carries social penalties that may give birth to emotional instability. Therefore the power of communication cannot be over-estimated. The parents of children with hearing impairments in this study placed it at the top of the list of the problems they faced.

The second item in terms of the difficulties parents faced was financial constraints. Out of 182 participants who responded, 130 participants (46%) indicated that they did not have enough money to pay for school fees and to buy hearing aids. A good number of these parents are based in rural, semi-urban and low-income areas and they send their children to the only special schools for children with hearing impairments. The schools uniforms, books and stationery are expensive. Parents from rural areas depend entirely on subsistence farming. The inconsistencies of earning a living in this way makes it very difficult for such parents to be able to pay school fees and also buy hearing aids.

Hearing aids are very expensive, bearing in mind that they are imported mainly from Europe. A study by Gelfand, Jenson and Drew (1988:52) indicates that 51% of all parents of children with hearing impairments, from a low socio-economic status had difficulties in obtaining sufficient money for transport, medical treatment and sometimes hearing aids. They also found that children from poverty-stricken families were more likely to be sent for special education before they were ready for school. In this study 122 (43%) of the participants out of 182, indicated that teaching the child basic living skills was also difficult for them. Hallahan and Kauffman (1994:495), Moores (1996:85), Moores and Meadow (1990:117) and Kauffman (1992:304) all endorse the opinion that parents of children with hearing impairments find the first two years particularly difficult to cope with their children. This may be due to the lack of skills necessary to teach the child basic living skills such as toilet, dressing, eating and sleeping habits. The community's negative

attitudes towards the child were one of the aspects mentioned. Sixty eight (68) out of 182 parents, (24%) stated that the community showed a negative attitude towards the child with hearing impairments. Some of the participants indicated that negative attitudes were shown in different ways, such as withdrawing their children from interacting with a child with hearing impairments, looking at the child with suspicion and talking ill about the situation. Cartwright, Cartwright and Ward (1995:401) assert that parents of children with hearing impairments and other disabilities, may suffer from an inferiority complex, feelings of inadequacy and guilty conscience as a result of the way in which society views them in relation to their child with hearing impairments. A study by Webster (1986:78) suggests that while society generally accepts the idea of living together with people with disabilities, when it came to effective interaction, very few indicated a willingness to share accommodation and/or any other facilities. The other difficulty that was cited by participants was transporting the child to school and to the hospital. Forty two (42) people (15%) out of 182 people who responded to this item, indicated serious transport problems. This is a common problem in developing countries where the transport system is poor and unreliable (Baine, 1988:23). In some places the roads are not rehabilitated, meaning that no buses service the areas. As a result parents walk long distances to get to bus stops or they simply give up and stay with the child at home.

On sources of counseling, out of 208 participants who responded, 25 (12%) received counseling from churches, 62 (30%) from hospitals, 46 (22%) from special schools and 75 (36%) from relatives and friends. According to Salkind (2000:98) participants in research studies are generally not keen to write long explanatory notes because it is both taxing and time consuming. This could be the reason why only 208 participants responded to this item. It may also be because this aspect was already covered in the previous section of the questionnaire. A comparison of quantitative and qualitative results of participants' sources of counseling, indicate some differences in percentages. Quantitative data were generated from 300 participants while qualitative data were generated from 208 participants who responded. Quantitative results (figure 4.3.2.2) indicate that 63% of the participants received counseling from special schools while results from qualitative data (table 4.6.3), indicate that 22% received counseling from special schools. Results from quantitative and qualitative respectively: churches 40% *versus* 12%, hospitals 47% *versus* 30%, relatives and friends 31% *versus* 36%. It would be difficult to account for these differences due to

the fact that some of the participants received counseling from more than one source. There is no guarantee that the same participants responded all the time. Participants could have noticed that they had covered the same items in the first questionnaire and therefore did not feel like writing them in an elaborate format. It might also be that most of the participants who did not respond to the qualitative questionnaire received counseling from one or two particular sources, which could also have affected the percentages.

In his research study, Howard (2000:126) indicates that parents of children with disabilities who were counseled by church counselors benefited more than parents who were counseled by secular counselors. Church counselors followed their clients, prayed with them, supported them morally, physically and spiritually. Secular counselors left their clients when they felt they could cope but seldom followed their progress timeously. It is therefore important for counselors to keep the line of communication open even after disengaging. In this study 47% of the participants received counseling from hospitals. Yet most parents go to the hospitals for initial diagnosis and treatment. Parents who visit hospitals are also referred to the Children's Rehabilitation Unit (CRU) where they are counseled and referred to ENT's and/or special school for further help. In this study 22% received counseling from special schools. These are also strategic institutions for parents to receive counseling but their priority is preferably to find a place for their child in the school. Counseling, in these instances, can only occur when the child has been offered a place. Very few parents would visit special schools primarily for counseling. However, it is likely that parents of almost all children enrolled in special schools have an opportunity to receive counseling, even in Zimbabwe. Hunt and Marshall (1995:357) and Hallahan and Kauffman (1994:325) all point out that special schools play an important role in counseling parents of children with hearing impairments during and after the placement of their children. Thirty six percent (36%) of the participants in this study were counseled by relatives and friends. It is interesting to note that, in the literature, there is very little information that explores counseling by relatives and friends. Gibson (1990:49) carried out a study with 54 parents of children with disabilities and established that 46 parents approached their friends and relatives for moral support and advice only. Only six parents in Gibson's study sought actual counseling from relatives and two from friends. This could be so due to the fact that parents of children with hearing impairments are well aware that their relatives are part of the family and so may also need counseling. To this effect

Cartwright, Cartwright and Ward (1995:403), Moores and Meadow (1990:126), Harry (1997:64) and Kauffman (1992:217) are all of the view that relatives of families that have children with disabilities also need counseling so that when, they give support, they do so with a positive attitude. In the quantitative results section, of this study (figure 4.3.2.2) indicates that relatives and friends were the smallest sources of counseling for parents of children with hearing impairments.

On the number of participants who received counseling and those who did not, out of 218 participants who responded, 97% indicated that they received counseling while 3% indicated that they did not. Fifty four percent (54%) of those who received counseling, indicated that counseling helped them to fully accept their children. As indicated in section 5.8, most parents who received counseling confirmed that it helped them accept and cope with their children. Both quantitative and qualitative results confirm that most parents received counseling. On whether the parents thought the counseling they received helped them or not and in what way if they were helped, out of 226 participants who responded, 70% indicated that counseling helped them while 27% did not think so, or were from the number that did not receive counseling. Fifty seven percent (57%) felt that counseling helped them to cope with their children. This was also discussed in section 5.8. Results from both quantitative and qualitative data concur that counseling helped parents to accept and cope with their children who have hearing impairments. Neukrug (1999:142) asserts that most parents have a positive towards the welfare of their children and therefore are eager to implement counseling outcomes. This result confirms the findings by Davis (1993:147) who interviewed 27 families of children with disabilities after they received counseling. Out of the 27 families in Davis' study, 25 indicated that counseling helped them to accept, cope and understand their children fully. About parents' views of what they thought could be done to make counseling more accessible, out of the 206 participants who responded, 35% suggested awareness campaigns using the media, posters and advertisements over the radio and/or television. In developing countries as pointed out by Baine (1988:78), there are limited counseling facilities and most of them are set up in urban areas. The majority of the people who badly need such services are situated in rural areas. Therefore for such services to be known there is need to publicize them through the printed media, television or radio. 76% of the participants suggested that seminars and workshops would inform more parents about the nearest available counseling services. Fear and

Woolfe (1996:370) endorse the view that workshops and seminars run by special schools and parents support groups enlighten parents of children with disabilities responding where to find relevant professionals in the fields of medicine, psychology, education and counseling services. Thirty eight percent (38%) of the participants suggested that parents support groups would help by sharing experiences, ideas, the problems they went through and the possible solutions to those problems. They suggested that such groups could also invite professionals to come and address them on topics of their choice. Counselors could also be invited to give advice and inform parents about the available services. Hardman, Drew, Egan and Wolf (1993:301) point out that parents prefer to share information with other parents who have experienced a similar situation and managed to cope. They have quoted some parents expressing their feelings. For example, one family expressed the following: "It would be helpful if a family that has gone through a similar experience and are in a similar situation could share with us the problems they faced and how they solved them". Parents support groups are the most relevant and powerful means of counseling, giving advice, sharing ideas and referring to other professionals (Kirk, Gallagher & Anastasiow, 1997:371).

Concerning how parents could help more through guidance and counseling, out of 172 participants who responded to this item, 16% suggested that counseling for children with hearing impairments would help both parents and children. Through such counseling children would be helped to understand their situation and how to handle certain situations in relation to their disabilities. Tucker and Nolan (1984:108) suggest that children should be counseled before they are fitted with hearing aids. They further point out that children with hearing impairments need to adjust emotionally, socially and psychologically, and such adjustment can be facilitated through counseling. 30% of the participants in this study suggested that parents be helped to cope and to integrate their child into the family network. Hallahan and Kauffman (1994:495) claim that for families to successfully integrate their children with disabilities into the broader society calls for the counseling of parents, siblings and close members of the extended family. Inclusion in broader society is very valuable for language, social, emotional and psychological development. Twenty five percent of the participants in this study suggested that counseling should include helping parents to plan the future of their children with hearing impairments. This is a topical issue throughout the literature because, so far, there has been very little success in this area (for

example transition to work life) as evidenced by short period and longitudinal studies (Edgar, 1987:556, Frank & Sitlington, 1997:48 and Gartner, Lipsky & Turnbull, 1991:121).

Many students with disabilities fail to complete college work and then, whether having completed or not, often fail to secure reasonably paying employment (Edgar, 1987:555). This is largely attributed to the education system, poor planning by parents and education authorities, general unemployment due to changes in economy and societal attitudes towards people with disabilities (Kisanji, 1993:43). In the next part the quantitative results obtained pertaining to the counseling of parents of children with hearing impairments by organizations is explored.

5.13 QUANTITATIVE RESULTS ON SERVICE ORGANIZATIONS

The 28 organizations that participated in the study were five special schools, five hospitals, fifteen churches, and three counseling organizations. All organizations indicated that they counsel parents of children with disabilities and in particular parents of children with hearing impairments. Out of the 28 organizations that responded to the item on counseling parents or families by gender, nine (32%) of the organizations indicated that they counseled women only and 19 (68%) counseled couples. It is interesting to note that no man was counseled to a family or parent on his own. Bristol, Gallagher and Schopler (1988:30) point out that traditionally fathers have not played a large role in seeking counseling and advice that can help the family in raising a child with disabilities. Studies by Meadow (1980:168), Moores (1987:84) and Hunt and Marshall (1994:359) all indicate that mothers play a far more active role than fathers in raising a child with disabilities. However, Kirk, Gallagher and Anastasiow (1997:29) in their study noted that there is a gradual change such that fathers are becoming more and more involved in family matters, thus supporting their wives in raising a child with disabilities. This may be why there is a substantial percentage of couples counseled. Hallahan and Kauffman (1994:315) endorse that the important factor for family harmony is when mother and father play their roles and take charge of their responsibilities.

On the qualifications of counselors, all the organizations indicated that they have qualified counselors. Out of 28 organizations that responded to this item, four (14%) separate

organizations each indicated that they had two, 12, 14, and 17 respectively. Another four groups of three separate organizations (43%) indicated four, six, 15, and 16 respectively. Four organizations (14%) indicated that they had eight uncertified counselors, while six thus 21% indicated that they had five. All the 28 organizations had a total of 109 uncertified counselors. These results are indicated in chapter 4, table 4.8.7. It would appear that many of the counseling organizations in Zimbabwe have quite a number of unqualified counselors. Howard (1996:15) carried out a study to find out counseling fees charged by counseling organizations and the qualifications of their counseling personnel. The results indicate that most counseling organizations use both qualified and unqualified personnel due to the fact that there are no gazetted rules to indicate who should and should not practice counseling.

Studies carried out by Richards (2000:144) in Zimbabwe, Webb (2000:304) in New Zealand, Howard (1996:78) in the United States of America and Dogan (2000:61) in Turkey indicate that many practicing counselors in developing countries and even in some developed countries are unregistered and unlicensed thereby confirming the findings of this study. Out of 28 organizations that responded to the item of counselors who qualified at certificate level, 15 (54%) had one, eight (29%) had two, four (14%) had three and one (4%) had four. Eight organizations responded to the question on qualifications at diploma level. Of these, six (75%) indicated that they had one counselor qualified at diploma level, while two different organizations (13%) had two and three counselors qualified at diploma level respectively. All eight organizations that responded had a total of six counselors qualified at diploma level. Only one organization (4%) out of 28 responded that they had one counselor qualified at degree level. All organizations had a total of 10 counselors qualified at certificate level, six at diploma level and one at degree level making a total of 17 counselors with some form of qualification. Tables 4.8.7 to 4.8.10 in chapter 4 indicate these results.

It is interesting to note that while clients have more confidence in qualified counselors (Howard, 1996:84), success in counseling depends on dedication and the relationship between the client and the counselor. In their study with 35 parents of children with disabilities, Gibson, Mitchell and Basile (1993:103) indicated that out of the 35 parents, eight were counseled by para-professionals and 27 by qualified counselors. All eight

parents who were counseled by semi-qualified counselors continued to receive moral support and frequent visits after the formal counseling sessions and they managed to adjust and cope with their situations. Eleven of the 27 parents in this study who were counseled by qualified counselors dropped from counseling and 16 continued until they were able to solve their problems. There seems to be strong relationship between follow up after disengaging from the formal counseling sessions and success in resolving one's problems. All counseling organizations counseled between 35 and 62 parents of children with hearing impairments per year. Quantitative results indicate that parents who were counseled in counseling organizations were better able to cope with their children with hearing impairments, after receiving counseling.

There is an indication that counselors in counseling organizations are well equipped generically, but not necessarily well equipped to counsel people with disabilities and/or parents of children with disabilities. Even in counseling organizations, the difference between counseling and advice continues to pose some problems due to the fact that some techniques in counseling include advice giving. The findings of Howard (1996:7) are confirmed in this study by the fact that participants indicated that it is not always the case that qualified counselors perform better than those not qualified in counseling. In his research study which he carried out with 15 counselors, seven trained and eight untrained, Colledge (2002:185) found that the counselors' effectiveness increased with regular interaction with clients, while confidence in counseling ability, generally acquired through qualifications, is after all necessary but not sufficient for effective practice.

Results obtained in this study from qualitative data generated from counseling organizations indicate confirmatory findings to those obtained from parents. All results corroborate in pointing out that communication and financial constraints are the major problems faced by parents of children with hearing impairment. It is also clearly indicated that parents find counseling helpful in order to support them to accept their child with a hearing impairment. This was corroborated in the data from counseling organizations.

5.14 CHAPTER SUMMARY

In answering the research question "In what ways did parents of children with hearing impairments access counseling in Zimbabwe during the period 1999 to 2000?" both quantitative and qualitative results from parents and from counseling service organizations indicate that parents of children with hearing impairments accessed counseling through special schools, hospitals, counseling organizations, churches, relatives, individuals and friends. The greatest number of parents accessed counseling through special schools, followed by individual counselors, hospitals, churches, counseling organizations, relatives and friends respectively. In this study most parents received counseling and are of the opinion that the counseling they received helped them to accept and cope with their children. Most parents expressed the difficulties they went through in raising their children; for example, lack of communication skills, lack of transport, lack of knowledge of teaching the child basic survival skills and financial constraints. They also expressed their views on how counseling can be made more accessible. In this regard parents suggested the use of campaigns through the media to bring about awareness in terms of disability, the existence of counseling organizations and where they are situated. The formation and use of parent support groups to encourage, share ideas and experiences with new parents was highly recommended. In the next chapter I will give conclusions of the research findings in relation to the objectives and assumptions of the study. I will also give recommendations on how sources of counseling can be made known and accessed. Areas of further research will also be highlighted.

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6 CONCLUSIVE FINDINGS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter will deal with conclusive findings of the study as related to its objectives. The findings obtained reflect on the objectives and reviewed literature. The research assumptions and claims will be revisited and discussed in the light of the findings of this study. It is my intention to then also give recommendations on how parents can be made aware of the available counseling services and how they can better access those services. Recommendations for further research will also be explored.

As stated in chapter 1, the main purpose of this study was to explain the ways in which parents of children with hearing impairments access counseling services in Zimbabwe. Through the findings obtained from the collected data, the study demonstrated that special schools provided most parents of children with hearing impairments with counseling services. Subsequently, hospitals, churches and registered counseling organizations also played an important part in providing parents with counseling services. These findings are discussed extensively in chapter 4. In the reviewed literature in chapter 2, there was a clear indication that parents of children with disabilities and hearing impairment in particular, generally access counseling from special schools, counseling organizations, individuals, professional counselors, churches and relatives. However, this literature review was obtained mostly from the western literature, and provided only cautionary guidelines as to what could be expected in Zimbabwe. The current study focuses on the Zimbabwean situation and illuminates the complex ways in which parents of children with hearing impairments access counseling services in this country.

In order to focus on all related aspects of the study, a research question was formulated and objectives were set out, these will be considered before discussing the assumptions of the study. The research question of the study was “In what ways did parents of children with

hearing impairments in Zimbabwe access counseling services during the period 1999 to 2000?"

6.2 OBJECTIVES AND FINDINGS

- **Objective one: To investigate whether parents who received or did not receive counseling were aware of organizations that offered guidance and counseling**

Results of collected data indicate that 90% of the parents received some form of counseling. Their sources of counseling ranged from special schools, hospitals, churches and counseling organizations to individuals, relatives and friends. The research indicated that a majority of parents were aware of organizations that offer counseling services. On the positive statement 55% indicated that they were aware of organizations that offer counseling while 52% indicated the same on the negative statement. Both figures show most parents to be aware of organizations that offer counseling services. It is clear that, even though most participants did not get counseling from registered counseling organizations, they were aware that these organizations existed. They may not have been certain about how much knowledge on disability in general and hearing impairment in particular was possessed by counselors in counseling organizations. Whereas parents would have assumed that personnel in special schools for children with hearing impairments would have more knowledge about hearing impairment and its effects on a child.

- **Objective two: To discover parents' perceptions on whether counseling helped them to accept and to be able to cope with their children**

Both quantitative and qualitative results from the study demonstrate that parents believe that counseling helped them in the process of accepting their children and enabled them to better cope with their children. Quantitative results in chapter 4, figure 4.3.8.17 show that 76% of the parents indicated that counseling helped them to accept their children with hearing impairments. In the same chapter in figure 4.3.8.24, results show that 85% of the parents indicated that counseling helped them to cope with their children who have hearing impairments. Qualitative results on table 4.6.4 show that 54% of the participants indicated

that the counseling they received helped them to accept their children with hearing impairments. Results on table 4.6.5 show that 70% of the participants indicated that the counseling they received helped them to cope with their children with hearing impairments.

- **Objective three: To establish the qualifications of the counselors who counseled parents of children with hearing impairments**

The study established that in all the 28 organizations that participated, 10 counselors were qualified at certificate level, six at diploma level and one at degree level. The majority of the counselors (109) were not certified. The use of unqualified counselors by counseling service organizations may indicate the lack of qualified personnel and the need for the introduction of counseling courses in colleges and at university level. To offer such services using unqualified personnel may compromise the quality of the services and even have adverse effects on the clients. There is a clear indication that counseling service organizations need to upgrade the qualifications of their personnel in order to provide a quality service.

- **Objective four: To explore recommendations by parents on ways in which counseling services could be made more accessible in Zimbabwe**

Parents suggested having awareness campaigns informing the public about available counseling services through the use of the media, posters and advertisements. They also suggested the use of seminars and workshops organized and run by special schools and counseling organizations, involving parents of children with disabilities. Some parents further suggested that in such workshops, parents could be enlightened on how they could access counseling services in cases where financial or transportation difficulties exist. The final suggestion was the formation of parent support groups which would enable parents of children with hearing impairments to meet. They would have opportunity to share experiences and ideas to find possible solutions to their problems. Apart from the objectives, three assumptions were also formulated for the study and these are considered next.

- **Synoptic Conclusion**

Most of the participants in this study received counseling from special schools. However, there is also an indication that most of the participants were aware of organizations that offer counseling services in Zimbabwe but could not access these services for various reasons. The majority of the participants acknowledged that counseling helped them to accept and cope with their children who had hearing impairments. Participants also indicated the importance of counseling to both children and parents of children with hearing impairments. The study also indicates that most counseling organizations had very few qualified counselors with even basic qualifications at certificate level. Most parents suggested the use of awareness campaigns in order to conscientize the public about the existing counseling services and how parents can access these services. The formation of parents support groups was also suggested to enable parents to gain more support and easy access to counseling organizations.

6.3 ASSUMPTIONS AND FINDINGS OF THE STUDY

- **Assumption one: Most parents received counseling from special schools**

This assumption was supported by the findings of this study. It has been established that most participants (63%) received their counseling from special schools. As pointed out before, there are five special schools and some other isolated units in Zimbabwe that cater for children with hearing impairments. All special schools are situated in big towns and some of the units are in small towns. Unfortunately all registered counseling organizations are in the capital city, Harare. Large hospitals that have the capability of dealing with children with disabilities are situated in big cities. Churches, relatives and friends are the counseling sources that can be found all over the country. Due to the educational needs of the child, parents visit special schools with the hope of securing an educational placement for the child. It is in this context that counseling often takes place. Sometimes parents visit hospitals and are referred to special schools for audiological tests where they are also counseled. In developing countries, according to Baine (1988:92) most parents and children receive counseling in special schools. Kisanji (1993:73) contends that most developing countries lack screening centres for children with disabilities and do not have

established guidance and counseling centres to help parents and children. All counseling is done in special schools that also have a shortage of qualified personnel and much-needed reliable equipment to carry out the necessary tests. In developed countries the situation is different, because there are registered counseling organizations run by qualified personnel. Hospitals have units from which audiologists operate, carrying out screening tests and also counseling of parents. In some developed countries, for example in the United Kingdom, some of the universities have centres for testing and fitting children with hearing aids. Parents are counseled and given the basics of working with their child with a hearing impairment. A good example is the University of Manchester where I took part in conducting hearing screening tests and the counseling of parents before fitting children with hearing aids. Hallahan and Kauffman (1994:312) point out that in most developed countries there are many sources of counseling run by professional people, giving parents choice. If they can afford to pay, they approach organizations that provide such services. If parents are not in a position to pay, state hospitals and peripatetic counselors and social workers will counsel them in either regular or special schools. It is possible that the site of the data collection might have influenced the results of the study. The fact that parents were gathered in special schools where some of them were likely to access counseling could have influenced their responses to the research questions.

In their study in the United States of America, Kretschmer and Kretschmer (1978:186) confirm that parents of children with disabilities are counseled as soon as the child is identified as having a hearing impairment and are referred to the appropriate professionals. However, they also point out that sometimes the child's hearing impairment is identified late, after parents had visited different doctors and psychologists without being given a correct diagnosis. Martin and Clark (1996:78) state that in England visiting health workers are trained in basic counseling skills and also in screening hearing in babies using basic equipment. Results obtained by qualified audiologists and those obtained by trained visiting health workers were very similar.

If this were to be done in developing countries, health workers could be stationed in hospitals and special schools to do both screening and counseling. It is interesting to note that even in developed countries where there are a lot of registered counseling organizations (Nolan & Tucker, 1981:110) most parents of children with hearing

impairments prefer to obtain counseling from professionals who have knowledge of hearing impairment. These are mostly found in special schools for the deaf. As explicitly pointed out by Kepceoglu (1986:517) counseling in developed and indeed developing countries started in schools, particularly in the United States of America, and then spread the world over. In the same vein, while developed countries have established other agencies to offer counseling services, developing countries still heavily rely on schools as major sources of counseling (Lansky, 1981:83). Taking note of the participants' responses in chapter 4, when they were asked about the difficulties they faced in raising their child with a hearing impairment, 130 participants (46%) indicated that financial constraints prevented them from taking children to hospitals, audiologists, special schools and/or counseling organizations. This could be one of the reasons why most parents were counseled at special schools where the service is free.

Considering the fact that most participants received counseling from special schools, it might be a good idea to strengthen the counseling services in these schools. This could be achieved by establishing counseling centres in these schools, run by qualified personnel in both special education and counseling. Awareness campaigns could also have their focus on special schools so that parents would have all the resources in one area, alleviating the problem of transport. Units for children with hearing impairments, that are set up in rural schools, could have peri-patetic counselors to service parents in rural areas.

- **Assumption two: Parents were not aware of different counseling organizations in Zimbabwe**

This assumption was not supported by the findings of the study. Analyzed data results indicate that slightly more than half (55%) of the participants were aware of counseling organizations in Zimbabwe. 41% of the participants indicated that they were not aware of such organizations. On the reverse question, 52% indicated that they were aware of counseling organizations while 44% indicated that they were not aware of counseling organizations in Zimbabwe. Tucker (1997:39) contends that despite the availability of other counseling services, many parents in developed countries make use of a multidisciplinary team of professionals: social workers, psychologists, audiologists, specialist teachers, counselors, speech therapists and doctors who give them counsel and

advice and are generally stationed in special schools or work as peripatetic service providers in state schools. The 44% of the participants who indicated that they were not aware of counseling organizations are likely to be those who live in rural and semi-urban areas since almost all counseling organizations are situated in big cities. Studies by Mba (1990:15) in Nigeria and Miles (1984:278) in Asia clearly indicate that, in developing countries, counseling and screening facilities for children with disabilities are limited and generally centralized in big cities. They further point out that in spite of all efforts by different governments, counseling is still a new phenomenon in most developing countries and there is lack of information, knowledge and understanding of counseling among ordinary people. A study carried out by Msengi (1987:7) in Tanzania shows that the commonly used term is guidance, which has connotations of leading, directing, coaching and advising at problematic times. In this study it may be that even if parents were aware of other counseling organizations, they preferred to go to special schools where they could be guided and given advice by teachers who knew more about hearing impairment. Moreover most education systems refer to guidance practitioners as guidance teachers, denoting guidance as a tool of instruction. Parents in this study might have thought that special schools would tell them what to do and possibly give them solutions to their problems, since they were continuously dealing with parents and children with similar problems. Another study by Yahaya-Isa (1980:14) indicates that both groups of parents those who were aware of registered counseling organizations and those who were not, all preferred to obtain guidance and counseling from special schools. This ties up the first two assumptions in this study, for example site of access and awareness of counseling: Most participants were aware of counseling services and most participants accessed it at special schools.

- **Assumption three: Counseling organizations do not have qualified counselors**

This assumption was supported by the findings of the study. As indicated in chapter 4, in all 28 organizations these were only 17 counselors with some form of qualification ranging from certificate to degree level, plus 108 uncertified counselors. A study by Kepceoglu (1994:60) in Turkey, shows that persons who were appointed as counselors were in actual fact specialized in different disciplines, other than counseling, such as sociology, psychology, education and philosophy. While developing countries use schools as their

major sources of counseling, for both parents of children with disabilities and children, Sloman (1991:6) points out that most of the personnel responsible for this counseling are not specifically qualified in that area.

A study carried out by Webb (2000:310) in New Zealand indicates that for a long period New Zealand mainly used teachers, social workers and church ministers as counselors. There the trend is slowly changing with the government demanding that counselors be qualified and registered. This helps to control standards and the quality of service provided. More and more authorities (Blocher, 2000:8; Neukrug, 1999:25; Webb, 2000:304 and Dogan 200:61) suggest that counseling has never been taken as a serious profession since it used to be carried out by external sources of support such as extended family, friends, relatives, neighbors and social clubs. These are still deemed more effective than professionals and counseling agencies (Hallahan & Kauffman, 1994:511), mostly due to the fact that they nurture clients, offering moral, social and material support until they master their problems.

In this study, this is also mentioned in chapter 2 on reviewed literature. Unfortunately these informal supports, once so prevalent in our society, are fast disappearing. This is largely due to demographic changes such as the increase in single–parent families. Thus families today are less able to rely on informal social networks for counseling support. While developing countries will continue with the same trend until they address the situation of the shortage of qualified counselors, developed countries are fast clamping down on uncertified counselors and unregistered counseling agencies (Howard, 1996:15).

Colleges and universities in Zimbabwe did not offer counseling courses until the year 2000 when Zimbabwe Open University (ZOE) started offering such courses at degree level. The first intake will complete the course in 2004. Prior to the establishment of ZOE, Institutions of higher learning offered students counseling as a component of other courses such as psychology, special education and social work. The current degree programme offering counseling is likely to alleviate the shortage of qualified counselors in Zimbabwe.

An unpublished survey carried out by Richards (1996:12) in Zimbabwe, indicates that in 1996 there were only 13 qualified counselors within the registered counseling organizations

and in special schools for children with hearing impairments. It should be noted however, that this number was not that of counselors in the whole country but only counselors in counseling agencies and special schools. Some developed countries have institutions that offer dubious counseling qualifications. This is however, also evident in developing countries. Keith-Spiegel (1991:55) points out that the United States of America is cluttered with bogus institutions of higher learning that issue master's and doctor's degrees that are not worth the paper they are printed on. These outfits are unconcerned with ethical standards or with whom they might hurt, and simply prey on people who are looking for short cuts. Counselors who go through such institutions cause more harm than good to their clients.

From this discussion it is evident that two assumptions of the study were confirmed at its conclusion. One assumption was de-confirmed. In the next section concluding remarks will be made.

6.4 MAJOR CHALLENGES ARISING FROM THE STUDY AND SUGGESTIONS TO ADDRESS THEM

It is clear from the research findings and discussions that there are challenges at hand that need to be addressed in order for parents of children with hearing impairments to cope with their children and to access counseling services effectively. It is my intention to point out the concerns of this study and suggest possible means of addressing them after which I will give recommendations for further research.

- **Improving ways in which parents can access counseling services**

If special schools join hands with counseling organizations to provide workshops and seminars for parents of children with hearing impairments, the ways in which they access counseling services is likely to be enhanced. As suggested in this study by parents themselves, such workshops could be the means of empowering parents to inculcate basic living skills in their children. Such skills involve eating, dressing, and personal hygiene, turn taking and bathroom habits. Means of communication can also be taught to parents over a period of time.

Mobile teams made up of personnel from counseling organizations and special schools could run such workshops and seminars in rural and semi urban areas to reach parents who cannot meet the expenses of traveling and accommodation in towns. Such workshops and seminars can be run on a yearly basis with the support of schools' psychological services, which are allocated funds for such activities. The situation can be reviewed from time to time depending on the needs of the parents and the feedback received from them.

- **Parents need to be made aware of counseling service organizations**

As mentioned by parents, awareness campaigns through the use of the media, posters and advertisements can be undertaken. The exercise would have names of counseling organizations, contact numbers, maps that indicate where they are situated and the services they offer. Radio and television programmes can be launched to reach as many parents as is possible. Informative posters can be put at shops, clinics, schools, post offices and banks, both in towns and in rural areas.

- **Financial constraints**

There are various options that can be explored in terms of alleviating financial constraints. Financial assistance should be sought through social welfare. Unfortunately the department operates on a shoestring budget that has become just a drop in the ocean considering the ever-increasing demand for financial aid. Special schools, on behalf of parents in need can approach non-governmental organizations. Funds are needed for transport to hospitals, treatment fees, school and boarding fees, uniforms and hearing aids. Swedish International Development Agency (SIDA) used to fund such causes but due to deteriorating relations between the two countries, the fund has been stopped. Parents can also empower themselves by embarking on community projects that may bring together relevant stakeholders to raise funds for specific causes.

- **Lack of qualified counselors**

More institutions of higher learning can be encouraged to introduce programmes that offer counseling courses. Personnel already in counseling institutions should be encouraged to

register with Zimbabwe Open University to study for a qualification. In-service workshops and seminars can be run to equip counselors in practice with the skills needed for effective counseling for parents of children with hearing impairments. Uncertified counselors can be phased out in time as more and more qualified counselors join these counseling organizations. Hospitals, special schools and churches can be encouraged to use personnel who have acquired qualifications in counseling.

6.5 RECOMMENDATIONS FOR FURTHER RESEARCH

This study left a number of areas untapped. In order to fully understand what is going on in the area of special education and hearing impairment in particular, concerning counseling, there is need to investigate and find out:

- The actual status of counseling skills used by counselors.
- The effectiveness of the counseling offered to both the parents of children and children with hearing impairments themselves.
- The effects of counseling on parents of children with hearing impairments.
- The role of guidance and counseling in the lives of children with hearing impairments.

I recommend these as areas for further research in order to understand the effect and influence of counseling in the life of parents and children with hearing impairments. Such a study would include children with hearing impairments as is suggested in the qualitative results of this study.

6.6 CONCLUDING REMARKS

Different countries the world over, developed and developing, have now adopted counseling, originally an American phenomenon, to assist people to cope with the problems brought about by natural, social and economic changes in the modern world. Although many families whose children have disabilities manage their lives as effectively as other families, most of them require counseling to facilitate the integration of the disabled child into the family. Whilst most parents experience diverse problems and stress in raising their

children, parents of children with disabilities appear to experience more stress and hence seem to have a greater need for counseling than others.

In agreement with the observations in other countries of the world, counseling has received a positive response from parents of children with disabilities in Zimbabwe for the reasons indicated in chapter 4. Counseling serves the purpose of:

- equipping parents with knowledge about hearing impairment and its causes.
- helping parents adopt a positive attitude towards the child, that would lead to acceptance.
- equipping parents with the necessary skills to cope with the child.
- helping parents integrate the child into the family.
- making parents aware of how they can access counseling and other professional services such as medical, educational and audiological services.

Given the historical background of counseling that was explored in chapter 2, it would stand to reason that families and parents lacking peace and harmony would seek the services of counselors. Even though almost half of the parents of children with hearing impairments in Zimbabwe were aware of organizations that offered counseling, hardships in the form of financial constraints and lack of transport prevented them from accessing such services in good time. Due to financial constraints, most of the parents' received spasmodic counseling free of charge from special schools instead of from registered counseling organizations that demand payment. Even then, most special schools and units for children with special needs are located in the big cities so that people in the rural areas need to travel long distances using expensive and unreliable public transport. This makes it difficult for parents to easily access counseling from the people who have knowledge about hearing impairment and skills in counseling. Instead they resort to relatives and friends who might themselves be in need of counseling. While external support systems, such as members of the extended family, friends and the community neighborhood still play a part in counseling, this is fast disappearing due to current developments that have fashioned many single-parent families. Unfortunately counseling organizations and special schools are not spread throughout the country nor do they have branches across the country that can service parents in small towns, semi-urban areas and villages in rural areas. In chapter 4,

the results of the study clearly indicate in parents' responses that counseling is important for both children and parents. Against this background it is imperative that counseling plays a significant role in families that have children with hearing impairments. With this premise the importance of access to counseling services cannot be over-emphasized.

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APPENDICES

Appendix A (First Pool of Questions)

QUESTIONNAIRE TO PARENTS

SECTION A

Please put a ring around the appropriate number at the end of or below every statement or question.

(i)	Gender of parents	Man	Woman	
		1	2	
ii)	Gender of child	Boy	Girl	
		1	2	
(iii)	My child was born deaf	Yes	No	
		1	2	
(iv)	My child became deaf later	Yes	No	
		1	2	
(v)	How old is your child?	5-8 yrs	9-13 years	14-18 years
		1	2	3

SECTION B

Please put a ring around the appropriate letter/letters closest to your level of agreement.

KEY: (5) SA - Strongly Agree
(4) A - Agree
(3) U – Undecided
(2) D – Disagree
(1) SD – Strongly Disagree

1. Counseling is totally different from advice. SA A U D SD

2. I am not aware of any organization that offers counseling in Zimbabwe
SA A U D SD

3. Counseling does not help parents to accept the idea of having a hearing impaired child in the family.
SA A U D SD

4. Counseling helped me to plan the future of my child.

SA A U D SD

5. **We do not allow our child to play with other children in our community because they may not treat him well.**

SA A U D SD

6. **My child does not relate well and interact effectively with other members of the family.**

SA A U D SD

7. Most people, who counseled us, told us what to do.

SA A U D SD

8. Counseling is a must for parents of children with hearing impairments.

SA A U D SD

9. The counseling we received did not help us to cope with the child at all.

SA A U D SD

10. Guidance and counseling does not help much without money.

SA A U D SD

11. My child fits well and interacts effectively with family members.

SA A U D SD

12. It is almost impossible to plan the future of a child who is hearing impaired.

SA A U D SD

13. Most counselors did not give us any guidance at all.

SA A U D SD

14. Without counseling one cannot fully accept having a child with hearing impairment in the family.

SA A U D SD

15. With or without help from other organizations, it is parents' responsibility to fully cater for their children who are hearing impaired.

SA A U D SD

16. We allow our child to make friends and play with other children in our neighborhood.

SA A U D SD

17. The problem with counseling is that one is not provided with answers.
SA A U D SD

18. Parents can equally do well for their child without guidance and counselling.
SA A U D SD

19. Counseling really helped us to understand the child.
SA A U D SD

20. Counselors also referred me to other professionals for further help.
SA A U D SD

21. Counseling helped us to cope with our child who is hearing impaired.
SA A U D SD

22. Guidance and counseling are important for both parents and the child.
SA A U D SD

23. It is difficult to separate counseling from advice.
SA A U D SD

24. Relatives are the best counselors in family problems.
SA A U D SD

25. I received counseling from individuals. SA A U D SD

26. The church played an important part in counseling me.
SA A U D SD

27. I received counseling from special schools and hospitals.
SA A U D SD

28. Organizations that offer counseling helped in my situation.
SA A U D SD

29. I was counseled by well-trained counselors. SA A U D SD

30. I never received counseling from anybody. SA A U D SD

31. Counseling did not help us to understand the needs of our child.
SA A U D SD

32. My child has both male and female friends. SA A U D SD

33. I now have a peace of mind concerning my child with a hearing impairment.
SA A U D SD

34. My child is not free to discuss things with other people.
SA A U D SD

35. My child is living freely and happily. SA A U D SD

36. The problem with counseling is that one is not provided with answers.
SA A U D SD

37. My other children have fully accepted my child with a hearing impairment.
SA A U D SD

38. Different people came to counsel us in connection with our child.
SA A U D SD

39. I can easily tell that my child is frustrated. SA A U D SD

40. Counseling helped to change my way of thinking concerning my child.
SA A U D SD

41. My child hardly has a friend. SA A U D SD

42. My partner is not interested in going for counseling.
SA A U D SD

43. Counseling helped us to cope with our child who is hearing impaired.
SA A U D SD

44. Since the birth of this child with hearing impairments, our friends and relatives have stopped visiting us.
SA A U D SD

45. Children who are hearing impaired should be looked after by the Social Welfare.

SA A U D SD

46. Relatives only give advice but not counseling. SA A U D SD

47. Parents of children with hearing impairments do not need counseling.

SA A U D SD

48. The government should deploy counselors in rural areas to help parents who have children with special needs.

SA A U D SD

49. I am aware of organizations that offer counseling in Zimbabwe.

SA A U D SD

50. We do not allow our child to play with other children in our community because they may not treat him well.

SA A U D SD

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Appendix B (Second Pool of Questions)

QUESTIONNAIRE TO PARENTS

SECTION A

Please put a ring around the appropriate number at the end of or below every statement or question.

(i)	Gender of parents	Man	Woman	
	1	2		
ii)	Gender of child	Boy	Girl	
	1	2		
(iii)	My child was born deaf	Yes	No	
	1	2		
(iv)	My child became deaf later	Yes	No	
	1	2		
(v)	How old is your child?	5-8 yrs	9-13 years	14-18 years
		1	2	3

SECTION B

Please put a ring around the appropriate letter/letters closest to your level of agreement.

KEY: (5) SA - Strongly Agree
(4) A - Agree
(3) U – Undecided
(2) D – Disagree
(1) SD – Strongly Disagree

1. Counseling is totally different from advice. SA A U D SD

2. I am not aware of any organization that offers counseling in Zimbabwe.
SA A U D SD

3. Counseling does not help parents to accept the idea of having a hearing impaired child in the family.
SA A U D SD

4. Counseling helped me to plan the future of my child.

SA A U D SD

5. We do not allow our child to play with other children in our community because they may not treat him well.

SA A U D SD

6. **My child does not relate well and interact effectively with other members of the family.**

SA A U D SD

7. Most people, who counseled us, told us what to do.

SA A U D SD

8. Counseling is a must for parents of children with hearing impairments.

SA A U D SD

9. The counseling we received did not help us to cope with the child at all.

SA A U D SD

10. I am aware of organizations that offer counseling in Zimbabwe.

SA A U D SD

11. My child fits well and interacts effectively with family members.

SA A U D SD

12. It is almost impossible to plan the future of a child who is hearing impaired.

SA A U D SD

13. Most counselors did not give us any guidance at all.

SA A U D SD

14. Without counseling one cannot fully accept having a child with hearing impairment in the family.

SA A U D SD

15. With or without help from other organizations, it is parents' responsibility to fully cater for their children who are hearing impaired.

SA A U D SD

16. We allow our child to make friends and play with other children in our neighbourhood.

SA A U D SD

17. The problem with counseling is that one is not provided with answers.
SA A U D SD

18. Parents can equally do well for their child without guidance and counselling.
SA A U D SD

19. Counseling really helped us to understand the child.
SA A U D SD

20. Counselors also referred me to other professionals for further help.
SA A U D SD

21. Counseling helped us to cope with our child who is hearing impaired.
SA A U D SD

22. Guidance and counseling are important for both parents and the child.
SA A U D SD

23. It is difficult to separate counseling from advice.
SA A U D SD

24. I was counselled by well trained counselors SA A U D SD

25. Counseling did not help us to understand the needs of our child.
SA A U D SD

26. Counseling does not help without money. SA A U D SD

27. Counseling helped us to cope with our child who is hearing impaired.
SA A U D SD

28. Children who are hearing impaired should be looked after by the Social Welfare.
SA A U D SD

29. Parents of children with hearing impairments do not need counseling.
SA A U D SD

30. Relatives are the best counselors. SA A U D SD

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Appendix C (Third pool of questions)

QUESTIONNAIRE TO PARENTS

SECTION A

Please put a ring around the appropriate number at the end of or below every statement or question.

(i)	Gender of parents	Man	Woman	
		1	2	
ii)	Gender of child	Boy	Girl	
		1	2	
(iii)	My child was born deaf	Yes	No	
		1	2	
(iv)	My child became deaf later	Yes	No	
		1	2	
(v)	How old is your child?	5-8 yrs	9-13 years	14-18 years
		1	2	3

SECTION B

Please put a ring around the appropriate letter/letters closest to your level of agreement.

KEY: (5) SA - Strongly Agree
(4) A - Agree
(3) U – Undecided
(2) D – Disagree
(1) SD – Strongly Disagree

1.	Counseling is totally different from advice.	SA	A	U	D	SD
2.	I am not aware of any organization that offers counseling in Zimbabwe.	SA	A	U	D	SD
3.	Counseling does not help parents to accept the idea of having a hearing impaired child in the family.	SA	A	U	D	SD

4. Counseling helped me to plan the future of my child.

SA A U D SD

5. We do not allow our child to play with other children in our community because they may not treat him well.

SA A U D SD

6. **My child does not relate well and interact effectively with other members of the family.**

SA A U D SD

7. Most people, who counseled us, told us what to do.

SA A U D SD

8. Counseling is a must for parents of children with hearing impairments.

SA A U D SD

9. The counseling we received did not help us to cope with the child at all.

SA A U D SD

10. I am aware of organizations that offer counseling in Zimbabwe.

SA A U D SD

11. My child fits well and interacts effectively with family members.

SA A U D SD

12. It is almost impossible to plan the future of a child who is hearing impaired.

SA A U D SD

13. Most counselors did not give us any guidance at all.

SA A U D SD

14. Without counseling one cannot fully accept having a child with hearing impairment in the family.

SA A U D SD

15. With or without help from other organizations, it is parents' responsibility to fully cater for their children who are hearing impaired.

SA A U D SD

16. We allow our child to make friends and play with other children in our neighborhood.

SA A U D SD

17. The problem with counseling is that one is not provided with answers.
SA A U D SD

18. Parents can equally do well for their child without guidance and counselling.
SA A U D SD

19. Counseling really helped us to understand the child.
SA A U D SD

20. Counselors also referred me to other professionals for further help.
SA A U D SD

21. Counseling helped us to cope with our child who is hearing impaired.
SA A U D SD

22. Guidance and counseling are important for both parents and the child.
SA A U D SD

23. It is difficult to separate counseling from advice.
SA A U D SD

24. Counseling did not help us to understand the needs of our child.
SA A U D SD

25. Counseling helped us to cope with our child who is hearing impaired.
SA A U D SD

26. Children who are hearing impaired should be looked after by the Social Welfare.
SA A U D SD

27. Parents of children with hearing impairments do not need counseling.
SA A U D SD

28. Relatives are the best counselors. SA A U D SD

---oOo---

Appendix D (Final Questionnaire)

QUESTIONNAIRE TO PARENTS

SECTION A

Please put a ring around the appropriate number at the end of or below every statement or question.

(i) Gender of parents — Man 1 Woman 2

ii) Gender of child — Boy 1 Girl 2

(iii) My child was born deaf — Yes 1 No 2

(iv) My child became deaf later — Yes 1 No 2

(v) How old is your child? — 5-8 yrs 1 9-13 years 2 14-18 years 3

(vi) Did you receive any counseling at all? — Yes 1 No 2

If yes, from which of the following; (Special Schools) 1 (Counseling Organizations) 2

(Churches) 3 (Hospitals) 4 (Relatives) 5 (Individuals) 6 (Friends) 7 (None of these) 8

SECTION B

Please put a ring around the appropriate letter/letters closest to your level of agreement.

KEY: (5) SA - Strongly Agree
(4) A - Agree
(3) U – Undecided
(2) D – Disagree
(1) SD – Strongly Disagree

1. Parents of children with hearing impairments do not need counseling.

SA A U D SD

2. Although we received guidance and counseling, we still cannot cope with the child.

SA A U D SD

3. I am not aware of any organization that offers counseling in Zimbabwe

SA A U D SD

4. Counseling did not help us to understand the needs of our child.

SA A U D SD

5. Counseling does not help parents to accept the idea of having a hearing impaired child in the family.

SA A U D SD

6. Children who are hearing impaired should be looked after by the Social Welfare.

SA A U D SD

7. Counseling helped me to plan the future of my child.

SA A U D SD

8. We do not allow our child to play with other children in our community because they may not treat him well.

SA A U D SD

9. My child does not relate well and interact effectively with other members of the family.

SA A U D SD

10. Most people, who counseled us, told us what to do.

SA A U D SD

11. Counseling is a must for parents of children with hearing impairments

SA A U D SD

12. The counseling we received did not help us to cope with the child at all.

SA A U D SD

13. I am aware of organizations that offer counseling in Zimbabwe

SA A U D SD

14. My child fits well and interacts effectively with family members

SA A U D SD

15. It is almost impossible to plan the future of a child who is hearing impaired.

SA A U D SD

16. Most counselors did not give us any guidance at all.

SA A U D SD

17. Without counseling one cannot fully accept having a child with hearing impairment in the family.

SA A U D SD

18. With or without help from other organizations, it is parents' responsibility to fully cater for their children who are hearing impaired.

SA A U D SD

19. We allow our child to make friends and play with other children in our neighborhood.

SA A U D SD

20. The problem with counseling is that one is not provided with answers.

SA A U D SD

21. Parents can equally do well for their child without guidance and counseling

SA A U D SD

22. Counseling really helped us to understand the child.

SA A U D SD

23. Counselors also referred me to other professionals for further help.

SA A U D SD

24. Counseling helped us to cope with our child who is hearing impaired.

SA A U D SD

25. Guidance and counseling are important for both parents and the child.

SA A U D SD

26. It is difficult to separate counseling from advice.

SA A U D SD

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Appendix E (First Pool of Questions)

OPEN ENDED QUESTIONS TO PARENTS

SECTION A

1. What five major difficulties did you meet in raising your child with hearing impairments?

2. Which individuals or organizations counseled you?

3. Did the counseling you received help you?

   If yes, how?

   If no, why?

4. What do you think the government should do to help parents of children with disabilities?

5. In your view, what should counseling organizations do to make their services more accessible to parents of children with disabilities?

6. Do you believe counseling really works? Why do you say so?

7. Do you think counseling helps parents to cope with their children? Give reasons.

8. In your view why should parents of children with hearing impairment get counseling?

9. What do you think should be done to make guidance and counseling accessible to parents?

10. How can guidance and counseling help you more as parents?

11. What should be done to improve the counseling situation for parents of children with hearing impairments?

12. In a family with a child with hearing impairments, who should be counseled? Why?

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Appendix F (Second pool of questions)

OPEN ENDED QUESTIONS TO PARENTS

Please try and answer all questions explaining your ideas fully.

1. What 5 major difficulties did you meet in raising your child with hearing impairments?

2. Which individuals or organizations counseled you?

3. Did the counseling you received help you?

   If yes, how?

   If no, why?

4. What do you think the government should do to help parents of children with disabilities?

5. In your view, what should counseling organizations do to make their services more accessible to parents of children with disabilities?

6. Do you believe counseling really works? Why do you say so?

7. Do you think counseling helps parents to cope with their children? Give reasons.

8. In your view why should parents of children with hearing impairment get counseling?

9. What do you think should be done to make guidance and counseling accessible to parents?

10. How can guidance and counseling help you more as parents?

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Appendix G (Third pool of questions)

OPEN ENDED QUESTIONS TO PARENTS

Please try and answer all questions explaining your ideas fully.

1. What five major difficulties did you meet in raising your child with hearing impairments?

2. Which individuals or organizations counseled you?

3. Did the counseling you received help you?

   If yes, how?

   If no, why?

4. What do you think the government should do to help parents of children with disabilities?

5. In your view, what should counseling organizations do to make their services more accessible to parents of children with disabilities?

6. Do you think counseling helps parents to cope with their children?

   Give reasons for your answer.

7. What do you think should be done to make guidance and counseling accessible to parents?

8. How can guidance and counseling help you more as parents?

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Appendix H (Final Questionnaire)

OPEN ENDED QUESTIONS TO PARENTS

Please try and answer all questions explaining your ideas fully.

1. What five major difficulties did you meet in raising your child with hearing impairments?

2. Which individuals or organizations counseled you?

3. Did the counseling you received help you?

   If yes, how?

   If no, why?

4. Do you think counseling helps parents to cope with their children? Give reasons.

5. What do you think should be done to make guidance and more accessible to parents?

6. How can guidance and counseling help you more as parents?

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Appendix I (First pool of questions)

QUESTIONNAIRE TO SERVICE ORGANIZATIONS

SECTION A

Please circle the appropriate number below or at the end of the statement or question.

1. (Special Schools Hospitals Churches Counseling Organizations)
   1 2 3 4

2. Have you counseled parents of children with disabilities? Yes No
   1 2

3. Have you counseled parents of deaf children? Yes No
   1 2

4. Who did you counsel? Father Mother Both
   1 2 3

5. Do you have qualified counselors in your organization? Yes No
   1 2

6. Please indicate the number under each qualification

Uncertified	Certificate	Diploma	Degree
(i)_____	(ii)_____	(iii)_____	(iv)_____

7. How many parents of children with hearing impairments do you counsel per year?

five	ten	twenty	Less than thirty	forty	fifty	one hundred
(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)

SECTION B

Please put a ring around the appropriate letter/letters closest to your level of agreement.

KEY: (5) SA - Strongly Agree
(4) A - Agree
(3) U – Undecided
(2) D – Disagree
(1) SD – Strongly Disagree

8. Most parents who were counseled at our organization are able to cope with their children.

SA A U D SD

9. Knowledge of special education is necessary in order for one to counsel parents of children with disabilities

SA A U D SD

10. Our counselors are well equipped to work with parents of children with hearing impairments.

SA A U D SD

11. Not all of our counselors know the difference between counseling and advice.

SA A U D SD

12. It is important to have qualified counselors in our organization.

SA A U D SD

13. Most parents who were counseled keep on coming back for more help.

SA A U D SD

14. Counseling organizations should serve parents in rural areas.

SA A U D SD

15. Our counselors are not comfortable to deal with parents of children with disabilities.

SA A U D SD

16. Our qualified counselors perform better than our unqualified counselors.

SA A U D SD

17. We counsel very few parents of children with disabilities.

SA A U D SD

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Appendix J (Second pool of questions)

QUESTIONNAIRE TO SERVICE ORGANIZATIONS

SECTION A

Please circle the appropriate number below or at the end of the statement or question.

1. (Special Schools Hospitals Churches Counseling Organizations)
   1 2 3 4

2. Have you counseled parents of children with disabilities? Yes No
   1 2

3. Have you counseled parents of deaf children? Yes No
   1 2

4. Who did you counsel? Father Mother Both
   1 2 3

5. Do you have qualified counselors in your organization? Yes No
   2 2

6. Please indicate the number under each qualification

Uncertified	Certificate	Diploma	Degree
(i)_____	(ii)_____	(iii)_____	(iv)_____

7. How many parents of children with hearing impairments do you counsel per year?

			Less than			
five	ten	twenty	thirty	forty	fifty	one hundred
(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)

SECTION B

Please put a ring around the appropriate letter/letters closest to your level of agreement.

KEY: (5) SA - Strongly Agree
(4) A - Agree
(3) U – Undecided
(2) D – Disagree
(1) SD – Strongly Disagree

8. Most parents who were counseled at our organization are able to cope with their children.

SA A U D SD

9. Our counselors are well equipped to work with parents of children with hearing impairments.

SA A U D SD

10. Not all of our counselors know the difference between counseling and advice.

SA A U D SD

11. Most parents who were counseled keep on coming back for more help.

SA A U D SD

11. Our counselors are not comfortable to deal with parents of children with disabilities.

SA A U D SD

13. Our qualified counselors perform better than our unqualified counselors.

SA A U D SD

14. We counsel very few parents of children with disabilities.

SA A U D SD

15. Counseling organizations should serve parents in rural areas.

SA A U D SD

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Appendix K (Final Questionnaire)

QUESTIONNAIRE TO SERVICE ORGANIZATIONS

SECTION A

Please circle the appropriate number below or at the end of the statement or question.

1. (Special Schools Hospitals Churches Counseling Organizations)
   1 2 3 4

2. Have you counseled parents of children with disabilities? Yes No
   1 2

3. Have you counseled parents of deaf children? Yes No
   1 2

4. Who did you counsel? Father Mother Both
   1 2 3

5. Do you have qualified counselors in your organization? Yes No
   3 2

6. Please indicate the number under each qualification

Uncertified	Certificate	Diploma	Degree
(i)_____	(ii)_____	(iii)_____	(iv)_____

7. How many parents of children with hearing impairments do you counsel per year?

			Less than			
five	ten	twenty	thirty	forty	fifty	one hundred
(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)

SECTION B

Please put a ring around the appropriate letter/letters closest to your level of agreement.

KEY: (5) SA - Strongly Agree
(4) A - Agree
(3) U – Undecided
(2) D – Disagree
(1) SD – Strongly Disagree

8. Most parents who were counseled at our organization are able to cope with their children.

SA A U D SD

9. Our counselors are well equipped to work with parents of children with hearing impairments.

SA A U D SD

10. Not all of our counselors know the difference between counseling and advice.

SA A U D SD

11 Most parents who were counseled keep on coming back for more help.

SA A U D SD

12. Our counselors are not comfortable to deal with parents of children with disabilities.

SA A U D SD

13. Our qualified counselors perform better than our unqualified counselors.

SA A U D SD

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Appendix L (Interview questions)

1. Is your child a boy or girl? How old is your child?

2. When did you discover that your child was deaf?

3. What problems did you meet in bringing up your child?

4. What did you do when you discovered that your child was deaf?

5. Did you get any counseling from anybody? Who?

6. Did you approach any Service Organizations for help?

7. What help did you get from them?

8. Does your child mix freely with his/her siblings? Other children in the community?

9. Are you able to cope with your child?

10. What future plans do you have for your child?

11. **In your view does counseling help parents of children with hearing impairments to plan for their future?**

12. What do you think should be done to make counseling more accessible to parents?

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Appendix M (Research Diary)

After completing my college education I joined the teaching profession. I taught for four years in an ordinary school and then joined special education in 1984. I taught children with hearing impairments. As a young teacher I found it challenging, sometimes depressing and unsatisfying. The success rate was minimal. In 1986 I went for further education and studied in the area of special needs. I specialised in the education of children with hearing impairments. I taught for one year and went for further education in the UK where I obtained a master's degree in Special Education International at the University of Manchester. In the UK I got experience with children of different disabilities. The course I studied included, audiology, speech, assessments, counseling, teaching and programme planning.

I worked with parents of children with disabilities as a teacher, counselor, headmaster and lecturer. During all the years of my working career, I got to know the problems parents of children with disabilities experienced. When I studied counseling I learnt more about how such parents felt and how they could be helped. The first parent-group I organized helped me to fully interact with parents and in turn they confided in me. At the time my main duty was to carry out assessments, counsel parents and children and advise them of where to get professional help. It is during that time that I noticed the importance of counseling parents of children with disabilities.

Many parents who had children with hearing impairments in primary schools continued to come back to these schools for advice and guidance. Having observed this I spoke to some parents to find out their problems. The parents did not seem to know exactly what to do with their children. This motivated me to carry out this study.

I registered with the University of Zimbabwe in 1997. The whole of 1998 I worked on the literature review and the instrument to be used in data collection. In 1999 and part of 2000, I collected the data. During the second term of 2000, my supervisor left for overseas. The rest of 2000 and 2001 I was stuck, frustrated and decided to shelf my study. The most disturbing point was that nobody was suitably qualified to supervise me in the areas of special education and counseling. Fortunately when I moved to Botswana I met a South

African friend who told me about the University of Pretoria. He stressed that it was the most efficient University in South Africa but warned me that the standards were very high. He pointed out that I needed to work day and night if I was to make it. In October 2002, I forwarded my personal documents and qualifications for consideration. I was accepted and I registered. I was then allocated a promoter. I made an effort to contact her and she spoke to me on the phone. She asked me to send her the work I had done and at the same time encouraged me to continue working on the literature review and Chapter one.

With time, through her guidance I continued to work on my document. I also gave her copies of my instruments and showed her the collected data. The working title kept on changing and the study took a new direction. It indeed was almost a new study. We arranged that I visit the University of Pretoria to meet her in person and to get to know each other as well as to discuss my study. The arranged date was a PhD proposal defence for some students. This was a great opportunity for me to experience how students prepare and defend their proposals. It helped me to prepare for the defense of my proposal. When I came back I worked on my proposal, which went to and from my promoter six times before she accepted it as one worth presenting to the Department of Educational Psychology and then the Faculty of Education. The department provided good suggestions, passed it and a date was set for me to defend my proposal at Faculty level. On that particular day I was the second one to defend my proposal. I had prepared well and I knew my study but it was not easy. I managed and my proposal was accepted.

It is important for me to point out that studying through distance education is not easy, particularly when you are far away from the University and do not have the opportunity to share your difficulties with your promoter while you are talking face-to-face. Sometimes you want to see what other students have done or some PhD theses that have been passed. Although I missed out on face-to-face conversations, I must point out that my promoter is excellent in communication, quick feedback, support and encouragement. I cannot ask for more as far as supervision is concerned. She has never failed me once. We worked mornings, afternoons, evenings and during the holidays but she never complained, instead she encouraged me to forge ahead. Although I worked very hard, the time that I have taken to complete this study is owed to her. One disadvantage is that being a part-time student for example, in my case, there is almost no opportunity to meet other students from UP in

order to discuss and share ideas. However, I had to travel long distances in order to meet some UP students but all of them were studying for a master's degree. Most of the students are Unisa students, with whom I shared ideas, success stories and difficulties. The demands of UP and Unisa are totally different, and at one point I thought I made a mistake, I should have enrolled with Unisa which is less demanding. However, I like to take up challenges and to produce quality work and also to study with universities of good reputation. Indeed studying with the University of Pretoria is very challenging and at the same time satisfying.

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