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EXAMINING COMMUNICATION PATTERNS AND IDENTITY IN FAMILIES

WITH CHILDREN WHO ARE DEAF OR HARD OF HEARING

BY

AMBER L. ALVEY

A thesis submitted in partial fulfillment of the requirements for the

Master of Arts

Major in Communication and Media Studies

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2020

THESIS ACCEPTANCE PAGE

Amber L. Alvey

This thesis is approved as a creditable and independent investigation by a candidate for the master's degree and is acceptable for meeting the thesis requirements for this degree. Acceptance of this does not imply that the conclusions reached by the candidate are necessarily the conclusions of the major department.

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TABLE OF CONTENTS

ABSTRACT

EXAMINING COMMUNICATION PATTERNS AND IDENTITY IN FAMILIES

WITH CHILDREN WHO ARE DEAF OR HARD OF HEARING

AMBER L. ALVEY

2020

"Deafness in the context of the hearing family attacks the backbone of the family structure, namely communication" (Ahlert & Greeff, 2012, p. 402). There is a link between communication and identity, specifically the role of communication on identity (Jung & Hecht, 2004). The purpose of this study is to better understand the experiences of families with children who are deaf or hard of hearing by investigating the relationship between family communication patterns and identity. In this study, I conducted in-depth interviews with the parents of children who are hard of hearing to investigate family communication patterns and identity. Using Family Communication Patterns Theory and Communication Theory of Identity as a theoretical lens, seven participants within four families shared their experiences. Results show that these families were high in conversation orientation and did not create a family identity around their child's hearing loss. Participants also described their experiences of family communication with their child who is hard of hearing, including the challenges, triumphs, and chosen communication mode. These results offer a greater understanding of these families and introduce important theoretical and practical implications.

CHAPTER 1

Introduction

Recent estimates propose that one in four adults in the United States (61 million) have some type of disability (Center for Disease Control & Prevention [CDC], 2019). Despite this large number of individuals with a disability, society has yet to find solutions to the many barriers people with disabilities face. For example, those with a disability are much less likely to be employed compared to those with no disability (Bureau of Labor Statistics, U.S. Department of Labor, 2018). Besides employment challenges, people with disabilities can face other obstacles such as lack of accessibility and communication, often as a result of lack of awareness from the hearing community and society. These obstacles are also evident in family structure, which this study will focus on.

Families with members who have disabilities can face additional challenges and opportunities compared with families that have no members with disabilities. Diagnosis of a disability or chronic condition can have an impact on the family, especially in children (Steinberg, Bain, Li, Delgado, & Ruperto, 2003). One example of a disability involves deafness or hard of hearing. Deafness involves moderate to severe hearing loss, while hard of hearing can describe a person with mild-to-moderate hearing loss (National Association of the Deaf [NAD], 2019). Not all families respond to the diagnosis of deafness or hard of hearing the same way, just as not all families may communicate in the same way as well (Steinberg et al., 2003). In fact, there can be many influences on the reactions of a family and the decision-making process of choosing the communication a family will utilize, such as culture (Steinberg et al., 2003). The way a family communicates can be something such as the language chosen to be used in the home,

such as American Sign Language (ASL), spoken English, or a combination, to the degree of communication practiced. This communication can have an impact on the family function.

Furthermore, the family can also face challenges and opportunities with identity following the diagnosis of deafness or hard of hearing. In their study of Hispanic families with hearing parents and a child diagnosed as deaf or hard of hearing, Steinberg and others (2003) noted that cultural background played a role in the identity of the family and directly impacted the decision-making of the families in the communication used within the home. With many decisions to be made when receiving a diagnosis of deafness or hard of hearing for their child, it is vital to have research to better understand the experiences of these families.

The many variables, opportunities, challenges, and complexities that families with hearing parents and children who are deaf or hard of hearing face and are important to investigate from a communicative standpoint. From this standpoint, we can gain a better understanding of the communication challenges and triumphs of families with children who are deaf or hard of hearing and parent(s) or guardians who are hearing. Through this research, families can be better equipped with knowledge on the importance of family communication and the role of identity within family structure. Further, professionals and educators within the field of deaf education can get a glimpse into the lives of families they may serve and develop more understanding on how to better meet the needs of these families. In order to achieve these outcomes, we first need to understand the history, community, culture, and advocacy of the disability community and the discipline of disability studies.

Disability

The Americans with Disabilities Act (ADA) defines disability as "a person who has a physical or mental impairment that substantially limits one or more major life activity" (ADA National Network, 2019, paragraph 2). However, the definitions detailed in law, by society, and by those with disabilities are complex (Kaplan, n.d.). The status of people with disabilities in society is continuing to change (Kaplan, n.d.). Therefore, this section will highlight the history of the challenges and experiences of those in the disability community, along with the introduction of disability studies. Following this section, deafness and the Deaf community will be introduced.

The biomedical model of disability. The biomedical model of disability is one that focuses mainly on functional "impairments" (Hahn, 1988). Without the ability to be flexible, this model only focuses on one aspect or definition of disability, limiting the scope to which it can be applied to. Furthermore, the biomedical model predisposes medical professionals to think of disability as a condition that is in need of treatment and repair (Llewellyn & Hogan, 2000). Medical professionals using this model focus on the disability in the form of a condition that is in need of treatment. Therefore, the concentration is on the disability and the individual simultaneously, while working to provide a cure (Llewellyn & Hogan, 2000). However, the biomedical model is not just used in medicine. Psychology uses the diagnostic measures and clinical approach found in the biomedical model (Llewellyn & Hogan, 2000). This model allows for quantification of systems, finding a particular cause to the "problem", while searching for

treatment (Llewellyn & Hogan, 2000). This is especially problematic, as not all individuals with disabilities view their disability as something to be fixed.

The biomedical model has various criticisms, such as the ability to divide the disability community by placing labels (Smart, 2009). Smart (2009) goes on to describe further criticisms by discussing how this model can validate practices of prejudice and discrimination to those in the disability community. One of the largest complaints regarding the biomedical model involves its failure to adjust to changing definitions of disability (Smart, 2009). An example is those who are deaf or hard of hearing often embrace their disability as part of who they are and not something that they wish to be corrected. Dirth and Branscombe (2018) further this by stating the limitation of focusing on solely the impairment neglects the role of other factors that contribute to disability, such as sociopolitical circumstances. For example, those who are deaf or hard of hearing may have a multitude of other factors that contribute to their experiences with a disability, such as language barriers, certain employment challenges, and the perception of deafness from others.

By only focusing on the challenges of the actual disability, in this case deafness, it is difficult to take into account all circumstances that affect deafness besides the physical and medical background. Further, this model can make it seem that those with disabilities have something wrong with them or that they are different from the "norm." Therefore, the biomedical model of disability is one that was relied upon in prior research and often investigated how to make individuals with disabilities as normal as possible (Smart, 2009). However, another model of disability has started taking precedent.

The sociopolitical model of disability. People with disabilities tend to move away from viewing their disability as a problem. Therefore, they often reject the biomedical model of disability (Llewellyn & Hogan, 2000) in favor of the sociopolitical model of disability. This model, which emerged in the 1960s, is typically more reflective of the experiences of those with disabilities. It focuses on the sociopolitical factors in disability, stating that disability occurs from the failure of social environment rather than from the inability of the individual with a disability (Llewellyn & Hogan, 2000). Furthermore, this model directly challenges the tendency of biomedical model to look into the direct cause of the disability at the level of the individual who has the disability (Smart, 2009). Llewellyn and Hogan (2000) discuss how this model shifts the focus from the individual with the disability to the functions of society. For example, a person with a physical disability, such as deafness, can run into challenges regarding language not because of the impairment itself, but rather because society is designed to favor auditory language. Because society can set up those with disabilities with challenges, those with a disability can feel isolated.

Besides feeling isolation, those with disabilities can feel marginalized by society. Smart (2009) suggests individuals with a disability often view themselves as a minority group forming their own group identity. This identity creation can combat the isolation those with an identity may feel from being viewed as an "other" to the rest of society. Thus, those who identify as having a disability often identify as being a marginalized group (World Health Organization [WHO], 2017). A marginalized group is one that is excluded from meaningful participation in society. Therefore, certain groups, such as those in the disability community, are marginalized through isolation, power distance,

and lack of access. Historically, being marginal status can create conflict and uncertainty, leading to conflicts of social interactions and thoughts of self (Barker, 1948).

Those from minority groups have been oppressed, being deemed as lesser than the majority group (WHO, 2017). Individuals with a disability are often seen as and identify as a marginalized group (Bickenbach, Chatterji, Badley, & Ustun, 1999; Fine & Asch, 1988; Finkelstein, 1993; Hahn, 1988). Hahn (1988) suggests marginalization can occur due to assumed biological inferiority of those with disabilities from those without a disability. For instance, those who are deaf may be deemed inferior based on the communication barrier associated with their disability. Often, those who are deaf are referred to as "dumb," associating their disability with their intellectual ability. People often see those who are deaf as silent and dumb based on many in the deaf community not using voice to communicate, something that is offensive to the deaf community. Those in the deaf community continuously have to prove their contribution to society and defend their identity (National Association for the Deaf [NAD], n.d.). Therefore, viewing a disability such as deafness as a biological inferiority contributes to the marginalization of deafness and disability as a whole.

Disability studies. During the same period that the social or sociopolitical view of disability was challenging the traditional medical view, disability studies emerged as a scholarly discipline (Finkelstein, 2001). Specifically, disability studies is "about the development of critical enquiry into those social and political forces that frame and inform our relationships with each other and the institutions of society that we have created" (Johnstone, 2012, p. 2). Johnstone (2012) discusses the complexities that frame our relationships, our viewpoints, and our experiences. These complexities create varying

opinions and inconsistencies, all of which must be considered to discern what disability truly means. This is the focus of disability studies, discussing how these forces and complexities affect people with disability from a political and social standpoint and what can be done to alter society to change outcomes. Furthermore, disability studies has been coined as an academic discipline (Johnstone, 2012), one that came about during the rise of disability advocacy.

The emergence of disability studies came at a time in when people with disabilities were left without adequate access to necessities like public transportation, bathrooms, and stores (Anti-Defamation League, 2018). As veterans with disabilities began coming forward asking for rehabilitation from the government following World War II, a civil rights movement began shifting. Like movements for various societal changes today, this movement toward disability rights came with challenges such as negative attitudes and pushback (Anti-Defamation League, 2018). One of the breakthroughs for this movement came when disability rights advocates lobbied to include rights for people with disabilities into the Rehabilitation Act of 1973 (U.S. Department of Justice, 2009). After the revision of this act, several other monumental breakthroughs occurred, one of the most significant being the Americans with Disabilities Act of 1990 (U.S. Department of Justice, 2009), ensuring equal access and treatment for people with disabilities (Anti-Defamation League, 2018).

Deafness has not been highly focused on by the communication discipline, perhaps due to perceived communicative barriers. However, this emphasizes the importance of such scholarship to the communication discipline. Therefore, the purpose of this study is to better understand how families with hearing parents and children who

are deaf or hard of hearing describe their family communication patterns and their family identity. Through a better understanding of the communication used and how these families and children see themselves, families who may relate to these experiences can discover communicative strategies they can utilize for family cohesiveness and positive identity.

Deafness

There are many differences to how someone becomes deaf or hard of hearing (DHH), just as there are many differences to how they navigate their experiences after. People label themselves personally, often by their identification with the DHH community and the degree to which they can hear (NAD, n.d.). The term deaf often refers to an individual with little to no functional hearing (Deaf Technological Education Center [Deaf TEC], 2019). As defined earlier, hard of hearing is someone with mild-to moderate hearing loss (NAD, n.d.). Deaf and hard of hearing are the most common terms used to describe an individual with hearing loss, but there are other terms that have been utilized by those outside the community. Often, those who are hearing have referred to those who are deaf or hard of hearing as hearing impaired. However, while this was at one time considered politically correct, it is no longer accepted by most in the community (NAD, n.d.). This term refers to what those who are deaf or hard of hearing can't do and implies something should be fixed if possible (NAD, n.d.). Therefore, hearing impaired is not a term that will be utilized in this study.

"Deaf and hard of hearing people have the right to choose what they wish to be called, either as a group or on an individual basis" (NAD, n.d., paragraph 9). Those who are hard of hearing may also be those who choose not to identify with the Deaf

community (NAD, n.d.). Individuals who are DHH may not associate with the Deaf community or the culture based on looking at deafness from an audiological or cultural perspective (NAD, n.d.). Certainly, the same could go with families with a DHH member in choosing whether to identify with the Deaf community or not. Further, some members of the family may choose to identify and not others. To get further insight into identification of those who are DHH, I will now introduce the significance of Deaf culture in the Deaf community.

Deaf Culture and Community

A communicative approach to studying disability is especially useful when considering people who are DHH, particularly those who identify with the Deaf culture, which shapes the communication and identity of those who are DHH. "Culture and language intertwine, with language reflecting characteristics of culture" (NAD, n.d., paragraph 1). Deafness as a disability is unique compared to other disabilities because of the community formed around deafness. In fact, deafness has developed its own culture within the world. According to DOOR International (n.d.), there are different abbreviations and terms that are reflected in Deaf community. The term "Deaf" with a capital D refers to those who identify as part of the Deaf community and Deaf culture (DOOR, n.d.). The use of the lowercase letter in deaf reflects the physical disability of deafness characterized by hearing loss or inability to hear. Often, text will refer to deafness with the term d/Deaf to include both those who identify with the Deaf community and the disability itself (DOOR, n.d.). This study will utilize the lowercase d when referring to participants' children until they identify that they are part of the Deaf community.

The National Deaf Education Center (NDEC) at Gallaudet University (2019) describes American Deaf culture as centered around the use of ASL and the unison of others who are Deaf. ASL is a language in which gestures, otherwise known as signs, are paired with facial expressions to create a visual language with no vocal components (NDEC, 2019). ASL is different than Signed Exact English (SEE), as ASL has its own grammar and vocabulary usage that is intended for the use of the Deaf community. Signed Exact English uses signed language in the format that it is spoken in English and has some different signs than American Sign Language. It is important to note that ASL is not a universal language, as other countries have their own signed languages (NDEC, 2019).

Deaf culture has its own set of values, behaviors, and traditions that make it distinctive to not only the disabled community, but also to other cultures. Examples of these values include promoting an environment that supports vision as the primary sense used for communication, encouraging the use of a signed language, support for bilingualism, perpetuation of Deaf culture through traditions, and more (NDEC, 2019). One of the most prominent values expressed by the Deaf community is the support for signed language. This comes from many in the Deaf community embracing their disability and not viewing deafness as a handicap (DOOR, n.d.). The DOOR (n.d.) furthers this by stating those in the Deaf community view deafness as an integral part of their identity and who they are. With deafness being such an important part of identity within Deaf culture, it is clear that deafness within the family can also play a part in the identity of the family as well.

Since being deaf is a large part of the identity in Deaf culture, there is controversy among the communication used by those who identify as party of the Deaf community. This controversy is rooted in the history of audism and the oppression of individuals who are deaf. Audism is defined as the discrimination of people based on their hearing ability (Bauman, 2004). Audism claims that being hearing is superior than being Deaf (Bauman, 2004). Bauman (2004) explains the frustrations of the Deaf community to be facing audism in many different settings; however, the most frustrating of these settings are the institutions that serve d/Deaf populations, like medicine and education. Families with children who are DHH may also experience some of these frustrations, especially after their child is diagnosed and is introduced to the educational system.

One frustration that some people who are DHH have with the medical community, especially those still operating within the biomedical model, is the push for cochlear implants among the deaf population. This has caused great controversy within Deaf culture because the use of sign language is a critical part of identifying as part of the Deaf community. The reason this is so important is because it can be interpreted by the Deaf community that at the root of the push for the cochlear implants is the viewpoint that hearing is superior and that speech is true language (Bauman, 2004). Bauman (2004) furthers this by stating, "Perhaps the largest problem to be solved for deaf individuals is that once speech is defined as language and vice versa, the concept of what it means to be human becomes intimately tied with speech" (p. 242). This shows the weight of the decision on individuals who are DHH and parents who may come to face with that decision for their children who are DHH. Families who have children who are DHH may feel the pressure to have hearing devices due to information from the medical community

or personal attitudes and beliefs. Therefore, it is important to research the communication used within families with children who are DHH to understand what leads families to that decision, which will be discussed further in the following section.

Deafness and Communication in Families

Many parents are left searching for answers about how to best serve their child and yet are left with conflicting information and lack of resources. Families are being left without insight on how communication and identity contribute to family function. In recent years, language acquisition has been a huge topic of interest in the advocacy for children who are deaf or hard of hearing. Language acquisition is the ability to process language. Without language acquisition, children can be exposed to setbacks and harms. Humphries, Kushalnagar, Mathur, Napoli, Padden, Rathmann, and Smith (2012) discuss the harm to an individual from linguistic deprivation. One of the harms is psychosocial problems from isolation and frustration of lack of shared language (Humphries et al., 2012). Further, society can harm and be harmed from linguistic deprivation as well. Those who are linguistically deprived are less likely to participate constructively in society (Humphries et al., 2012). With conflicting information given by medical professionals and the lack of communication research in this area, parents are left without answers. There are serious consequences to not understanding the communication patterns within families of this demographic, for the family as a whole and the child who is DHH.

Deafness is a unique disability, making it an important area of interest for research. Specifically, deafness uses communication as a way to embrace and in some cases overcome the disability. Using another language, such as American Sign Language,

can bring forth challenges and opportunities associated with bilingualism to the individual and the family. Bilingualism is described as the knowledge of two or more languages (Grosjean, 2001). Not only can bilingualism affect the family communication and identity, but it can also influence the culture of that family as well. As previously discussed, Deaf culture is associated heavily with American Sign Language. Therefore, families who adopt various languages, such as American Sign Language, may also adopt various cultures and identity as well (Grosjean, 2001). This can lead to communicative complexities and identity challenges within the family structure. Therefore, I posit that research investigating these two areas, family communication patterns and identity, can illuminate greater understanding of the uniqueness of deafness within the individual and the family.

The communication discipline has room for growth in providing insight into families with the complexity of having parents who are hearing and children who are DHH. Thus, the purpose of this study is to better recognize the communicative challenges, strengths, and patterns used in families with parents who are hearing and children who are DHH. Through this study, the identities of families with this demographic can also be better understood. Knowledge gained from this study can assist parents in making crucial decisions for their children and provide strategies for families to utilize in order to navigate communication and identity with a member with a disability. Even more significantly, medical and support professionals can be more informed on the communication complexities that occur within these families from an in-depth perspective.

In review, this chapter introduced the history of disability studies, Deaf culture, and presented the purpose of this study to better understand the communication patterns and identity within families with parents who are hearing and children who are DHH. Learning more about the communicative experiences of these families can help other families feel a connection in experiences and give them strategies they can utilize in their own homes. To investigate this, chapter two will include a review of literature regarding family communication patterns and identity within families with DHH members. Chapter three will include the methodology used to study this phenomenon. Chapter four will introduce the results of the study. Chapter five will discuss the results in greater detail, along with theoretical implications, limitations, and areas for future research.

CHAPTER 2

Review of Literature

Close to 96% of children who are DHH are born into families with parents who are hearing (Mitchell & Karchmer, 2004). With such a high number of children who are DHH born into families who they may imm ediately face a language barrier with, it is vital for families to have the resources necessary to communicate with their children. Furthermore, this language barrier can affect the identity of not only the child who is DHH, but the family as a whole.

Communication scholars have not investigated the role of family communication patterns and identity together in these families. Thus, the purpose of this study is to better understand the family communication patterns used and identity in families with parents who are hearing and children who are DHH. Furthermore, the various ways these families manage, communicate, and express their identity will be investigated through this research. This study will be using Family Communication Patterns Theory and Communication Theory of Identity to analyze how families with parents who are hearing and children who are DHH communicatively describe their experiences. Prior to the explanation of proposed methodology in chapter 3, this chapter will provide insight in previous literature that investigates this problem.

Family Communication

Communication is an essential building block of robust family relationships (Peterson & Green, 2009). The ability to communicate is an important part of relationship-building, expression, and creation of a stable environment within the family. Peterson and Green (2009) further this by emphasizing the importance of healthy, open

communication in allowing families to solve problems effectively and be satisfied in interpersonal relationships. Not only can communication influence the relationships in the family, it can also influence the concept of the family structure. Luckner and Velaski (2004) propose that family forms the human experience and impacts future development. For example, one can have a positive experience within the family through effective communication and stable relationships. This positive experience can then lead to a positive impact on future development (Luckner & Velaski, 2004). When difficulties arise in families that alter their communication, such as in the case of a family member with a disability, relationships and development can be affected. Therefore, just as effective communication influences healthy families, experiences, and development, poor communication can influence unhealthy experiences and family relationships (Peterson & Green, 2009).

Researchers have found that communication, specifically in families with children who are DHH, can greatly impact family relationships and contribute to family functioning (Ahlert & Greeff, 2012; Desselle, 1994; Eleweke & Rodda, 2000; Henderson & Hendershott, 1991). Ahlert and Greeff (2012) found that communication positively impacted family adaptation. In interviews with families with DHH members, participants discussed quality of communication as one of the key factors in determining the ability to adapt to disability as a family. In fact, one of the greatest factors impeding the adaptation process in these families was the inability to communicate with their child due to a language barrier (Ahlert & Greeff, 2012). Therefore, this language barrier can greatly impact family relationships and inhibit family functioning.

Henderson and Hendershott (1991) support the crucial role communication plays in family functioning. Regarding the family's natural language, Henderson and Hendershott state, "It facilitates the socialization and enculturation processes" (p. 326). The family system suffers when a member is excluded based on language barriers (Henderson & Hendershott, 1991). With a suffering family system, facets of the family function and relationships are damaged. This lack of communication and decreased family function threaten the resources available to children who are DHH (Henderson & Hendershott, 1991).

Thus, communication challenges, such as not having a shared language, can greatly affect various aspects of the family system. This example of not having a shared language is one that occurs commonly in families with hearing parents and children who are DHH. However, research has yet to discuss the role of patterns of communication within this family type and how this contributes or hinders the family system. This study will contribute to research by further investigating communication used within families with parents who are hearing and children who are DHH, specifically the role of communication patterns.

Hearing families with children who are DHH often do face similar challenges as those families without children who are deaf (Luckner & Velaski, 2004). However, there may be additional obstacles experienced by these families in the face of communication, stress, and accommodation. Luckner and Velaski (2004) investigated obstacles and qualities of healthy families with children who are deaf through interviews with nineteen families. Researchers found that some of the obstacles that families faced included finding educational programs, learning to sign, understanding deafness, finances, and

friendships for the child who is deaf. One of the most common obstacles discussed by Luckner and Velaski (2004) include the communication barrier between parents who are hearing and children who are deaf, thus creating a stressful, yet important decision the family must make regarding communication used. While families with children who are DHH do face similar challenges as other families, they often do face additional stressors that come with having a family member with a disability.

Coming to terms with having a child experiencing hearing loss can be stressful on the family (Pipp-Siegel, Sedey, & Yoshinaga-Itano, 2002). Researchers have often focused on the stress families face in having a child with a disability (Park & Yoon, 2018; Pipp-Siegel, Sedey, & Yoshinaga-Itano, 2002; Zaidman-Zait, Most, Tarrasch, Haddad-eid, & Brand, 2015). In a study by Park and Yoon (2018), parenting stress was investigated in Korean mothers with children who were DHH. Using qualitative research methods, interviews were conducted with five mothers between the ages of 45 and 50 years. Mothers in the study describe feeling grief upon diagnosis of deafness, which was amplified by the lack of information provided by the hospital (Park & Yoon, 2018). Other stressors felt by participants included negative perceptions of the disability from lack of experience, receiving diagnosis without support, struggling to choose between mainstream and special education, and lack of information regarding educational transitions. Other results of this study also showed that these mothers experienced difficulties in maintaining family relationships due to paying less attention to other siblings of the child who is deaf, higher parental expectations, lack of communication within the family, and exhaustion from being the family mediator (Park & Yoon, 2018).

However, stressors do not have to always be negative, but rather a place for challenge and growth (Moores, Jatho, & Dunn, 2001).

Communication Modality Choices in Families

One of the biggest stressors placed on hearing parents in families with children who are DHH is the choice of communication used within the family. Ahlert and Greeff (2012) emphasize this stressor by stating, "Deafness in the context of the hearing family attacks the backbone of the family structure, namely communication" (p. 402). Because of a language barrier, families struggle to decide on what communication mode is used with a child who is DHH. Communication modes can typically range from sign, spoken, written, other, or a combination of multiple choices. This decision can be influenced by a multitude of factors, including family perception of disability, expectation, and roles within the family (Kluwin & Gaustad, 1991).

Kluwin and Gaustad (1991) investigated the predictors of family communication choices in families with children who have hearing loss. Using a parent questionnaire distributed to 192 parents, Kluwin and Gaustad (1991) investigated communication modes used, who was using the communication mode, and factors influencing the mode of communication. Three modes of communication choices emerged: speak, sign, or other. Other modes of communication could include a form of communication such as writing. These modes of communication are often unique to family systems with deaf or hard of hearing members, making the study of the communication used in these family systems even more vital. Various factors contributed to the selection of communication mode including education, gender, and the perception held by the parent of the severity of the disability. One example Kluwin and Gaustad (1991) suggest is that the degree of the

child's impairment significantly influences the mother's selection of a communication mode. Thus, if the child were to have greater hearing loss, it is likely that the mother may lean toward a more manual form of communication such as writing or sign.

Eleweke and Rodda (2000) further support the idea of predictors of communication choices within families, while also adding additional influences such as information given to parents, attitudes toward services professionals, and available support. Specifically, the attitudes and policies of the professionals working with the parents of children who are DHH can influence the type of support and information provided to the parents. As a result, parents often felt that the resources provided could never be useful to them because they were not meeting their child's communication needs (Eleweke & Rodda, 2000). These results emphasize the importance of quality support services and proper information and guidance given to parents of children who are DHH. Therefore, the communication utilized within families with children who are DHH can be influenced by a multitude of elements, such as medical information, that in turn have an impact on the family as a whole.

Another study investigated the influences that drive the decision of communication mode in families with children who are DHH. Li, Bain, and Steinberg (2003) used a survey reviewed by a panel of professionals who care for children who are deaf in order to confirm the accuracy of scales and relevance of their study. 83 returned surveys, 18 of which were distributed to parents attending a workshop for the American Society for Deaf Children, were analyzed to show that parental attitudes, beliefs, goals, and aspirations all contributed individual choice of communication mode (Li et al., 2003). For example, personal attitudes of the parents regarding deafness and sign

language influenced the decision of oral training for the child. "A parent was more likely to choose oral only training if he or she thought that all deaf children should go to ordinary schools and all deaf children could learn to speak if enough time and effort was put into teaching them" (Li et al., 2003, p. 165). Like with the study from Eleweke and Rodda (2000), this study supports that attitudes and beliefs from both the parents and medical professionals can have impact on the communication mode chosen. Therefore, it could be likely that the attitudes of the parents in this study may affect the communication mode chosen for the family.

To summarize the importance and impact of decisions regarding communication mode, Porter, Creed, Hood, and Ching (2018) conducted a systematic literature review to understand the extent have shared decision-making and informed choice have been practiced in families with children who are DHH. The studies had to meet several criteria to be considered:

> (a) target hearing parents or caregivers of children who had a bilateral or unilateral permanent hearing loss and who made decisions on behalf of their child aged from birth to 12 years of age; (b) include a proxy decision made on behalf of the child as a result of the child's hearing loss; (c) examine any component of the decision making process, (i.e., information exchange, deliberation or implementation), either explicitly or implicitly using quantitative, qualitative, or a mixed methods approach; and (d) be peer-reviewed papers describing the results of original research published from 2000 to 2017 (Porter et al., 2018, p. 298).

Factors that contributed to decision making included ability to understand the information being presented to them through medical professionals or the media,

perceived benefits and risks of cochlear implants, pressure to make a decision, and

cognitive biases (Porter et al., 2018). This review highlights the need for quality,

unbiased information provided to parents regarding the decision of communication mode

used with their children who are DHH.

Communication and Social Development

The use of communication is crucial to the family system, as it facilitates the

process of socialization (Henderson & Hendershott, 1991). Therefore, shared

communication can assist with the process of socialization within families. Families with

a family member who is DHH can experience a barrier to shared communication,

meaning a communication choice that is understood and utilized between members of the

family. Lack of shared communication can isolate family members, weakening the family

system (Kluwin & Gaustad, 1991). Feelings of isolation inhibit the ability to develop

strong relationships within the family as a whole. Furthermore, communication mode can

also affect the development of the child who is DHH. Communication plays a crucial role

in how we develop, adapt, view the world, and even view ourselves. Children deprived of

shared communication can struggle to develop a sense of self (Henderson & Hendershott,

1991). This sense of self is even more vital in families with children who are DHH. As

Henderson and Hendershott (1991) propose, children who are deaf or hard of hearing

often struggle to develop a strong sense of self due to lack of dialogue, specifically within

the family, and lack of developing a natural language. Thus, communication becomes

central to developing a strong sense of self in children who are DHH in families who are

hearing.

Developing a sense of self also plays a role in social behavior. As Kushalnagar, Topolski, Schick, Edwards, Skalicky, and Patrick (2011) discuss, the communication mode utilized in families can create a social barrier for youth, making it challenging to participate in dialogue with family members. Using a multivariate modeling framework, Kushalnagar and others (2011) investigated the relationship between specific communication variables and perceived quality of life of 230 youths. Findings from this study suggest that youth who understand the communication used by their parents have a higher reported quality of life in association with their sense of self. Therefore, in families with children who are DHH, social barriers caused by not having shared communication can be detrimental to the child's sense of self. This social barrier can also contribute to reduced socioemotional well-being. Just as a social barrier can contribute to negative outcomes, removing that barrier can increase the self-acceptance felt by children who are DHH (Kushalnagar et al., 2011).

In addition to social barriers, family communication choice and family members play a large role in the self-esteem of children who are DHH. A significant factor into the self-esteem of children who are deaf or hard of hearing born into hearing families is that their deafness is viewed as a defect from their family members (Desselle, 1994). Desselle (1994) investigated the impact of communication method on the self-esteem of children who are deaf by utilizing a modified Self-Esteem Inventory that has been utilized with people who are DHH. A variety of communication choices were presented, including speech, fingerspelling, sign, and a combination of the three. The more parents were able to effectively communicate to their child, the higher the child's self-esteem. The findings supported that the child who is DHH can be influenced by the communication method

chosen by the parents. Desselle (1994) proposed that families who use total communication, meaning speech, fingerspelling, and sign, reported higher self-esteem in their children than those who used the speech-only method of communication. Therefore, parents and families have an impact on their child's self-esteem through multiple variables, especially in communication choices (Desselle, 1994). This self-esteem can be important in the identity of their child, showing the importance of investigating identity in relation to communication in this study.

While the mode of communication is an important aspect to family structure, well-being, and outcomes, this study will not be solely focusing on the choice of communication modality in the families of interest. Research has been conducted to show what leads into the decision-making process of communication mode, as presented above. However, little research has been done to look at what happens after a communication modality has been chosen with children who are DHH by investigating the nature of communication itself. In other words, this study aims to investigate content, relational meaning, and patterns of communication regardless of the modality or modalities used within these families. Further, this study will use the information collected with communication to see how it relates to the development of family identity with hearing parents and children who are DHH. Simply, it is not about what modality is used, but rather *how* it is used in these families.

Family Communication Patterns

Family is an important part of the human experience yet is never the exact same between families due to diverse communicative patterns present in each family (Galvin, Braithwaite, & Bylund, 2016). As previously supported, communication contributes to

many outcomes of the family, especially within families with parents who are hearing and children who are deaf or hard of hearing. Furthermore, communication also contributes to the understanding of family relationships. One of the most influential theories in family communication, Family Communication Patterns Theory (FCPT), has the potential to inform how families with children who are DHH communicate and create knowledge on family behavior. While this theory is influential in communication, it has not met its potential in a complex family demographic, such as families with members with a disability like deafness. Communication scholarship has often focused on family relationships and communication but has yet to emphasize the role of family communication patterns within families with hearing parents and children who are DHH, which . This study aims to fill this gap by investigating the role of family communication patterns in families with hearing parents and children who are DHH.

FCPT refers to the way family members think about relational schemas, such as their nonverbal and verbal behaviors (Koerner & Fitzpatrick, 2002). A schema is a set of memories utilized when interacting with others, which are informed from prior knowledge. Relational schemas involve the knowledge about others, yourself, and the family as a whole, thus providing insight on how to interact with others. Therefore, this knowledge influences your interaction with others and the communication chosen to navigate these interactions. Galvin and others (2016) discuss the impact of demographics on structure and characteristics within a family. These demographics, such as having a member who is DHH, can influence the view of relational schemas within the family. The knowledge one may have about themselves as a family member who is hearing may differ from the knowledge a family member who is deaf or hard of hearing may

experience. Therefore, family communication patterns in families with children who are DHH may differ from families with a different demographic of members.

There are two communication orientations outlined within this theory: *conversation orientation* and *conformity orientation* (Fitzpatrick & Ritchie, 1993). Conversation orientation refers to the degree family members are encouraged to participate in conversation and interaction on a wide variety of topics. Meaning, if a family is on the high end of this orientation, much interaction and time is spent without restriction. If a family is on the low end of this orientation, family members may not discuss as many topics (Fitzpatrick, 2004). Conformity orientation is defined as the degree to which families create shared attitudes, beliefs and values. A family who is united in beliefs and values while also harmonious are characterized on the high end of this dimension. Families on the low end of this dimension will have more individuality of family members, with conversations and interactions focused on the independence of these family members from the family system (Fitzpatrick, 2004). Therefore, these orientations help describe family structure based on how information, emotional and factual, is exchanged within the family (Fitzpatrick & Ritchie, 1993).

Family communication patterns and orientations have direct associations with relationships. Using FCPT, Ledbetter (2009) investigated family communication patterns and the association with friendships and relational maintenance. Participants enrolled in a large, public University located in the Midwestern United States were recruited for this study. Results from this study supported the communication behavior used in family environments can influence behavior in other relationships as well, including friendships. Furthermore, Ledbetter (2009) argues that communication environments characterized by

open discussion can lead to children in those families experiencing closer friendships. In contrast, those in family environments with inflexible rules and expectations focused on conformity may have reduced friendship closeness in childhood (Ledbetter, 2009). Therefore, family communication patterns can have tremendous impact on relational maintenance in many kinds of relationships, demonstrating the need for further investigation.

Family orientation patterns can also have impacts on the outcomes of the family. One example from Schrodt, Ledbetter, Jerobero, Larson, Brown, and Glonek (2009) investigated communication patterns in families as mediators of communication competence in the parent-child relationship. Distributing a questionnaire to 417 young adults at a large, Midwestern university, Schrodt and others (2009) found that communication patterns are influenced by the communication competence of the parents. For example, if one were to have strong communication competence, family environments would emerge that encourage children to discuss a wide range of topics. Further, Schrodt and others (2009) argue that competence communication skills can assist parents in enhancing their children's social development. This study argues the impact family communication patterns can have on the family.

Family communication patterns can contribute to activities, relational behaviors, and individual well-being (Schrodt, Witt, & Messersmith, 2008). Using a meta-analysis review of 56 studies, Schrodt and others (2008) examined the relationship between family communication patterns and information-processing, behavioral, and psychosocial outcomes. Using electronic databases like Academic Search Premier, Sage Full Text, JSTOR, and Psychology and Behavioral Science Collection in EBSCO, the researchers

found that family communication patterns have meaningful association with individual family member outcomes (Schrodt et al., 2008). Schrodt and others (2008) suggest that conversation orientation is a stronger predictor of psychosocial outcomes than conformity orientation. In other words, families interacting in communication on a variety of topics and freedom of expression are more likely to enhance the well-being of individual family members (Schrodt et al., 2008). I posit that this study can further the results of the work of Schrodt and others (2008) by investigating family communication patterns in a family that is under researched, those with DHH members.

Using these orientations of conversation and conformity, four family types emerge: (1) consensual; (2) pluralistic; (3) protective; (4) laissez-faire (Littlejohn, Foetz, & Oetzel, 2017). First, consensual families are defined by high conversation and conformity, meaning that they interact often, but the family authority – mainly the parent – is the one making the decisions. Often, these families try not to disturb the existing power dynamic in the family (Fitzpatrick, 2004). Second, pluralistic families are high in conversation but low in conformity. These families value free-flowing conversation, while also giving decision-making power to each individual in the family. Within families with parents who are hearing and children who are DHH, conversation and decision-making can be limited if a communication barrier is present. Third, protective families are low in conversation and high in conformity, meaning there is little conversation, but high amounts of respect for authority. Children within these families are influenced highly by outside authorities (Fitzpatrick, 2004). Fourth, laissez-faire families are both low conversation and conformity, meaning there is low involvement and interaction (Littlejohn et al., 2017). Children in these families are often influenced by

social groups external from the family structure (Fitzpatrick, 2004). This is important in families with deaf or hard of hearing family members because many who are deaf or hard of hearing seek community outside the family, such as in the Deaf community (DOOR International, 2019).

Charoenthaweesub and Hale (2011) used family communication patterns to investigate the effects of communication on the well-being in Thai families. This study is unique in that it differs from the common communication studies focused on families located in the West. Researchers recruited high school students and their parents to participate in completing the Revised Family Communication Patterns instrument by Koerner and Fitzpatrick (2002), along with other scales to assess wellbeing. Around 47.7% of respondents indicated that their family participated in a more consensual style of communication (Charoenthaweesub & Hale, 2011). However, the family communication style that reported the highest rates in relation to well-being was pluralistic (Charoenthaweesub & Hale, 2011). Charoenthaweesub and Hale (2011) determined that while there were some varying styles, consensual communication was mainly used in these families as parents were trying to maintain their power and be open-minded at the same time. Of importance is the relationship between communication patterns and the well-being of children in those families. These results support the importance of continued research in family communication patterns, especially in families of underrepresented or understudied populations.

A study by Rueter and Koerner (2008) investigated the role of family communication patterns on adopted adolescent adjustment in 592 families, both adoptive and nonadoptive. This family structure was investigated due to complexities within the

family demographics, similar to families with members who are deaf or hard of hearing. Using self-report surveys, videotaped interactions, and interviews, researchers found that family communication patterns directly relate to adolescent adjustment. Results indicated adoptive families who used conformity over conversation orientation struggled to alleviate challenges with adolescent adjustment. Specifically, this study showed that families who emphasized a combination of conversation and conformity were least likely to have adjustment problems (Rueter & Koerner, 2008). Furthermore, adoptive families high in conversation orientation mitigated their risks for child adjustment problems (Rueter & Koerner, 2008). The results of this study are significant because it investigates the interactions and family communication patterns within a family with additional complexities and challenges, similar to families with members who are DHH. A shortcoming of this study was the ineligibility of families with children who had a physical or mental disability that could affect the assessment. This could exclude families with children who are deaf or hard of hearing, thus contributing to limited research in these families. Therefore, my study aims to meet the unmet need to investigate the impact of communication patterns used within families with children who are DHH.

Another study of significance involving family communication patterns in families with additional challenges and complexities was conducted by Schrodt and Ledbetter (2007). 567 young adults at a midwestern University participated in a questionnaire containing multiple scales, including the Revised Family Communication Patterns instrument by Koerner & Fitzpatrick (2002), to reflect on their mental well-being, feelings toward their parents, and the communication between their parents and themselves (Schrodt & Ledbetter, 2007). Family conversation orientations were found to

have direct, positive effects on the children's well-being. Furthermore, researchers presented findings that supported parental communication behaviors mediate the influence of family communication patterns and conformity on a child's well-being (Schrodt & Ledbetter, 2007).

Through this study, Schrodt and Ledbetter (2007) emphasize the impact family communication environment has on childhood development and well-being by stating, "When parents create a family communication environment that encourages open discussion on a variety of topics, participatory decision-making, and freedom to express concerns, such environments tend to facilitate healthier childhood development and well-being" (p. 349). This research by Schrodt and Ledbetter (2007) is significant in that unique family types were investigated and compared, in this case divorced and non-divorced, using family communication patterns, in which prior research conducted had overlooked using the same measurement. Therefore, through investigating another type of unique family, one with children who are DHH, I aim to contribute to scholarly knowledge by researching family communication patterns in this unique family structure.

Although studies have investigated family communication patterns in various family structures, it is important to add to communication literature by studying the underrepresented population of families with parents who are hearing and children who are deaf or hard of hearing. Furthermore, unlike many studies that investigate FCPT, this study will qualitatively investigate family communication patterns, rather than utilize Koerner and Fitzpatrick's (2002) measurement. By investigating FCPT qualitatively, I hope to gather deeper understanding of these patterns in families with children who are DHH. This study will provide an opportunity to educate professionals and families on

what communication patterns are used commonly within the home of families of this demographic.

Identity

The prejudices, stereotypes, and marginalization people with disabilities face can affect the way these individuals view themselves (Finkelstein, 1993). These effects can include feelings of doubt, lowered self-esteem, and apprehension. Hahn (1988) introduced two anxieties that commonly present themselves within the disability community: *aesthetic anxiety* and *existential anxiety*. Aesthetic anxiety refers to the fear one feels due to appearance that differs from the norm or can be viewed as unappealing. For instance, those who have cochlear implants can feel fear based off of others viewing their implants as something that makes them different. Further, those who have a more visible physical disability can feel apprehensive that their physical features stray too far from the "usual" human form (Hahn, 1988).

Existential anxiety refers to the fear associated with the potential loss of function felt by those without a disability. It is the fear that developing a disability would severely interfere with quality of life and ability to pursue desires. This anxiety assists in keeping those with a disability in a state of helplessness or perceived dependency. Furthermore, these feelings can contribute to the detrimental viewpoint of disability as a tragedy or that disability is worse than death (Hahn, 1988).

These anxieties and challenges can not only affect the identity of the individual, but also the identity of the family as a whole. While stereotypes and offensive terms may affect the family in different ways than the individual who is experiencing these claims, the family identity can be impacted by the acceptance or rejection of a disability such as

deafness. The family may choose to communicate their identity differently depending on patterns used, viewpoint of disability, and a plethora of other factors. Thus, this study will also investigate how families with parents who are hearing and children who are DHH describe their family identity.

Communication Theory of Identity

Our identities are created through our own internal reflection and the negotiation of identities by others (Jung & Hecht, 2004). There is a link between communication and identity, specifically the role of communication on identity (Jung & Hecht, 2004). Therefore, Communication Theory of Identity (CTI) offers a communicative approach to identity. This theory claims that identity is acted out from social roles internalized by individuals. Thus, identity is something that defines us while also being reflective of social roles and relationships through communication (Jung & Hecht, 2004).

To understand CTI, we must first define some of the overarching propositions for identity. According to Hecht and Choi (2012, p. 139), there are 10 common axiomatic propositions to define identity:

1. Identities have individual, social, and communal properties.

2. Identities are both enduring and changing.

3. Identities are affective, cognitive, behavioral, and spiritual.

4. Identities have both content and relationship levels of interpretation.

5. Identities involve both subjective and ascribed meaning.

6. Identities are codes that are expressed in conversations and define membership in communities.

7. Identities have semantic properties that are expressed in core symbols,

meanings, and labels.

8. Identities prescribe modes of appropriate and effective communication.

9. Identities are a source of expectations and motivations.

10. Identities are emergent.

Although all propositions are significant in describing identity, the proposition that "identities prescribe modes of appropriate and effective communication" (Hecht & Choi, 2012, p. 139) can describe the experience of families with DHH members as they navigate their identity with the communication they use. Therefore, identity formation and management are an ongoing process in which communication shapes through interactions with the self and with others (Hecht, 1993). Hecht and Choi (2012) summarize the relationship between communication and identity as "reciprocal" (p. 139). Thus, it is important to investigate the role of identity along with communication in families with children who are DHH.

CTI has several loci of identity such as the individual, communication, relationships, and society (Jung & Hecht, 2004). These loci play into the four frames of identity: *personal, enacted, relational, and communal identities* (Hecht, 1993). Personal identity is the sense of self, including the images of self. Personal identity plays a key role in how we view the world around us. As Desselle (1994) states, children who are DHH are at risk for lower self-esteem, which can impact their personal identity. This identity can impact the family as well, as the family can take on the identity of the member with a disability (Henderson & Hendershott, 1991). Enacted identity is the identity that is performed to others. Enactments hold high value as not an expression of communication, but the process of communication itself (Jung & Hecht, 2004). Enacted

identity can be impacted by language barriers that can be present in families with members who are DHH. Relational identity has layers to describe each way an individual can shape their identity through relationships. The first layer, referred to as *ascribed relational identity* (Jung & Hecht, 2004), is how individuals shape their identity based off of how others view them. Members of the family can influence ascribed relational identity in children who are deaf or hard of hearing. By extending acceptance and support to the child, the ascribed relational identity of that child can be improved (Desselle, 1994). The next layer describes how an individual can identify themselves through their relationships with others. These relationships can be spouses, family members, friends, and others. In families with DHH members, relationships can be viewed differently based upon similarities or differences in communication and social barriers.

Next, people can have multiple identities that can exist in relationship with one another. These identities can come from various aspects of our lives that we live out daily, such as the identity we have at our job and the identity we have in our home. For children who are DHH, their identity can be different between school and home. Lastly, relationships can also be a unit of identity (Jung & Hecht, 2004). Communal identity is the final frame of identity, which can be described as how groups define their identity. Moving beyond the individual, communal identity characterizes a collective group (Jung & Hecht, 2004). Those who are DHH can choose to identify with the Deaf community, creating a frame of identity that may or may not be supported by their identity within the family. Investigating the role of these loci within children who are DHH can help inform the outcome of these roles on family identity.

With CTI comes the tendency to focus on one frame at a time rather than investigating how all frames operate collectively. Frames can intersect and interact as different parts of our identity come together and overlap. In fact, frames can contrast and contradict each other, yet still coexist as part of identity (Jung & Hecht, 2004). Prior research has often focused on the individual frames of CTI, limiting its communicative potential. Jung & Hecht (2004) sought to fill this gap in the research by presenting a way to interpret the frames simultaneously. Researchers developed the theoretical construct of *identity gap* to describe the discrepancies among the frames of identity. These gaps develop as a biproduct of communication between individuals, yet the degree of the gaps vary depend on the frames involved and communication utilized. Thus, frames of identity can intersect, contradict, and coexist between various parts of an individual's life, from relationships with others to perceptions of self (Jung & Hecht, 2004). With those who are DHH, various frames of identity can intersect and contradict with family relationships, creating communication challenges and breakthroughs.

These frames of identity play a role in the family. As Henderson and Hendershott (1991) discuss, families create meaning and understanding through interactions. These interactions also play a role in the sense of self. This sense of self heavily relates to identity as a personal frame, with this frame helping individuals define themselves (Hecht, 1993). Specifically, in hearing families with children who are deaf or hard of hearing, this sense of self can be difficult to develop. Many factors can contribute to this difficulty, such as children who are DHH experiencing lack of dialogue because of communication barriers. Henderson and Hendershott (1991) reinforce the importance of communication mode in developing a strong sense of self for a child who is deaf within a

hearing family. Without shared communication, children who are DHH can struggle to create shared meaning between family members and can inhibit the quality of that child's personal frame. Furthermore, without shared communication, the relational frame can be affected, such as how a child who is DHH views themselves through the relationship with their family members.

Kushalnagar and others (2011) further this by investigating how reduced communication impacts the wellbeing of children who are deaf. By not having an accessible form of communication, a child who is DHH may experience a social barrier that can affect quality of life and quality of communication between the child and the child's parents (Kushalnagar et al., 2011). Additionally, children who experience this social barrier may develop feelings of isolation (Kluwin & Gaustad, 1991). Isolation from family members can influence more than one frame of identity within the life of a child who is DHH. Lastly, this isolation can lead to detrimental effects on these frames of identity for that child.

Identity in the family has been an area of investigation for researchers in varying types of families. Atkin, Ahmad, and Jones (2002) investigated the ways that South Asian individuals who are deaf negotiate their relationships and identities. The sample consisted of South Asian youths varying in age from under 14 to 29 years of age. Using in-depth interviews, Atkin and others (2002) investigated the complex reality of negotiating identity in comparison to ethnicity, religion, gender, and deafness. The challenge of finding a shared language can be viewed as a perceived threat to the dynamic of family communication and family identity. For example, in the study by Atkin and other (2002) Deaf culture, which can include the use of a signed language, was viewed as a threat to

the children's ethnic identity. Therefore, there are many parts of communication and identity that can be affected by being DHH. However, research has yet to connect the role of identity in family communication patterns within families with children who are DHH. This study aims to fill that gap.

Communication research is needed in families with hearing parents and children who are DHH to better understand the complexities of family communication and identity. Through investigation of these families, more awareness can be created about deafness and disability, along with communication patterns and identity in families that have children who are DHH. Thus, I present research questions to help uncover the complexities of family communication patterns and identity in families with parents who are hearing and children who are DHH. Using Family Communication Patterns Theory and Communication Theory of Identity, I will analyze how families with parents who are hearing and children who are deaf or hard of hearing describe their experience with family communication and identity. Therefore, the following research questions guide this study:

RQ1: How do parents of children who are DHH describe their experience with family communication?

RQ2: How do participants' descriptions of family communication reflect family communication orientation and patterns?

RQ3: How do participants describe their identity/identities?

CHAPTER 3

Methodology

Procedure

To investigate previously addressed research questions, naturalistic qualitative design was utilized. Participating in naturalistic inquiry involves focusing on how people behave in their life experiences observed in natural settings (Frey, Botan, & Kreps, 2000). Further, qualitative methods allow access to multiple realities, deeper meanings of the human experience, and interactions from an intimate insider perspective (Frey et al., 2000). Using naturalistic, in-depth interviews was necessary to get rich information about the experiences of families with children who are deaf or hard of hearing. I conducted semi-structured interviews with participants, meaning I asked primary questions for each participant, but asked probing questions to gather more specific details (Frey et al., 2000). Probing questions were flexible throughout the interview process, allowing me to have some prepared questions and create questions on the spot depending on the responses from the participants in the study.

Before beginning the interview process, I obtained approval for this study from the University's institutional review. Following approval, I planned to conduct in-person interviews with the participants. These in-person interviews were to take place at a public library in a small rural community in a private study room. Due to interviews scheduled during the COVID-19 global pandemic, in-person interviews were not possible in order to follow social distancing guidelines. To safely practice the CDC recommendations of six feet of distance, maintaining groups under ten, and self-quarantine if symptomatic of COVID-19 (CDC, 2020), it was determined that interviews were safer to conduct over an

online platform. As an alternative, I used the Zoom platform for all interviews, which will be explained in following sections. I allotted time for interviews to be 45 minutes per family, allowing modification of the interview protocol to occur as necessary and in-depth information to be collected from participants.

Sample

This study aimed to better understand the experiences of families with children who are DHH and the role of family communication patterns and identity within the family. For the purpose of this study, the parents self-disclosed whether the child is considered deaf or hard of hearing. Because I investigated the experiences within the family, it was important to have families that consider themselves to have children who are deaf or hard of hearing in this study, rather than restrict the sample to children who meet a certain qualification of deaf or hard of hearing. I used a nonrandom purposive sample, as I intentionally chose participants based on preformed judgements (Frey et al., 2000).

Further, I gave participants the opportunity to refer other families for recruitment in the study in order to assist reaching a difficult sample, although no participants were able to recruit others into the study (Frey et al., 2000). I had four families participate, consisting of seven individual participants who self-reported having a child or children who were hard of hearing. Three of the four families had two parents, consisting of a father and mother, represented in the interviews. All families in this study identified as having a child who was hard of hearing, not deaf. Hearing loss ranged between families, where one was described as the hearing of a "65-year-old man," while others were

considered severe hearing loss in only one ear. Families were recruited from small, Midwestern communities in Minnesota.

Sampling

Two contacts, a teacher for the deaf and hard of hearing with a Co-Op in a small, Midwestern community, and a representative for the Communication Services for the Deaf (CSD) in a Midwestern community, assisted with recruitment. Both contacts distributed study details via email to families that met the study description. Families interested in participating clicked the link provided in the study description and completed a short QuestionPro survey collecting demographics, background information, and interest in the study. These demographics were collected before interview participation so that I could know more about my participants prior to interviewing in order to create a personalized experience.

Of the seven participants, four were female, three were male. All families identified as White/Caucasian. Three of the four families indicated their marital status as married and one family indicated their marital status as divorced. The parents provided the demographics of the children during the interviews, including age and sex: one was 13 and male, one was 20 and male, one was 17 and female, and one was nine and female. Additionally, families described the type of hearing loss their child had. Two families indicated their child had unilateral hearing loss, meaning hearing loss in one ear. Two families indicated that their child had general difficulty hearing syllables and the beginning of words with their hearing loss. All of the children in this study were diagnosed before they were seven years old, with two families stating their child was specifically diagnosed during their kindergarten screening. We can expect much of the

results to apply to White/Caucasian families, although they may still be applicable to families of other ethnicities and races. Further, since all families were located in small, Midwestern communities, we can expect the results to apply mostly to families that also live in similar environments.

My contact information was provided in the link and the study description, allowing participants to reach out directly to me with interest and questions. Data collection began once participants were secured and continued until further restrictions with COVID-19 affected the ability to recruit more participants. Interviews took place at times that were convenient with the participants, even if the recruitment phase was not completed yet. During the third interview, I felt that saturation was reached, as some responses became redundant. Frey and others (2000) state that redundancy supports the thoroughness of results, allowing me to feel more comfortable with my results, even with a smaller sample size.

I had originally set a goal between 10 to 20 participants for this study and ended up with a total of seven participants in four total families. It was also my goal to have both parental figures represented in each interview if there were two in the home. I was able to have two parental figures represented in each family that had two in the home. While the participant goal was not reached due to difficulty of study population and the effects of COVID-19, I do feel saturation was reached with research questions even with a smaller sample size.

Instrumentation

Before the interviews, I sent the family the interview protocol without probing questions via email for them to prepare. Although it was originally intended to do

interviews face-to-face, an online format was utilized due to COVID-19. Zoom, a platform that allows audio and video meetings to take place on a device such as a computer, phone, or tablet, was used to conduct interviews. This allowed video and audio capabilities during the interview, along with transcription ability.

Interviewees picked a time of day that worked best for them to participate in the interview. Allowing the participants to choose the time and date for the interview can increase their comfort level, increasing the ability to get the best interview results (Lindolf & Taylor, 2002). Zoom was used to record and transcribe the meetings. The transcriptions were then checked to ensure accuracy. The audio recordings were safely stored in an iCloud Zoom drive and a password-protected computer file to preserve the confidentiality of the participants.

The interviews were conducted in a funnel format, beginning with large, open questions and concluded with closed questions that call for more specific information (Frey et al., 2000). Since the interviews were semi-structured with broad questions, I allowed participants to answer questions with their own stories in detail (Frey et al., 2000). Further, I had the ability to adjust questions during the interview to dig deeper into responses. For example, I would ask additional probing questions that would allow more detail to come from participants' answers. One example is when I started to ask participants about their siblings' reactions and adjustments to family communication because it began appearing early in the interview process between different families. Lastly, I offered compensation by allowing each family to enter into a drawing for a $25 Amazon gift card. One family was selected to receive the gift card and it was distributed.

Analysis

Analysis was conducted in several stages. First, I watched the interview video recordings and edited the transcripts for accuracy. Next, I read through the transcription manuscripts several times to familiarize myself with the data. Following, I recorded themes that emerge among the responses (Frey et al., 2000). This use of thematic analysis is a method used for "identifying, analyzing, and reporting patterns (themes) within the data" (Braun & Clarke, 2006). Thematic analysis allows for flexibility and the ability to pull rich, detailed data from the research (Braun & Clarke, 2006). Then, using the constant comparative method, I created and compared exhaustive categories to explain the data.

Frey and others (2000) explain one way of conducting this method as writing each response from an interview on a card and then placing cards together as commonalities are discovered. I conducted this method differently by recording significant ideas and observations in a notebook while transcribing the data to create potential themes and ideas (Creswell & Poth, 2018). After listening to the transcriptions several times, I highlighted specific words and phrases from the transcripts into units that fit various codes. Then following separating those words and phrases by coded color, I created a separate Word document that had the themes and the codes organized and placed the words and phrases into their respective places.

During thematic analysis, I applied pseudonyms to each family to preserve their confidentiality during reporting of the results. To do this, I changed the names of each family's first and last names so that there were no real identifiers attached to their names. The names of the families were randomly selected as follows:

- The Smith Family: Jane (mother/wife), Mike (father/husband), Emily (child who is hard of hearing), Rebecca (sister), Sarah (sister)

- The Hahn Family: Mitch (father/husband), Jill (mother), Andrew (child who is hard of hearing), Audrey (sister), Anthony (sister)

- The Johnson Family: Kayla (mother), Dylan (father), Logan (child who is hard of hearing), Erin (sister), Shelby (sister), Nick (sister)

- The Miller Family: Ashley (mother/wife), Rick (father/husband), Derrin (child who is hard of hearing), Anna (sister), Joe (brother)

This study used both inductive and deductive analysis. Inductive analysis is similar to grounded theory in that the themes are strongly related to the data or questions asked in the interview (Braun & Clarke, 2006). As some of the questions in my study were not driven by theoretical interest, I used some inductive analysis. Deductive analysis is driven by theoretical interests, having the data fit a specific theory (Braun & Clarke, 2006). Using FCPT and CTI to frame some of the questions within my study, I utilized some deductive analysis in this process. For example, I asked specific questions that were intended to discuss FCPT and CTI individually, so those responses were coded into the larger themes of the theoretical framework.

To increase validity and credibility of my research, I used member checking following thematic analysis to ensure that participant responses were accurately depicted. Member checking involves taking the data and interpretations and allowing the participants to confirm that I accurately described the information and narratives in the interviews (Creswell & Miller, 2000). Frey and others (2000) describe member checking as giving a draft of the report to the participants in order to allow the participants to

verify that the researcher(s) reported their responses correctly. To do this, I emailed my

findings to each of my participants and received feedback that ensured I represented their

contributions accurately. Three families in this study responded, with one family

providing a clarification of one of the quotes used in chapter four. Following that

family's feedback, chapter four was edited to provide that clarification. After the

indication of accurate results, I concluded thematic analysis.

CHAPTER 4

Results

This chapter will present the results from four interviews with families with children who are DHH. From these four interviews, seven individual participants in these families discussed their experiences with family communication patterns and identity. In order to present responses clearly and preserve confidentiality, participants and their children will be referenced by pseudonyms. To do this, I changed the names of each family's first and last names so that there were no true identifiers attached to their names. The names of the families were randomly selected as follows:

- The Smith Family: Jane (mother/wife), Mike (father/husband), Emily (child who is hard of hearing), Rebecca (sister), Sarah (sister)

- The Hahn Family: Mitch (father/husband), Jill (mother), Andrew (child who is hard of hearing), Audrey (sister), Anthony (sister)

- The Johnson Family: Kayla (mother), Dylan (father), Logan (child who is hard of hearing), Erin (sister), Shelby (sister), Nick (sister)

- The Miller Family: Ashley (mother/wife), Rick (father/husband), Derrin (child who is hard of hearing), Anna (sister), Joe (brother)

Thematic analysis was guided by the following research questions:

RQ1: How do parents of children who are DHH describe their experience with family communication?

RQ2: How do participants' descriptions of family communication reflect family communication orientation and patterns?

RQ3: How do participants describe their identity/identities?

Each research question will be presented in sections as follows: *Experiences in Family Communication* (RQ1), *Family Communication Patterns* (RQ2), *Family Identity* (RQ3).

Experiences in Family Communication

RQ1 asked participants to generally describe their experience with family communication. As previously discussed, families with children who are DHH can experience the same challenges and triumphs as families of different demographics but can also experience different triumphs and challenges as well. Therefore, participants described the challenges and triumphs of their communication with their child who is DHH, along with the choices in communication modes used within the family. Those challenges and triumphs are discussed below, along with connections to communication and prior research.

Challenges. Like any family, challenges can arise in families with children who are DHH for various reasons. One of the challenges can surround the diagnosis of their child, the communication used with their child, and the experiences their child has with being DHH. Many participants reflected on both themselves and their child feeling frustrated. Jane Smith reflected when their child was little and first diagnosed, "I think of some of the frustrating things was when she was little. Emily had a hard time communicating with us. . . Lots of temper tantrums and that kind of thing." This family stated that experiencing these tantrums and difficulty communicating was hard for all involved. Prior research has shown that a child who is deaf or hard of hearing can experience frustrations due to difficulty to or lack of language access (Henderson & Hendershott, 1991). When families described their experiences of frustration, often it came when the child was not able to fully access language or communication with other

family members. Like Henderson and Hendershott (1991) discuss, this can lead to a child experiencing feelings of anger and frustration when trying to obtain accessible communication with others.

Other families experienced similar frustrations, some of which stemmed from devices such as hearing aids. Jill Hahn said:

> Only one time he said to me in kindergarten, 'I don't want to wear hearing aids.' And I said, 'I get that, I don't want to wear glasses, but I said I get up in the morning.' I said, 'God gave me good eyes. They just need glasses to look better. So, God gave you good ears. You just need hearing aids to tweak the sound a little bit.' I said, 'It's no different than if a kid broke his arm or has braces. It's just who you are.'

Some of the frustration in this scenario is from getting adjusted to the hearing aids. While the hearing aids were helping their child reach accessible communication, it also was a frustrating transition for their child. Other families may experience similar obstacles in adjusting to things such as braces, glasses, and other devices designed to aid the child in some way. However, some of the frustration in this experience may have come from identifying with the hearing aids, which could be a process of adjustment for a child who is hard of hearing. Coming to terms with a hearing aid being part of an identity that is often visible to others may be an area of frustration for children who are hard of hearing and warrants further discussion.

Other challenges that families introduced included their child's experiences with being hard of hearing in school. One of the challenges came with success in the classroom. Ashley Miller shared about her child's experience in a school spelling bee.

They discussed that their child had been reported as doing well by her teachers, but her child was still frustrated because she could only hear about "80-85%" of what was being said. That little lack of hearing ended up causing some issues in their child's ability to participate in the spelling bee, an event that their daughter was passionate about. Ashley said, "They had a spelling bee every year. And she got knocked out of the spelling bee with like, if she would have one more, she would have been in the spelling bee and she was just devastated." Because Derrin did not have her hearing aids at this point, her hearing caused her to not hear key parts of a word, such as the beginning and ending of words. While Derrin was still overall successful in school, this challenge of not having the adequate equipment to hear at the time provided additional challenges. These experiences are similar to other families who may need additional equipment, like glasses, for their child. While these experiences may not be entirely unique, they are worth discussing so that these families' experiences may be better understood by professionals in the field.

Some of the challenges included the ability to clearly hear in the classroom and school environment before the addition of hearing aids. Kayla Johnson discussed the issues Logan was having before hearing aids, "He's got all these coping skills, you know, but he's still struggling at lunchtime. I'd say, you know, like in the gym after a lot of people. And there's a lot of noise. For whatever reason, it's really irritating. And the other thing he plays trombone in band, and he does well, but he gets horrible headaches." Jane Smith shared similar experiences about loud school environments being a source of frustration, specifically in the hallway and the lunchroom. These areas of loud, erratic noises can be difficult for children who are hard of hearing due to the amount of different

noises occurring at once. Bess, Tharpe, and Gibler (1986) discuss that children who are unilaterally hard of hearing, which means hearing is lost in one ear, can have increased difficulty understanding speech in noisy environments along with the localization of this noise. As half of the children in this study were described as unilateral hearing loss, this can explain the frustration of the children in these environments. This problem was discussed by multiple families, who saw relief following the addition of hearing aids.

Families in this study displayed the change in dynamic following the addition of hearing aids for their child. While there were adjustments that needed to be made following hearing aids, families in this study often reported a dramatic change in the demeanor, behaviors, and social experiences of their child. This study is not to argue whether a child should receive hearing aids or not, but the experiences of these families do show the effects of their child gaining access to clear communication following the addition of hearing aids. Like prior research shows, there are many positive effects of accessible communication, such as higher self-esteem and feelings of acceptance (Desselle, 1994; Henderson & Hendershott, 1991). Therefore, the importance of communication is highlighted through these families' stories, showing the need for further investigation from a communicative perspective into families with children who are DHH.

One family described the challenges of the school environment as a whole for their child, even following hearing aids. This challenge occurred in social interactions with classmates. The Miller family discussed their child's experiences playing with others in their class:

> At school, I think, given her age of third grade from like first grade kindergarten. First grade, second grade, and third grade girls, I think sometimes she has problems in that area where they'll be playing a game and you know how kids will play tag, but then they turn it into a mermaid tag or like a change the rules. Well, she might not catch the rule change and then they'll be like, 'You're cheating or you lied.' Or, you know, I think it creates social problems sometimes with her friends.

Children who are deaf or hard of hearing may need to develop coping skills when it comes to socialization and relationships, especially in the mainstream school environment. Past research has supported that children who were deaf and female who asked clarifications were able to achieve better relationships with their classmates who were hearing (Martin & Bat-Chava, 2003). Not only does this study discuss the role of gender in how children who are DHH cope in the school setting, but also how that can affect socialization skills as well. Those who are hard of hearing may experience more challenges in social interactions based on miscommunication and misunderstanding from their peers. The experience described above shows some of the misunderstanding that came from Derrin's friends in a normal game of tag.

Families in this study showed that their child developed coping skills based on their school environment and emphasized the need for further development of coping skills based on their child's hearing loss. While the classroom and school environment are not necessarily family centered, it is important to note that many of the frustrations that come in those environments also appear in the family environment as well. This shows the need for effective and accessible communication for children who are DHH in

order to help eliminate the frustrations seen within the family system and outside environments.

      Triumphs. Along with challenges, families in this study reported many triumphs in their communication with their child who is hard of hearing. Families reported celebrating when the hearing devices helped their children, when communication became clear, and when milestones had been reached. The Smith family provided an example of milestones reached following a hearing device, "Yeah, well and the milestones. I've noticed as well is like, when she got the personal FM system [a system that is put in the ear to amplify sound while someone else wears a microphone] when she was four, that opened a whole new door for her." They went on to describe the emotions they felt when another milestone was reached when their daughter got hearing aids at 17 years old, "And I, the tears started streaming because when she was working with her and she put them in, the same confidence came back that her face lit up." While other families also celebrate at the achievement of milestones, the Smith family celebrated a milestone of confidence when the hearing aid was added to their child's experience. This triumph comes following years of frustration and lack of confidence based on challenges associated with hearing loss and access to communication.

      Referring back to the spelling bee in school the Johnson family discussed that their child did "much better with the hearing aids" and that "she got much closer with the spelling bee and other tests are perfect." Jane Smith discussed that she sees less frustration at home, "She [their child] says she's less tired. So, for me, those are just huge for her." Other families excitedly say that their child has "adapted extremely well." Therefore, from a communication perspective, the addition of hearing aids was not only a

triumph just to hear, but to understand. The hearing aids allowed these children to access communication in a more profound way. These experiences of triumphs are important to note for families who may be experiencing the struggles in communication. Fitzpatrick and others (2008) discuss that one of the things that families need after diagnosis of hearing loss in their children is support from other parents. One of the most significant things needed from families is emotional support and hope (Fitzpatrick et al., 2008). By discussing the triumphs of families with children who are hard of hearing, this study can offer hope to other families needing further support from other parents who have had similar experiences.

Communication modes. Families also shared the communication modes used in the home such as American Sign Language, signed exact English, spoken English, and lipreading. This is important to consider as prior research has discussed the impact of communication modes on the family (Ahlert & Greeff, 2012; Eleweke & Rodda, 2000; Kluwin & Gaustad, 1991). It is also important to consider how the choices in communication modes can be influenced by the degree of hearing loss as well. As all families in this study identified as having a child who is hard of hearing, all participants discussed using spoken English in their homes as the primary communication mode and that their child was provided a hearing aid or other hearing device growing up. This decision could have been influenced by the degree of hearing loss of their children.

The Smith family shared their child's hearing loss as "moderate to severe" in one ear, saying they put a hearing aid in when she was one year old. Jane said that they spoke English as the main form of communication but did do some American Sign Language growing up. They said, "Only it's a lot more like signed English because I'm not really

very great at American Sign Language, but we're really just straight English. That [ASL] is what we dabble in a little bit." No other families reported using any signed language with their children. The fact that the Smith family could "dabble" in ASL is also an experience that may be more unique to families with children who are hard of hearing compared to those with children who are deaf. Luckner and Velaski (2004) interviewed families of children who are deaf, and the results showed that those families urged other families with children who are deaf to learn ASL. There may not be as much of a push to learn ASL in families with children who are hard of hearing because they have another communication mode, spoken English, that they can always fall back on relatively easily.

The fact that many did not use sign language could also be because of various factors. First, research has discussed that families with children who are DHH are immediately introduced to various individuals such as physicians, audiologist, teachers, counselors, and others (Henderson & Hendershott, 1991). And since many in this study decided to amplify their child's hearing ability through the use of hearing aids, cochlear implants, and other devices, the choice of language mode could have been influenced by a lack of options given to them by the professionals they worked with during their child's diagnosis. Furthermore, this particular family, the Smith family, that used ASL discussed that Jane had a background in ASL. The background knowledge discussed by Jane and Mike Smith resulted from their experience as teachers. This background knowledge could have influenced that family to use a signed language over other families who had no prior knowledge. Therefore, part of their identity influenced their choice of communication mode.

All families reported that their child had done lip reading either before they were diagnosed, after, or both. One family reflected that their child "lip reads a ton." The Hahn family discussed how they discovered their child's ability to lip read when he was participating in a hearing screening. They said, "And he was passing okay, until the screener started covering her mouth and then she discovered he had learned to become fairly proficient at lip reading." The fact that all families reported their child became proficient at lip reading is significant from a communication standpoint. Listening is a key part of communication. As children in this study were hard of hearing and had the ability to hear for the most part, they adapted their communication ability by learning to lip read.

Furthermore, the fact that these children were able to lip read to supplement communication they were missing out on could have impacted the families' decision on whether to incorporate another language such as ASL. This is supported as many families said their children were doing "so well" without another language and with lip reading, that this could have impacted the choice to incorporate anything else besides English. However, lip reading has its limitations. Families with children who are deaf or have less hearing abilities than the children in this study may have greater difficulty adapting their communication, further demonstrating the need for accessible communication for children who are deaf and hard of hearing.

When asked if families had a formal discussion as to how they came to the decision of a communication mode, many stated that they did not have a discussion about it due to their child's ability to hear relatively well. Therefore, it can be inferred that the degree of hearing loss impacted the families' decision on what communication mode was

most appropriate. This supports prior research that states the degree of hearing loss contributes to decision on communication mode (Kluwin & Gaustad, 1991). If families had a child with more significant hearing loss, it could be possible that (a) more direct conversations may have occurred to decide what communication mode to use as a family; (b) a different communication mode or a blend of communication mode may have been used.

Family Communication Patterns

RQ2 asked how participants' descriptions of family communication reflect family communication orientation and patterns. To recap, family communication patterns theory has two orientations outlined within it: conversation orientation and conformity orientation. Conversation orientation is how much the family members are encouraged to engage in conversation on a plethora of topics. Conformity orientation is the degree to which families share values, beliefs, and attitudes (Fitzpatrick, 2004). From these orientations, four patterns of family communication arise: consensual, protective, laissez-faire, and pluralistic. Consensual families are high in conversation and conformity orientation. These families are interested in what their children have to say, while also believing that they, as parents, should make the decisions for the family (Koerner & Fitzpatrick, 2006). Protective families are low in conversation orientation and high in conformity orientation. They emphasize obedience and have little concern for open communication in the family (Koerner & Fitzpatrick, 2006). Laissez-faire families are low in conversation and conformity orientation. These families have few interactions between family members and have little interest in their children's decisions (Koerner & Fitzpatrick, 2006). Pluralistic families are high in conversation orientation and low in

conformity orientation. These families allow their children to participate in the decision making and are accepting of their children's opinions (Koerner & Fitzpatrick, 2006).

While prior research has investigated FCPT using quantitative methods (Charoenthaweesub & Hale 2011; Ledbetter, 2009; Schrodt et al., 2009), RQ2 investigated FCPT using qualitative inquiry. RQ2 asked families to describe their experiences with traits of conversation and conformity orientation. Participants were high in conversation orientation and no prevalent responses in conformity orientation. Families blended the need for individuality of their child who was deaf or hard of hearing and the desire for united beliefs and values of family members.

RQ2 asked families to describe their family communication patterns; however, while descriptions of orientations appeared, there were no communication patterns presented in the families' responses. This could be due to a limitation of the study and sample size, but also a potential limitation of the theory. It could be inferred that patterns should show up when asking about conversation or conformity orientation. However, the fact that no patterns showed up in this study is an area for discussion, which will be discussed in chapter five. Therefore, the results below will only involve conversation and conformity orientation.

Conversation orientation. Families on the high point of conversation orientation spend more time without restriction of conversation (Fitzpatrick, 2004). Participants in this study supported less restriction of conversation, suggesting a higher conversation orientation. With conversation orientation comes encouragement to speak on a wide array of topics (Koerner & Fitzpatrick, 2006). Families came to say things like, "We've not shied away from any other conversations; we are a pretty open family; we are a very open

family." This open communication was in regard to general conversations that family members were able to participate in. By investigating conversation orientation through qualitative interviews rather than a quantitative instrument, more specific details and context were able to be given compared to quantitative instruments. For example, a study by Charoenthaweesub and Hale (2011) investigated FCPT in Thai families to determine quality of parent-adolescent communication and wellbeing within these families. While they found that Thai families employ a consensual pattern of communication, there is no context as to why that communication was specifically selected. Further, the idea of culture was left out of that study, although culture could significantly impact the family communication patterns used. Therefore, this study introduces how various contexts and situations can relate to the family communication patterns.

The Smith family continued to reflect on the degree of encouragement of open conversation used in their family stating generally, "I think we're pretty open. The family dynamics is pretty wide open." However, they also agreed that there were restrictions based on what was being discussed. "So, it kind of depends on the topic, I guess, that's going on" one family member said. This family stated that there were certain topics that were restricted involving their child's hearing. Mike Smith stated, "If we're talking to, like, Emily specifically about anything hearing related or whatever, that's a pretty off to the side kind of conversation. Unless, the siblings need to know, 'You need to look at Emily and talk,' you know what I mean?" The family explained further, "I guess it's kind of like what we do in a classroom, we don't want to embarrass the kid in front of everybody. So, you take them off to the side and you find out the detail part. . . we don't want to embarrass her in front of, even if it's siblings." Therefore, some families may

choose to privately discuss their child's deafness with just that child, showing lower conversation orientations in different settings.

This context can be influenced by the age of when these conversations were taking place, the relational dynamics of the family as a whole, the amount of time that has passed since Emily's diagnosis and other examples. Thus, the context of why families may choose lower conversation orientations is something that is important to understand but is vastly left out of prior research. While past research regarding communication orientations has used Koerner and Fitzpatrick's (2002) revised FCPT instrument, these responses show the necessary details that go into whether a family decides to practice high conversation orientation on certain topics or whether they practice lower conversation orientation on others, such as their child's hearing. Those details are absent from the Koerner and Fitzpatrick (2002) measurement tool, which presents a major gap in our understanding of FCPT.

On the contrary, the Johnson family stated that all family members discussed the child's hearing, demonstrating an example of high conversation orientation on that specific topic. Kayla Johnson reflected, "We talk about everything and the siblings do. Um, Logan does as well." She went on to say more about discussing the context of discussing the child's hearing, "I wouldn't say that we make an issue of it ever, you know, or bring it up out of the blue. Only if it is relevant for some reason, you know, a surgery, or you know, we might need to sit in the front of class talking to a teacher." At times, humor is even beneficial to bring into these conversations, "Yeah, no, but otherwise we're very open and Logan almost kind of jokes about it sometimes. We don't ever joke about it, but he likes to occasionally at home." More qualitative research on

FCPT, specifically in families with children who are DHH, is needed in order to investigate the contexts and situations in which a family may choose higher conversation orientation regarding their child's hearing.

Families can also choose to participate in lower conversation orientation in relation to the child's deafness with other family members, such as grandparents. Ashley Miller described situations in which she and her husband restricted the conversation regarding their child's deafness, "I would say there are times where we're kind of done with that conversation, depending on how other people interpret it." In this instance, others' perceptions influenced the restrictiveness of conversation regarding certain topics. This is a phenomenon that has not been highly discussed in research regarding family communication patterns and is an area for further investigation.

Ashley talked about ways they restricted conversations about Derrin's deafness with outside family members, "So, like for a while, her grandma was saying, 'Well if we can just get her on this herbal supplement, then it'll fix it.' Or, you know, maybe she'll just heal and she won't need to have hearing loss anymore." This response can come from medical misinformation given to the grandparent by either medical professionals or other sources such as blogs, websites, and more. The use of medical misinformation can lead to reduced communication within the family, directly impacting family communication orientations. Therefore, there are many details and circumstances that can contribute to the family communication orientations in these families that have not been accounted for in prior research.

Additionally, when it comes to accepting a child's deafness, research has shown that families, and specifically mothers, can have a difficult time overcoming feelings of

devastation when raising a child who is DHH (Park & Yoon, 2018). This could explain why the grandmother, although not the mother of the child, could feel negative emotions regarding their grandchild being hard of hearing. Furthermore, social networks can provide families, and again specifically mothers, with the support they need (Lederberg & Golbach, 2002). With the lack of support for their child's diagnosis from relatives, this could lead the topic of their child's hearing loss to become an area of low conversation orientation.

Ashley further emphasized the need for restricting conversation topics others introduce the topic surrounding why their child may be hard of hearing. She said, "And then, I had cancer when I was pregnant with her. So, then grandma had said that, well maybe the MRI caused her hearing loss." For some families, restricting conversation mostly occurred outside of the immediate family rather than within. Therefore, this study introduces the idea that FCPT can overlook the intricate details that arise when deciding between high or low conversation orientation, such as the reactions from others and specific situations. Based on families' responses, there are certain topics and even situations in which their degree of conversation orientation may be higher or lower. Furthermore, the experience of the Miller family can illustrate that FCPT may not account for intergenerational communication. In this case, intergenerational communication, along with medical misinformation, resulted in a certain conversation orientation within the Miller family. This is an area of FCPT that should be investigated in future communication research.

Conformity orientation. Families with high conformity orientation have beliefs and values that are harmonious, while families on the low end of this orientation have

more individuality among family members (Fitzpatrick, 2004). While families did not show much preference one way or another, this orientation still appeared in some participants responses. One family discussed their shared Christian beliefs as something their family values by "just teaching the girls to be kind" and to "live your faith openly by just being kind because you never know what the battles that other kids have to face." While Christianity may be one area of individual values of each family member, the Smith family stresses a climate of uniformity in these beliefs and values, demonstrating higher conformity.

Another area of conformity orientation involves the equality of all members regarding communication, meaning children may or may not be involved in the decision-making (Koerner & Fitzpatrick, 2006). Several families in this study discussed giving their child who is hard of hearing the opportunity to be involved in decisions, especially when it came to identity and their hearing devices. The Miller family discussed the emphasis on their child's ability to take charge of how they want to be identified in the deaf or hard of hearing world. They stated that they lean toward not identifying with their child's hearing at all so that their child can decide on her own "whether or not she wants to identify as hard of hearing." By emphasizing the individuality of their child who is hard of hearing, this family emphasized the need for their child's independence and supporting their child's ability to assist in decision-making. This shows that there may be opportunities for families to be lower in conformity orientation in situations regarding their child's hearing loss.

The Johnson family expressed lower conformity orientation by allowing Logan to make the decision about his hearing devices and which one, if any, he wanted to wear. He

had the option of choosing his hearing aid or his cochlear implant, instead he now

chooses to wear neither. Kayla says that Logan sits towards the front of class and does his

own adjustments as necessary. Giving Logan the decision to choose the hearing devices

he wanted was an example of low conformity orientation demonstrated by this family.

Because conformity orientation can have an influence on children's resiliency, coping

skills, and well-being (Koerner & Fitzpatrick, 2002), giving Logan the ability to be part

of the decision-making and cope without the hearing devices could positively impact his

well-being, as suggested by prior research.

An area where high conformity orientation appeared was in the decision-making

of communication mode. All families stated there was little to no conversation regarding

communication mode choices for the family. High conformity families typically operate

with the parents making most of the decisions and expect children to cooperate (Koerner

& Fitzpatrick, 2006). Parents in this study demonstrated high conformity by making the

decision regarding the communication modes used within the family. For example, Kayla

discussed that she did not know if there was ever an "official" discussion because

Logan's hearing was "good with his right ear." Other parents also took on the decision of

communication mode for their family, stating that they just speak English. This lack of

participation in the decision-making could be a result from the age of when the children

in this study were diagnosed, which was at an age young enough where parents would

almost have to make the decision for the family. However, the children in this study may

have continued the conformity orientation by remaining with what the parents' decisions

were about the communication mode.

Family Identity

RQ3 asked participants to describe their identity/identities. Using CTI as a framework, participants discussed their identity as a family, along with whether they identify with their child's deafness or hard of hearing identity. This discussion informed how these families describe their four frames of identity according to CTI: personal, enacted, relational, and communal identities.

Personal. Personal identity includes the image and sense of self (Jung & Hecht, 2004). In this study, identity can be looked at as the individual child who is hard of hearing or at the individual parent's identity. Because the parents were asked to describe what they thought their child's identity was, some ascribed identity emerged in the responses. Ascribed identity is the identity that is assigned by others or in other words, others' perception of your identity (Huddy, 2001). Families described ways in which their child's personal identity was affected by their hearing loss. Jane and Mike Smith described their child's experience as difficult, "She definitively identified that being hard of hearing as something that was difficult for her." Being hard of hearing can create difficulty in deciding where one belongs, whether to the Deaf community or to the hearing community. Sometimes, those who are hard of hearing may choose not to identify with the Deaf community or hearing community at all (NAD, 2019).

Often, this difficulty can come from feeling a gap in identity. Gaps can develop as a biproduct of communication (Jung & Hecht, 2004). These gaps of identity can occur when frames intersect or contradict one another. Thus, it is possible that identity gaps can occur from feeling not completely in one frame of identity over another. The Smith family said that their child was not fully in the hearing world or deaf world, making personal identity a challenge. "She's not fully in the hearing world because she is hard of

hearing. And it's also hard because she's not in the deaf or hard of hearing world because she is hearing. . . so that's not really an identity." Emily is not alone in that feeling. Students in a study by Kersting (1997) experienced feelings of loneliness and isolation based on an "in-between" identity between Deaf and hearing cultures. While this study did not investigate the underlying feelings behind feeling in-between the hearing and Deaf world, it is possible that the detachment from the identity of one over the other can present itself from an identity gap due to contradicting identities.

Not only was the personal identity of the child discussed in interviews from the viewpoint of the parents, but the personal identity of the parents was as well. The Smith family had their own personal identities that played a role in the communication mode chosen, along with the intervention for their child when she was diagnosed as hard of hearing. Jane recalled what they felt when Emily was first diagnosed saying, "We both, being educators, knew we wanted to get her help." Mike stated similar sentiments by saying their identities with their educational background helped guide their decision-making throughout Emily's diagnosis. "I think because we're in the educational system, we can see the effects of not having those issues [issues with hearing loss] addressed… We got to be aggressive about it because otherwise they kind of get lost, especially with hearing loss in one ear." Continuously throughout the interview process, both Mike and Jane reflected upon their educational background solidifying their personal identity around their teaching experience. This is significant because identity can prepare families extensively for many decisions that they will make regarding their child being hard of hearing. For example, the Smith's educational background prepared them for getting early intervention and making decisions about their communication mode. Other families

in this study, and certainly other families elsewhere, may not have that personal identity to assist them in the decision-making process. This can illustrate the impact identity can have on multiple decisions in the family, including communication.

Families with children who are DHH have the ability to give their child the opportunity to choose their own personal identity in regard to their hearing loss. Ashley Miller stated that while they do not feel connected to the identity of hard of hearing, they are encouraging their child to explore. "I would feel like lean towards not at all [identifying with their child's hard of hearing diagnosis]. I think we are weighing in on whether or not she wants to identify as hard of hearing." This acceptance of personal identity is important for the development of self-esteem and sense of self in children, as demonstrated by prior research (Desselle, 1994). By offering Derrin an opportunity to discover her own personal identity in regard to her hearing loss and by offering acceptance to whatever choice is decided, Derrin's self-esteem can be positively impacted. This experience can show the need for future research in how personal identity can be impacted by the extent to which others validate that identity, as can be in the case with the Miller family.

Enacted. Enacted identity includes the identity that is performed to others and can be the process of communication itself (Jung & Hecht, 2004). What is unique about deafness is that at times, identifying as DHH can be concealed to an extent until the individual decides to perform their identity to others. That is the experience of several families in this study, in which their child can choose to conceal or reveal their identity as hard of hearing to others. The Smith family reflects, "I don't think there's anything glaring about her deafness." When they state that there is nothing "glaring," this family is

referring to the degree to which people can perceive their daughter is hard of hearing based solely on physical appearance. They describe their child's ability to conceal her deafness stating, "people don't know she doesn't hear, so I don't think they would identify us with that" and reiterating that "most people don't know." Within CTI, enactments are not considered just an expression of identity, but also the identity of an individual itself (Jung & Hecht, 2004). Therefore, like stated earlier, Emily not identifying with her being hard of hearing can contribute to Emily's ability and decision to not enact being hard of hearing as an identity.

The Johnson family repeats the same sentiments of their child being able to choose when to perform their deafness to others. "So, a lot of times they [the hearing aids] can be covered." This is what makes deafness so unique is that the identity of deafness can be enacted sometimes by choice of the individual. On the other hand, the Hahn family said that Andrew embraced his enacted identity with his hearing aids, "Yeah hearing aids, like he's really open with it because Mitch has some older customers that he works with and Andrew is still confident to say, 'Oh yeah, I got these hearing aids.'" Further, Andrew even offers advice to others based on his comfortability with his identity with his hearing aids. "He's real open with people if people come up to him and say, 'Oh, you know, I might have to get hearing aids,' he'll tell them all about it." Qualitative research in identity, like this study, can discuss the contexts in which individuals feel more comfortable presenting their enacted identity to others. While the focus of this study did not investigate the various contexts behind when the enacted identity was performed, qualitative inquiry about identity can show the connections between identity and contributing factors such as contexts and environment.

This ability to choose when to present their identity as hard of hearing is similar to experiences of those within the LGBTQ community in choosing to "come out" and express their sexual identity to others. Because sexual identity can be a concealable identity, it can also be enacted at a time chosen by the individual. For example, a study by Gray (2013) discussed the contexts in which LGB teachers decided to come out at work. Gray (2013) stated similar experiences the participants' of concealing various parts of their identity until they determined they would come out and present that identity to others, in this case in their workspaces. Just as disclosing one's sexuality is a phenomenon that is unique to the LGBTQ community (Gray, 2013), disclosing or concealing one's hearing loss is a unique phenomenon to those who are DHH within the disability community.

While enacted identity can be communication, it can also affect communication that you display to and practice with others (Jung & Hecht, 2004). Therefore, enacted identity can be one frame that can contradict or support the personal frame of choosing to identify as hard of hearing or not. In this case, some may not identify as hard of hearing personally, but may feel comfortable with enacting the identity of their hearing devices out of comfortability with them or to offer assistance in some way with others' journeys with hearing devices.

Relational. Relational identity allows individuals to shape their identity through relationships, such as identifying themselves based on how others see them or how they see themselves through their relationships with others (Jung & Hecht, 2004). Participants overall indicated that they did not identify with their child's deafness, potentially creating an impact on the relational identity of their child. The impact this can have is if the child

identifies as hard of hearing and part of the Deaf community and the family did not relate to that identity, the relational identity of that child can be affected if they shape their identity through the family's perspective. In reference to relational identity, the Smith family stated, "But whether we identify as a family with someone with hearing loss, I don't think there's any different identity for us in that regard, no." Ashley Miller shared similar statements, "I would lean toward not at all [in identifying with their child's hearing loss]." There is the possibility that their child's identity in how they view themselves and their hard of hearing status may be affected by the family's ability to identify with their child being hard of hearing and vice versa. For example, a family may feel more compelled to identify with their child's identity in being hard of hearing if that child embraced that identity personally or vice versa.

Not only can relational identity come from how one views themselves through others, but it can also come from how others view them. Families were conflicted about whether or not they felt that others viewed their family in association with their child's diagnosis. Since all families came from smaller communities, they expressed that most in the communities they lived in knew of their child's hearing loss. However, there were mixed responses on whether they felt that others identified them as an overall "hard of hearing family" in association with their child being hard of hearing. Kayla Johnson said, "I don't think they identify us as a family with a deaf and hard of hearing child, unless it's, you know, the teachers." She said that their immediate family may identify more with their child's hearing loss, but otherwise not the general public.

Mike Smith said that many in the community knew about their child's hearing loss but did not associate their family with the hearing loss. "I mean, I think in a small

community like ours, everybody knows it just because she's had it since she's been little. So, I don't think people every identify us as a deaf and hard of hearing family." Since the community has had time to know about the Smith's child being hard of hearing, it could be that the Smith's perceive the community would have the time to develop other identities for the family rather than associate them with their child's diagnosis. Since the families in this study were from smaller communities, it could be possible that responses were narrowly focused on the perceptions of individuals that they know in the community, rather than the perceptions of the community as a whole. For example, the families in this study could assume they know most of the people in the community and therefore assume the public's opinions on their family identity. However, it could be possible that since families in this study did not overall identify with their child's hearing loss, they could infer that no other families could view them that way either.

Conflict can arise when others' perception of your identity is different from your own. Ashley Miller discussed the frustrations that come with others identifying their child as something different than they identify with themselves:

> People always think that she's had hearing loss forever or that she's had lots of ear infections and so I often bring that up. I'm like, she didn't have ear infections, it [the hearing loss] started at six, and they're just like their mouth drops open. Why? Like, do you think I'm a bad parent that I like didn't take care of her hearing aids like her, you know, her ears, but that she had all these infections and it destroyed her hearing? No. So sometimes, I feel a little bit of judgment, even when it took so long to get her hearing aids in place too. Like, what are you guys doing wrong that you can't get this organized? Because it's a specialty and

because this barrier ran into this barrier and into this barrier. So, just harder in a small town.

In this instance, Ashley discussed that the perceived identity that others placed on her was a "bad parent" because of her child being hard of hearing. This sense of feeling shamed and guilty as a parent because of a child being diagnosed with a disability is something prior research discusses. Ferguson (2002) emphasized the guilt parents of children with disabilities can feel, "Even parent involvement itself has been interpreted as based in an underlying guilt reaction by parents who believe that they are somehow responsible for their child's disability" (p. 126). Ashley was heavily involved in getting her child help when diagnosed and yet, can feel frustration on the identity others may place on her as a bad parent due to her child having a disability. Other families with children who are hard of hearing may experience similar feelings.

Lastly, there can be conflict in relational identity based on the perception of others, such as immediate family. Like discussed above, Ashley Miller had experiences with family members being upset with her daughter's hard of hearing diagnosis. She stated that Derrin's grandma suggested herbal supplements to "fix it [the hearing loss]." Ashley said, "I think it's just hard for them to accept this loss." This perception of their grandchild's hearing loss can affect the relational identity of the child who is hard of hearing if that child were to base their identity on how others see them. In fact, it is possible they could feel more of a relational identity with their family members' perceptions of their identity than others in the community. This warrants further discussion into the effects of intergenerational relational identity, especially in families with children who are DHH.

Communal. Communal identity moves beyond just the individual identity, characterizing a collective group (Jung & Hecht, 2004). Participants in this study disclosed that they did not think their child identified with the Deaf community. However, since the children were not able to confirm or deny these parental claims, communal identity was not something that was prominently discussed in this study. There was one family who brought up the idea of letting their child choose their communal identity in the future. The Miller family said:

> They are going on a field trip, just for the deaf and hard of hearing kids and I kind of had these reservations. And we both talked about it a little bit about whether she should go on this field trip she was really excited to go on a field trip by herself. None of the rest of her third-grade class gets to do this with her. It's special. And I think they're just going to go play together in a gym and it's kind of about identity with the deaf and hard of hearing. I wonder how she's going to come back from that. Like, are these the, are these the people that I want to associate with and relate to? Is this like a part of my identity or not, you know, and depending on lots of factors, you know? She has hearing aids in both ears. Some people have cochlear implants, all kinds of things that she probably doesn't really know a lot about yet. So, I'm just curious how she was going to take that afterwards. Like, I think right now she's excited because it's a special thing, but I wonder if she'll feel like separate from the rest of her class or she'll feel like, I don't know, did I relate to those people or not? I just wonder how she'll come back from it.

This reflection can reflect back to a lower conformity orientation, giving their daughter the ability to make a decision in their personal identity. They go on to confirm their decision to allow their child to choose her own identity personally and communally, "Yeah afterwards. . . if she feels like she's deaf and hard of hearing, then that's fine. If she feels like, nope I don't want to relate to that, that's fine too. So, it's kind of trying to figure out what she's going to want in life." This could be an instance where their child's personal identity can influence whether they feel called to identify with a community, such as the Deaf community, in the future. Further, an identity gap can also leave a gap in feeling tied to a communal identity, such as in the instance with Emily feeling in-between the hearing and Deaf community. More research in this area is needed to better understand the relationship between these identity frames with communal identity.

Support, Advocacy, and Labeling

This section of results covers the areas in which communication orientation and identity were connected, along with other results that were not originally anticipated, but still warrant discussion. This section will first discuss participants' perceived support from the medical and educational community, support given to other parents, then move into advocacy for their child, and lastly end on the discussion of their child being labeled as "different."

Support. Families in this study discussed mixed reviews on the support (or lack thereof) received from both the medical and educational community. The Smith family described their experience with the medical community as feeling like they got the "run around." They said that doctors would send them home, leading them to find answers for themselves. Ashley Miller also reflected on her frustration with the medical community

pushing her for hearing tests with her other children who are not hard of hearing. "You know, I think they're trying to be protective. But we also don't want it to be overkill from the medical community." This push from the medical community can be from the view of disability as something to be fixed or something that is out of the "norm" (Smart, 2009). Ashley goes on to say, "We want to do what's right for them, but we don't want to be pushed either." This supports prior research by Luckner and Velaski (2004), who discussed frustrations of parents of children who are deaf or hard of hearing when they experienced medical professionals who are biased in the communication and resources they pushed. Finding a balance between providing information to families in a balanced manner (Eleweke & Rodda, 2000) is an important goal for the medical community to reach.

Families in this study were overall satisfied with the support from their educational system. Many families reflected on various activities and outings their schools did to provide more social support for their children. The Smith family reflected on Emily's experience with one activity:

> And having like an overnighter or a weekend activity. And so really just getting together. We've met people from communities close by who had children with the same or similar kind of hearing loss. And then, so you're connected together and really can share those things. So, that's been a good thing to know.

The ability to be in an environment where another individual may have the same experience or type of hearing loss as their child could improve the communal identity of the family and their child who is hard of hearing. This type of support described by the Smiths is known as instrumental support. Instrumental support, known as spending time

with one another (Malecki & Demaray, 2003), can provide children the resources to feel supported in their experiences.

Not only did these outings allow for their child to experience support, but it also paved the way for parents to find others to receive support from and offer support to. The Smith family discussed, "I think they've [the school] been good about getting families together. And just to help them understand not feeling alone." This support was extended from the Smith family to others as well. However, the Smith family reflected on their educational background and identity playing a role in their ability to provide support to others. Mike said, "So, we've seen it where if parents aren't educated and don't know those resources, that they kind of stopped. Or if they don't have the finances or whatever might be that can be overlooked. So, kind of for us just having that experience, we can pass it on to other parents too." In this instance, the personal identity of the Smith family allowed them to provide support to other parents seeking resources. Whereas lack of support is something that is listed as a stressor in previous research (Park & Yoon, 2018), this is something in which the Smiths felt support in their personal identity as educators and were able to provide that support to others. Further, this type of informational support, which is providing someone with information or advice (Malecki & Demaray, 2003), can be helpful for families who need assistance through the guidance of others who have been through something similar.

Advocacy. During the interviews, several families discussed advocating for their child and ways that their child has advocated for themselves. While this was not an expected area of the study, many families received assistance through their school to establish skills in their children for self-advocacy. Self-advocacy is defined as, "speaking

up or taking action for oneself" (Michael & Zidan, 2018, p. 118). Because good self-advocacy skills can help children who are hard of hearing overcome various challenges present in the school system (Michael & Zidan, 2018), advocacy was of importance to note among results.

The Smith family discussed the importance of teacher intervention and assistance in developing Emily's self-advocacy skills. They said her deaf and hard of hearing teacher was especially helpful in assisting their daughter with self-advocacy skills. There were also times in which the parents discussed having to become advocates for their children. Kayla Johnson discussed the importance of advocating for Logan, "There have been several times that we've had to be definite advocates. Depending on the teachers, I would say there were probably three years that were kind of concerning." Ashley Miller discussed the way she advocated for her child in the educational system was by meeting with her daughter's teacher for the hard of hearing before each academic year to discuss important topics, such as how Derrin's hearing aids work. Ashley advocated for her daughter's teacher to fully understand Derrin's hearing aids and setting up a plan for the school year.

The school environment can be challenging, like discussed earlier, for children who are hard of hearing. Thus, self-advocacy skills, especially communication, are important for children who are hard of hearing to develop. While the purpose of this study was not to investigate advocacy skills in children who are hard of hearing, this is an area of research that would be helpful for families and professionals to better understand the experiences of children who are hard of hearing in developing self-advocacy skills

Labeling. Families had various perceptions of their child being hard of hearing that appeared during interviews. With various stressors families face at the diagnosis of a disability, one of the stressors can be accepting the disability (Lederberg & Golbach, 2002). At times, the perception of disability may affect the acceptance of disability. Parents in this study discussed moments where acceptance was challenging. In discussing learning of his daughter's diagnosis, Mike Smith said, "I had to die to the fact that she wasn't going to be 'normal', you know, and I now see how things are. And we've progressed." The Hahn family expressed their experience with the initial difficulty of acceptance:

> One of the most difficult things for me to get my mind around when talking with the audiologist was when she explained that when I put my glasses on, I've got 20/20 vision. And her comment to me that day was, 'You know, no matter what we do with hearing aids, it doesn't bring it [the hearing] back. It amplifies the sound, but it doesn't give him the same hearing as somebody with no hearing loss.' That was a little bit difficult for me to get my mind around and I felt bad about that.

Since individuals may have perceptions about disability and deafness specifically, it is important to understand that perceptions of disability may shape the responses to communication, identity, advocacy, and other experiences within the family. While families in this study have overall responded positively to their child being hard of hearing, they can still experience conflicting emotions, such as initial difficulty in acceptance, as expressed above.

In review, this chapter presented the results of four interviews with a total of seven participants who have a child who is hard of hearing. The participants described their experiences with communication with their child, including the challenges, triumphs, and communication modes used within the family. Further, conversation orientation was found to be high in the families within this study, meaning there is a greater range of openness in topics that are discussed within the family, including with their child's hearing loss. There were no family communication patterns that were identified from the interviews, which will be further discussed in the following chapter. Additionally, participants shared that they did not have a family identity based around their child being hard of hearing, nor did they think that others, such as community members, would identify them as a hard of hearing family as well. The following chapter will now further discuss the results of this study, along with introducing study limitations and future areas of research.

CHAPTER 5

Discussion

This chapter will provide further insight on each research question, the theoretical and practical implications from the results of this study, areas for future research, and the limitations this study presented. Additionally, disability identity will be discussed in this chapter, along with its relationship with FCPT and CTI. While disability identity was not part of the original scope of this study, it ended up being an important part of the interpretation. The results of this study show the challenges, triumphs, and decisions regarding family communication, along with showing high conversation orientation among families. Further, the results indicate that families in this study did not adopt a family identity around their child's hard of hearing.

Experiences in Family Communication

Families in this study shared their general experiences with family communication, including when they found out their child was hard of hearing, challenges, triumphs, and the decisions going into the communication mode used in the family. The families in this study were parents who were hearing and children who were hard of hearing, potentially creating a language barrier and other complexities in the family communication experience. Thus, it was important to understand the general experiences of these families in regard to the highs and lows of communication with their child who is hard of hearing.

Communication mode. The choice of communication mode used in the family is consistent with prior research that suggests the degree of hearing loss contributed to the decision of communication mode (Ahlert & Greeff, 2012; Eleweke & Rodda, 2000;

Kluwin & Gaustad, 1991). Further, families in this study all sought early intervention for their child. All families in this study had their children use a type of hearing device such as a hearing aid, FM system, or cochlear implant. One family reflected that they wanted to immediately get their child assistance with hearing so that there were no effects to other areas of their lives such as school or activities. Freeman, Dieterich, and Rak (2002) describe early intervention for children who are deaf or hard of hearing is expected to promote language acquisition and the skills for social functioning. However, results from this study suggest that early intervention was a tactic that families used to provide support for their children when it was discovered they were hard of hearing.

This early intervention could also be influenced by perceptions of being deaf or hard of hearing as well. Research suggests that personal attitudes, beliefs, and goals can all attribute to the decision of a communication mode and the response to a child's hearing loss (Li et al., 2003). Families in this study had personal attitudes, beliefs, and goals for their child regarding their hearing loss, thus leading to the decision to pursue hearing devices for their child. For example, the Smith family had the goal to get Emily early intervention based on their background as an educator and their experiences with those who have disabilities while teaching. This background and personal beliefs helped the decision of using hearing aids and early intervention. It is important to investigate the role of these attitudes and beliefs in the decision-making of a family with a child who is DHH, as it can have implications on the outcome of the child.

The families in this study all had children who were diagnosed as hard of hearing, also leading them to make certain decisions regarding communication mode used in the family. Research suggests that the degree of hearing loss can affect the choice of

communication mode in the family (Kluwin & Guastad, 1991). The results of this study support this, as families reported that they used spoken English and lip reading as a communication mode and the choice to use these communication modes were directly from the degree of hearing loss their children had. One family stated that their child heard well enough that they did not even have a discussion about using anything else besides spoken English. Another family said that they had introduced ASL briefly as their child grew up but did not have this as a main communication mode used in the family. This decision to not include ASL as a main communication mode stemmed from their child having enough hearing to speak English.

Therefore, communication mode in these families were not discussed as a family because their children were all able to hear well enough that the parents determined no conversation was needed. From a communication perspective, a lack of discussion about communication mode can give children who are hard of hearing less decision-making in the choice of communication mode. Investigation into the decisions of families with children who are DHH on whether the child who is DHH is involved in the decision-making would be beneficial for better understanding of these decisions.

Not only does the degree of hearing loss impact the communication mode choice, but support and information provided to the parents do as well. One family in this study, the Smiths, indicated that they received information from medical professionals that suggested they should not use sign language as a communication mode because their child would not learn to speak. This is similar to what past research has shown in the information that some professionals provide parents of children who are DHH. Eleweke and Rodda (2000) studied the factors behind the choice of communication mode in

families with children who are deaf. They found that families can be greatly influenced by the perspective of medical professionals. While the Smiths were not swayed by the perspective of medical professionals, other families may take the advice of medical professionals into account when choosing a communication mode for their child.

Further, past research has discussed how medical professionals either gave balanced information that was detailed and showed all available options, or families received unbalanced information that had the expectation that parents would follow what they said. This is because medical professionals would often push hearing aids because they did not believe in the signing approach (Eleweke & Rodda, 2000). While the Smith family was not greatly influenced by the advice of the medical professionals to not use ASL, their educational background and identity may have better prepared them to "stand up" to the medical professionals' advice. This highlights the connection between identity into some of the decisions families may make regarding communication with their child who is hard of hearing, highlighting the need for more investigation into the role of identity in these decisions.

Families reported feeling frustrated at one point or another when it came to communication with their child. For example, some of the frustrations came from the adjustment to hearing aids. The Hahn family said that their son did not want to wear hearing aids right away, a situation that many families who have children who are hard of hearing may experience. Another example of frustrations came from the loud environment in the educational system. Like research has shown, loud environments with many different sounds can cause difficulty for children who are hard of hearing (Bess et al., 1986). Since effective communication can lead to positive impact on future

development in children (Luckner & Velaski, 2004), investigating the reasons behind

frustration while also bringing to light the triumphs of overcoming these communicative

challenges is important in this study. Furthermore, by investigating the reasons behind the

frustrations, effective communication strategies can be introduced through further

research to better assist families with children who are DHH, as well as the medical

professionals who work with them.

The responses from participants regarding their child's assistance in the decision-

making of using a hearing device can show the connection between a communication

orientation and the level of decision-making children can have when it comes to their

choice of hearing devices. For example, families that are high in conformity orientation

may not give their child the ability to be part of the decision regarding whether to use

hearing devices or not because "what the parents say goes." While prior research has

focused on the factors that go into the decision-making for communication modes and

hearing devices for parents (Eleweke & Rodda, 2000; Kluwin & Gaustad, 1991), more

research can be done on what drives the decision for communication mode and hearing

devices in children, if they are given a role in the decision-making.

Overall, there was a lack of diversity in communication modes families in this

study, which could have been impacted by the small sample size and the fact that all

families in this study had children who were hard of hearing. Future studies can focus on

a greater sample size that is more representative of families with children who are deaf or

hard of hearing. Additionally, future research could focus on one over another, families

with children who are deaf or families with children who are hard of hearing.

Families in this study reported little to no family discussion in what communication mode to use, suggesting that the hearing loss of their children was not great enough to warrant a discussion. Future research could investigate what degree of hearing loss may warrant a discussion about communication mode and specify which parent, such as the mother or father figure, has the greatest influence on what communication mode is ultimately decided on. Furthermore, future research should focus on how family communication patterns relate to the communication mode chosen in the family as well.

Family Communication Patterns

The following section discusses the results of family communication orientations that appeared in participants' responses. Since communication patterns were not present in this study, the implications of those findings are discussed in implications for future research. Family communication patterns are typically investigated by a quantitative revised instrument developed by Koerner and Fitzpatrick (2002). This instrument consists of 26 Likert type items focused on conversation orientation and conformity orientation (Koerner & Fitzpatrick, 2002). This study took a different approach to family communication patterns by qualitatively investigating the theory. To my knowledge, there are no other studies that have studied FCPT within families with deaf or hard of hearing children. While a study by Desselle (1994) investigated communication patterns in families with children who were deaf, this study did not use FCPT and the communication patterns investigated were the communication modes and methods of these families. Further, there are no studies that have used a qualitative methodology to

investigate family communication patterns and orientations specifically. Thus, this study is significant in furthering the knowledge of FCPT using qualitative methods.

Conversation orientation. Past research has shown that family communication patterns and orientations are important for family adjustment and well-being of children (Charoenthaweesub & Hale, 2011; Rueter & Koerner, 2008; Schrodt & Ledbetter, 2007). Therefore, having high or low conversation orientation or specific family communication patterns can affect the adjustment and well-being of children who are DHH in ways similar and different than other families, although studies have yet to focus in that area. The results show that families in this study perceived themselves as having high conversation orientation, meaning they value free, open conversation with more topics.

Because conversation orientation accounts for both frequency of communication and the content of conversation (Koerner & Fitzpatrick, 2006), there are many factors that can go into families perceiving themselves as high conversation orientation. The majority of the families in this study reported more on the wide variety of topics rather than the frequency of conversation they had with their families. This is an area where FCPT can be limited, as it is difficult to measure, or observe, what constitutes a high enough frequency or openness of topics to truly be high conversation orientation. Through further investigation of qualitative methods of FCPT, these limitations may be discussed in greater detail and the theory can be improved or expanded.

Many of the families were very open about discussing topics focused on their child being hard of hearing with other family members. For example, the Johnson family discussed that they do not shy away from talking about their child's hearing loss as a family. Therefore, some families may have different perceptions on the appropriateness

of discussing their child's hearing loss. Not only were the Johnsons open about discussing their son being hard of hearing, they also said that they felt connected to their son's identity as hard of hearing. This could indicate, at least for this particular family, there could be a positive relationship between identification with being hard of hearing and the open communication of the family about it to others.

This potential connection between identification with a child's disability and the willingness to open with discussions about the disability has implications for future research and interventions. Communication researchers should further investigate the relationship between the parents' identification with their children who are DHH and the openness of family communication. Furthermore, early interventions can encourage families to discuss how their child being DHH plays a role in the family identity. These discussions have the potential to lead to greater comfortability discussing the child's disability and can improve the family communication environment. This finding also suggests that conversation orientation can differ between topics of communication, rather than characterizing all communication within a family.

Conformity orientation. Conformity orientation did not appear as prevalently as conversation orientation in these interviews. One family stated that they had shared values around their Christian faith but did not have shared value around their child being hard of hearing. This can show that families may feel high conformity in parts of their identity, such as their faith, rather than other parts of their identity. Just like any family, families with children who are hard of hearing can hold various values that result in different levels of conformity orientations. For example, one family reflected that they

wanted their child to establish their own identity and independence regarding their hearing, showing a lower conformity orientation.

While conformity orientation was not prevalent in this study, it remains to be seen whether families with children who are deaf, rather than hard of hearing, have high or low conformity orientation. This is why investigating FCPT qualitatively is vital to enhancing the theory and the communication discipline as a whole. Looking at FCPT in families with children who are DHH is important to better understand the complexities of these families, especially with the addition of disability. By better understanding the situations in which disability plays a role in the communication orientations in these families, we can better understand the communicative experiences of these families. Furthermore, by using qualitative inquiry with FCPT, we can better understand the contexts and situations that go into other families displaying an orientation or a pattern. Therefore, this study introduced a framework for better understanding the role of family communication patterns in families with children with disabilities, specifically who are DHH. Future research can expand on this framework with other disabilities, especially communication-based disabilities.

Family Identity

While all families as a whole and individual family members can experience challenges in identity, the experiences in this study are important to understand because the role of disability in identity. This role of disability identity in relation to the identity frames of CTI will be presented in later on in this chapter. Families with children who are DHH can experience challenges of identity based on communication, attitudes about disability, the viewpoint of others, and more. Using CTI, this study investigated four

frames of identity: personal, relational, enacted, and communal. Families did not report identifying with their child's hearing loss. Most families responded saying they would not count it as part of their family's identity. Some even stated that they did not feel that it was part of their child's identity as well. There were no prominent ties to their child's hearing loss within any frame of identity for the families in this study.

As discussed in the literature review, frames of identity can overlap and contradict. Therefore, some of the experiences and responses from participants fit in various frames of identity for the family. For example, the response from families that they do not identify with their child's disability can fit within the personal identity of the family as a whole, the relational identity of that family with their child, the enacted identity they present to others, and the communal identity of the family with the Deaf community. Therefore, there is great need for the communication discipline to further investigate the way that these families communicate various aspects of their identity, especially in regard to whether the family or individuals in the family identify with a disability.

Investigating the identity families with children who are hard of hearing using CTI as a framework was beneficial for better understanding their experiences with identity. Even more beneficial was using qualitative measures to investigate these frames of identity, as it brought forward several implications for the theory and the connections with disability. The family system can be seen as a single structure, while also acknowledging the individualistic properties a family has as well. Being that a family is both one single unit and comprised of several individuals, various frames of identity were difficult to investigate in this study, as discussed below.

One example is the investigation of personal identity. This study used interviews with parents of children who were hard of hearing, limiting the amount of family members present to describe the identity of the family. Furthermore, the personal identity of the family was discussed, along with the parents' perceptions of what their child would identify as. In other words, parents were asked to discuss how they thought their child would personally identify. Not only can this limit the responses, but it also shows the complexity of identity within family structure. Parents' perceptions of their child's identity could be completely different than what the child would identify as. Additionally, this perception of their child's identity could count as a relational identity frame, as it is the parents' perspective of another individual's identity, which could influence the identity of the child. Thus, this is where identity gaps may form within the family structure. Future research could help address these identity gaps by investigating the ways in which parents communicate their child's identity in comparison to how their child communicates their personal identity.

Another complexity of investigating CTI in a family structure is addressing the family as one unit and individual units. A family can have various frames of identity based off the perception of the family as one complete unit. Additionally, a family can have completely different frames of identity based off of the individuals comprising the family. Therefore, communication research should further investigate the ways in which families communicate their identity as one complete unit and how the individual identities within those families are communicated. This research can increase understanding in family communication, along with opening research opportunities to take that understanding into families with children who are DHH.

FCPT and CTI Connections

  This study aimed to establish a connection between family communication patterns and identity. Many studies have investigated family communication patterns on the family system, but still have yet to tie it to various identities of the family or of individuals in the family. The conversation orientation of the families in this study could have been directly impacted by the identity of these families. For example, these families could have reported high conversation orientation about a variety of topics, including their child's hearing loss, due to their children not identifying with the Deaf community and not reporting strong enough hearing loss to identify away from the hearing world. While prior research has not specifically addressed whether the degree of hearing loss would impact conversation orientation, it is shown that the degree of hearing loss can impact things such as communication mode within the family (Kluwin & Gaustad, 1991). Therefore, it could be possible that the degree of hearing loss could also impact the communication orientation that is most practiced within the family. This is why FCPT and CTI were important to investigate together in this study, as having a child who is hard of hearing can affect communication and identity, which can also affect each other.

  As mentioned in the literature review, there has not been research that connects the role of identity in family communication patterns within families of this demographic. Families in this study reported that they shared a language with their child who is hard of hearing, while also not feeling an identity surrounding their child being hard of hearing. It could be that families may not feel a strong sense of identity with their child being hard of hearing based on not having to negotiate the complexities of deafness with their child since they speak the same language. Finding a shared language can be a threat to family

communication and identity (Atkin et al., 2002). Since the families all shared a same language, their family identity may not have needed to mold much following the diagnosis of their child being hard of hearing. This could also explain why the family communication was so high in conversation orientation, as more frequent conversation and a wide variety of topics may be easier to participate in if there is no language barrier to overcome. Perhaps if families had a child who had more significant hearing loss or if there was a language barrier, families would rank lower in conversation orientation. Future research could discuss the role of communicative challenges, such as a language barrier, on the communication orientations used in a family with children who are DHH.

Further, conformity orientation can be influenced by whether the families value having individuality of members from the child's hearing loss or whether they value conforming to being harmonious in their child's hearing loss. Past research has suggested that accepting a child's hearing loss can significantly improve self-esteem (Desselle & Pearlmutter, 1997). Therefore, it could be possible that families who value conforming a harmonious identity with their child's hearing loss can affect their child's self-esteem as well. It could also be inferred that had the families had children who identified in the Deaf community, families may feel more compelled to be on the higher end of conformity orientation by uniting around their child's identity as a family. These are areas of future research that must be investigated.

Identity is constantly changing and evolving, including family identity and individual identity. It could be possible that identity gaps may form in the future if the identity of the family with their child being hard of hearing does not match the identity of the child who is hard of hearing. Narratives of LGBTQ Jewish American identities show

that communal identities can conflict with personal and relational identity (Faulkner & Hecht, 2011). This conflict came from not feeling enough in one identity over another to fit in (Faulkner & Hecht, 2011). Like a family in this study stated, their child felt that they were not completely of the hearing world nor of the hard of hearing world either. This can cause conflict with their personal identity and their communal identity. This is an area of future research that could investigate conflict in identity in individuals who feel a stronger tie to their identities.

Disability Identity

In discussions regarding participants' family communication patterns and family identity, it became clear that disability identity influenced both of these concepts. Whether the family or child identified with the disability affected the communication orientations used in these families and subsequently, affected various frames of identity as well. To my knowledge, the introduction of the relationship of disability identity to FCPT and CTI is a unique to this study and therefore, warrants further discussion.

Disability identity includes the taking of disability as another context of personal identity and marking an individual as part of a group (Dunn & Burcaw, 2013). Olkin (1999) discussed three disability-identity groups; one as an individuals with some functional limitation who can "pass" as nondisabled due to less severe disability, another as people who link their disability to their self-concept and feel part of the disability community, and the last is comprised of disability right activists who advocate for those with disabilities. In this study, the children who are hard of hearing would most likely fit into the first group, who have some functional limitation that can allow them to identify with the disability community, but often can pass as nondisabled. Therefore, investigation

of FCPT and CTI in other families with disabilities could present different results based on the influence of their identity with the disability.

While most families in this study did not directly identify with their child's disability, the presence of this disability still affected family communication patterns and identity, as proposed in discussion above. Furthermore, the fact that the children in this study were hard of hearing could affect their identity with a disability, potentially affecting their frames of identity, such as personal identity. For example, many families discussed their children being able to conceal their hearing aids, thus concealing part of their disability. This shows that these children may fit into the first group of disability-identity, where their disability is more salient (Olkin, 1999). These children are able to subsequently choose to identify more with people without disabilities because their disability is not "severe enough." However, others who have different disabilities may not get as much of a choice in the display of their disability, which could lead to a direct impact on not only the identity of that individual, but the family as a whole. In other words, a family with a child who is hard of hearing may experience different frames of identity than other families with a child with a different disability because of their identity with the disability. Therefore, the role of disability identity in FCPT and CTI is an area for future investigation in better understanding of families with children with disabilities.

Disability identity can also play a role in the communication orientations of the families in this study. For example, the comfortability of the family in their child's disability can affect the level of conversation orientation that family has. If a family is more comfortable with their child's disability, they may feel more comfortable discussing

the disability as a family or with others. Furthermore, if a family feels more comfortable with their child's disability and discusses it more openly, it can impact the child identifying with their disability. It could be that if the family is more comfortable with their child's disability, a child may feel more comfortable with identifying with their disability. Therefore, communication research should investigate how the presence of a disability can impact communication orientations in families. Additionally, research should also look at how families communicate about their child's disability and how that can influence the child's identification with that disability.

Implications and Future Research

This study used FCPT and CTI as a framework to better understand families with children who are DHH and to investigate the impact communication has on identity and vice versa. Through this study, several theoretical implications arose, allowing room for growth in FCPT and CTI. Furthermore, this study introduces areas of future research that could bring more understanding of families with children who are DHH. This section will introduce theoretical and practical implications, along with areas for future research.

Theoretical implications. This study has theoretical implications that warrant discussion. First, this study tested the ability to investigate FCPT qualitatively through semi-structured interviews. To my knowledge, there have not been other research studies aimed at studying FCPT qualitatively, let alone in families with children who are deaf or hard of hearing. This was done for two reasons: (a) I wanted deeper understanding of the context in which families chose to participate in an orientation or pattern and; (b) To provide an alternative way of viewing FCPT for future research. Therefore, by doing this, the theory itself is challenged, along with the means of quantitatively studying the

phenomenon. This brings forth the question: is FCPT reliable without the quantitative measure associated along with it? Does the theory stand any ground without the quantitative measurement?

This study revealed that families participated in high conversation orientation overall but had certain contexts in which one orientation was practiced over another. For example, the Smith family had stated that they practice conversation orientation as a family, encouraging open dialogue on a wide variety of topics. However, they also stated that when it came to Emily's hearing, they would restrict conversation of family members to allow privacy for Emily. Without qualitative inquiry, these contexts would not be shown to impact the communication orientation that a family practiced. This study adds to the theoretical knowledge by showing that certain contexts and situations may warrant various communication orientation practices within the family system.

These contexts and situations are important to continue investigating qualitatively for a better understanding of how these can affect family communication patterns and orientations. For example, culture can greatly influence family communication patterns and orientations, yet is not highly investigated when investigating FCPT quantitatively. An example study that was presented in the literature review by Charoenthaweesub and others (2011) investigated Thai family communication patterns. While this study did briefly introduce culture and cultural roles, it did not show the influence that culture had on the families' choices of communication patterns and orientations. Certainly, one culture may identify with more collectivistic qualities, which can create different family communication patterns and orientations than families that practice more individualistic

cultures. FCPT fails to take these details into consideration and these contexts should be presented in future research with this theory.

Furthermore, the results did not indicate the presence of the family communication patterns. There could be several explanations for why that could occur, (a) The interview protocol did not frame the questions in a way that allowed families to reveal their patterns; (b) Patterns within family communication may not be true for all contexts and situations, making it difficult to limit a family to one pattern overall; (c) More focus should be given to investigating the communication orientation and patterns alone using qualitative methods before examining the relationship between the orientations/patterns and identity. First, the interview protocol could have been more focused on investigating the patterns more by framing the questions in a different way. This could be an area for future research, but also an implication to the theory in how these questions should be framed in a qualitative way.

Next, the fact that patterns were not present in this study can show significance for theoretical implications. Tracy (2010) states that research that yields unsurprising or insignificant findings may still provide a significant contribution by "introducing and explicating a new methodological approach" (p. 846). Since family communication patterns were not present in this study, future research could use stronger qualitative inquiry to better understand, and even challenge, FCPT. As with orientation, it can be dangerous to assume a family is one orientation or another, or that families fall into a blanket term of patterns such as pluralistic, protective, and others. This is where the insignificance of results can show significant need for investigation into the role of

context, situations, and environment into the varying communication orientations and patterns of families using qualitative measures.

Moreover, since FCPT has been consistently measured quantitatively using a revised measurement from Koerner and Fitzpatrick (2002), investigation is warranted into the validity of FCPT. There has not been discussion into whether the concept truly exists without the measurement itself due to not studying this phenomenon from a different methodological perspective. "At its most basic, research may provide a theoretical contribution by examining how existing theory or concepts make sense in a new and different context" (Tracy, 2010, p. 846). Therefore, my research has made theoretical contribution by examining how FCPT may have the potential to make sense in a qualitative context and challenges investigation into the validity of the FCPT construct without the quantitative measurement. This study provided implications for the theory in which future research should aim to investigate.

Practical implications. Along with theoretical implications, the results of this study have several practical implications as well. These implications can help medical professionals in assisting families following the diagnosis of their child being DHH and educational professionals working with children who are DHH. This section will discuss some of the applied and practical implications of this study.

First, this study is important to the study of health communication. Specifically, this study can give medical professionals a better understanding of the experiences of families with children who are DHH. For example, some families in this study discussed receiving the run around by medical professionals, along with not being provided all the information they could have regarding communication choices with their child who is

hard of hearing. Like past research has shown, these experiences with medical professionals can cause frustration for these families (Eleweke & Rodda, 2000; Luckner & Velaski, 2004). These frustrations can be alleviated through effective communication of all options for families with children who are DHH. These options can include the choice of communication mode, benefits and drawbacks of hearing devices, and other supports that these families need unbiased information on. Future research in health communication should study how information given by medical professionals to families with children who are DHH can impact decision-making.

Furthermore, this study has implications for educational professionals. Park and Yoon (2018) found that families experienced high stress with decisions regarding the educational system they would send their child who is DHH to. There were several families in this study who reported having a deaf and hard of hearing teacher for their child while in the mainstream school environment. Additionally, these families also reported their school providing field trips for their child with other children who are DHH. This was reported to be something positive for their child, as it provided support for both the child and parents. Perhaps if families did not feel this support by their educational system, there would be more feelings of frustration, which could impact their experience with navigating their child's educational experiences. Communication and support are important for educational professionals to consider in their instruction of children who are DHH.

An example of implications in both the medical and educational system is the importance of early intervention. The Johnson family reported that had they not advocated for Logan he would not have gotten the help they deserved in time. The Smith

family emphasized the need for early intervention for their daughter, as it helped her develop self-advocacy skills and create plans to help her. This is important for medical and educational professionals to consider when working with children who are DHH. Even more important is to provide early intervention with proper communication on all the options of intervention available to these families. With a better understanding of the importance of early intervention, unbiased information, and support provided to these families, both the educational system and medical professionals can better serve these families.

There are practical implications in the professional support for families with children who are DHH as well. It is important that families with children who are DHH have support. While some families in this study had reported receiving support from the educational system they were involved in, there was a lack of reporting on outside support groups that these families participated in. It is essential that families have support in navigating their experiences with having a child who is DHH (Park & Yoon, 2018). Results of communication patterns and identity may have been different had the families in this study lived in different regions where they had greater support outside of the educational system. For example, they may be exposed to a greater variety of resources and informational support provided by other parents and professionals. It is important that families are able to receive the support they need, whether it be from the medical community, educational system, or other organizations.

Overall, the results of this study have important implications for families with children who are DHH and the professionals that support them. By describing their experiences in-depth, we can gain a better understanding of the challenges, triumphs, and

needs of families with children who are DHH. Furthermore, this study can give families affirmation in their experiences that they are not alone in the complexities of making decisions regarding the well-being of their child who is DHH.

Future research. Future research should aim to better understand the communicative experiences of families with children who are DHH. While past research has investigated the choices of communication in these families, more research should be done to create awareness and understanding of the experiences in these families in order to give other families who are experiencing similar things a sense of hope. For example, more research could be done to understand the perspectives, practices, and decisions made by parents of children who are DHH (Freeman et al., 2002). More information on these daily routines can give better insight into the lives of these families and provide recommendations to parents and professionals.

For future methodological choices, research should focus on investigating FCPT qualitatively. First, FCPT should be challenged by using qualitative methodology to test the strength of the theory. As this study suggests, framing questions in a more strategic way can assist in future research. By looking at the quantitative measure for FCPT developed by Koerner and Fitzpatrick (2002), one could create a stronger interview protocol that could give insight into the details of family communication patterns qualitatively. Future studies should also revise questions used in this study to get stronger responses from participants. Furthermore, family communication patterns in families with children who identify as deaf should be studied in the future. These families may have to adjust communication patterns differently than other families. This research could better understand the impact of family communication patterns and orientations in

underrepresented families, along with ones who may use a language besides spoken English.

Future research can be done to better investigate the beliefs and attitudes of parents regarding deafness. This would be important to investigate, as there are some perceived beliefs and attitudes that parents may have toward their child being deaf or hard of hearing. Understanding these beliefs and what influences them can give professionals working with these families more knowledge on how to address these attitudes and beliefs and provide clear information to these parents.

Rather than interviewing the parents of children who are DHH, future research can interview the children who are DHH to better understand their experience with identity. Research in this area can show the personal, relational, enacted, and communal identity in children who are DHH more effectively by investigating these frames from their perspective. This research could give medical professionals and educators a better understanding of the experiences of those who are DHH.

Lastly, there is need for future research on families who have parents who are DHH and children who are hearing or DHH. It is important to understand how communication and identity are affected in families of this demographic as well. Further, it is important for future research to continue involving those in the Deaf community when pursuing studies to better understand their experiences. While this study purposefully chose parents who are hearing, it would be valuable to interview parents who are DHH when trying to best understand the experiences of those who are DHH.

Limitations

This study has limitations that should be taken into consideration. First, the sample size created limitations of representation. With seven participants, this study is limited in representing the entire population under study. This population was difficult to reach, along with the paired difficulties of experiencing a pandemic during recruitment and interviews. Although the study population was small, I was still able to reach saturation in some areas and performed member checking to increase the validity of the results. Another limitation of the sample size was the communication modes represented within the participants. If the sample size had been larger, there could have been more communication modes represented in the results. While hosting the interviews over the Zoom platform was still successful, it could be possible more rich data could have been achieved had interviews been able to take place in person.

With the methodology used, Frey and others (2000) discuss the possibility of self-selection bias occurring, meaning that participants can hold strong opinions that are not necessarily representative of the whole population. For example, parents who have children who are deaf or hard of hearing may want to volunteer to discuss a sometimes controversial topic, such as disability. Although the use of this sampling may be a limitation, Frey and others (2000) state that this type of sampling is suited for populations discussing sensitive topics, like disability. Therefore, I feel that this sampling was the most appropriate given the target population.

Another major limitation is the specific participants all had children who identified as hard of hearing, not deaf. This could affect the identity of the child and the family as a whole in a different way. Additionally, the communication patterns within the family could be different if there were children who identified as deaf. Because the

children who were in this study were hard of hearing, this makes the findings less generalizable to families with children who are deaf. There is a possibility that parents with children who identify as deaf would have different experiences that are not represented in this study.

Additionally, participants in this study were all from rural communities, presenting a potential limitation of results. This rural context could have shaped my findings, such as in the experiences with medical professionals, the educational system, and support resources. These families may have had more intimate experiences with medical professionals in rural communities, teachers in mainstream school environments, and less outside support resources than families in areas with higher populations. Further, the experiences of the rural Midwest could be different than the experiences of the rural South, for example, leading to a limitation of the application of these results to other geographical locations.

Interview procedures used during this study also limit my findings. As stated previously, this study aimed to investigate FCPT in a qualitative analysis, rather than the typical quantitative measure. With this leap into a new way of looking at family communication patterns came limitations. In my interview, I had several questions intended to dig deeper into family communication patterns. However, because of time restrictions, not all of the questions regarding family communication patterns were able to be asked. Further, the questions that were asked in relation to family communication patterns were flawed. For example, questions could have been reworded to best get into the patterns deeper, rather than just the orientations. I asked questions that intended to gather more information about the orientations but did not have questions that dug into

the patterns of this theory. This became apparent as interviews went on and when analyzing the results. This can be a limitation of the study, but also a limitation of the theory. Since orientations comprise the patterns (Koerner & Fitzpatrick, 2006), then asking questions about the orientations should have led to the appearance of patterns. This is an area that communication scholars can further investigate by using qualitative methodology to research FCPT. While the interview procedure limits my results with FCPT, I do think that the results of high conversation orientation among these families is still present. This provides an area for future research as well.

There is limitation in the ability for identity to be described in more depth as well based on the interview protocol. In a study by Beckner and Helme (2018), they investigated CTI in individuals who felt in-between the hearing community and Deaf community. This study employed stronger interview questions that allowed researchers to better understand the various frames of identity. Thus, the wording used in the interview protocol specific to CTI could have been improved with stronger language that would highlight the various frames of CTI in the family and the children who are DHH.

Lastly, there is a limitation in the analysis of my results. While I did perform member checking to ensure accuracy of participant responses (Frey et al., 2000), an additional coder could have been used to ensure intercoder reliability. Due to time constraints and schedule availability of independent coders due to COVID-19, this reliability measure was not able to be utilized. Intercoder reliability would have allowed me to assess the reliability of observations by calculating the percentage of agreement between independent coders (Frey et al., 2000). While intercoder reliability would have

given me more reliability, I still feel confident in the use of member-checking as an effective form of reliability for this study.

Conclusion

Millions of individuals in America have a disability (CDC, 2019), yet those with a disability still face many obstacles and hardships. Specifically, hardships can arise in the family with an individual with a disability because of miscommunication, misunderstanding, and lack of awareness. Various challenges and triumphs can occur in families with children who are deaf or hard of hearing. Many families of this demographic can feel unsupported from the medical community and other individuals based on a lack of understanding (Park & Yoon, 2018). Further, families experiencing a diagnosis of a child being DHH can feel unsure of what resources are available to them or what they can do to best support their child. To assist in these complicated situations, more research needed to be done on communication patterns within families with children who are DHH and how families express their identity. Therefore, the purpose of this study was to better understand family communication and identity in families with children who are DHH and bring more awareness to deafness and disability through this investigation.

The results of four interviews with families with children who are hard of hearing show high conversation orientation, along with different frames of identity being influenced by their child being hard of hearing. An introduction of how disability identity can have an effect on FCPT and CTI was presented in this study, offering future areas for communication research. This study identifies the need for more understanding surrounding communication within these families and how their child being hard of

hearing can impact family and individual identity. These results are important because it can give families hope and knowledge if they are of similar demographics. Further, this provides an opportunity for medical and educational professionals who work with families with children who are hard of hearing to better understand the experiences of these families in order to provide the best support possible.

Studies like this one are important to give a better idea of the complexities, triumphs, and challenges families with children who are deaf or hard of hearing face. By using qualitative inquiry, families of this demographic were able to fully express their thoughts and experiences, allowing research to dive deeper into those experiences. Finally, this study introduced theoretical implications and strategies that could be implemented into investigating family communication patterns. These theoretical implications have the potential to expand on these two theories as they relate to the different complexities and contexts that families with children who are DHH face. It is my hope that this study can introduce more studies on families with deaf or hard of hearing members into the communication discipline in the future, along with bringing more awareness to the experiences of these families.

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APPENDIX A

Interview Protocol

1. Tell me about your family.

2. Tell me about the experience of discovering your child was deaf or hard of hearing.

    a. How long ago was it?

    b. How did you feel?

    c. What was your response?

    d. Did it change your family dynamic in any way? Positively/negatively? Were there any other effects?

3. What type of language(s) does your family use? Example: English, Signed Exact English, American Sign Language (ASL), another sign language.

    a. Do you use ASL? Why or why not?

    b. Have there been any influences on the choice of language? How would you explain?

    c. Does the type of communication/language you use depend on the situation? How would you describe a situation that it is different?

    d. Were you offered any support from medical professionals on what language to use?

4. Give me an example on how your communication works well with your child. Now give me an example of when it was challenging.

5. What kind of things do you talk about with your family?

    a. What kind of things do you talk about with your child?

b. Has it always been this way?

c. Are there times when what you talk about is different?

6. Are there certain topics your family chooses not to discuss?

7. How would you describe the identity of your family?

a. Are there certain parts of your family identity that you portray more to others? Example: religious identity, family traditions, etc.

b. Are there parts of your identity as a family that are more important? Is there one that is the most important?

c. Is deafness part of your family identity?

d. Is it important to have deafness as part of your family identity? Why? Has it changed over time?

8. How do you think others would describe your family?

a. Do you feel that anyone ever looks at your family differently based on your child?

b. Do you feel like people focus on your child?

c. Is that in a positive or negative light?

d. Do you recall any specific words or phrases?

e. How do you respond to those moments?