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Supernatural Healing: Narratives of individuals who report on the healing of a sensorineural hearing loss.

A thesis submitted to the Faculty of Humanities, University of the Witwatersrand,

Johannesburg, South Africa.

In the fulfilment of the requirements for the

Degree of Doctor of Philosophy

By

Dhanashree Pillay

2017

Abstract

Background: Science and Religion have been debated for centuries. Healthcare assessments and management have traditionally focused on the medical model of detecting and curing a disease, facilitating a narrow focus on the physical needs. There is little consideration for the psychological, social and spiritual factors that affect a human life. Healthcare however should operate in both the temporal and the spiritual spheres. More inclusive models of healthcare are becoming favourable as diversity of patients and health practitioners becomes more evident, hence this applies to the practice of Audiology services too. Hearing loss the 'hidden disability' is regarded as the number one disability in the world thus a significant proportion of the world's population is affection directly or indirectly by this communication hindering disability.

Prior to rehabilitation, finding a cure was the ultimate goal when considering any medical pathology. Presently there is still no surgical method available to replace the damaged hair cells of the cochlea that cause a sensorineural hearing loss (SNHL). The culturally diverse South African population comprises of individuals who belong to various ethnic and religious groups, thus the melting pot of rehabilitation techniques for any illness may vary from the predominantly used medical model. Supernatural healing may occur in various forms and from various sources within the South African population, including traditional healers, spiritual healers or religious leaders. Hence this study explored the narratives of individuals who claim that they have been healed supernaturally of a sensorineural hearing loss.

Methodology: This study aimed to fulfil three main objectives: to identify the recurring themes within the narratives of participants who reported a healing, with the purpose of deconstructing the aspect of healing amongst participants; to describe the cultural, religious, spiritual and social influences that impact the individual with a hearing loss; and to design a proposed working Audiological Model: An Integrated Model of service delivery in Audiology. There were three sub-objectives: to document the diagnosis of the sensorineural hearing loss; to identify the 'turning point' event or events that caused the reported healing; and to explore the influences of the healing on the participant's life. This study was an exploratory case-study design within a qualitative paradigm. Snowball sampling was employed. Semi-structured interviews were conducted with seven participants, six of which were female and one male. Two of the participants' mothers were interviewed as the reported healing occurred when the participants were children. All ethical parameters were maintained. The data analysis included a narrative inquiry into the *context* of the main event which was the supernatural healing. Thereafter the

content associated with the participant's life before and after the event was analysed and discussed. Thematic content analysis was employed to identify the common categories and themes within the narratives of this study.

Results and Discussion: This study identified four main categories and 13 themes within the narratives obtained. Categories included: Identification, assessment and management of a hearing loss; cause of a hearing loss; the healing event and the areas of a participant's life that changed by the healing event. Major themes included: Hearing loss and its relation to sin and curses; physical and non-physical healing; the life of prayer and reactions to the healing. The narratives illustrated that individuals with a hearing loss are seeking alternative healing practices in conjunction with Audiological care. There is a barrier between the audiologist and the individual with a hearing loss as there appears to be a lack of freedom to discuss pertinent aspects such as alternative care. There is a need for change within the service delivery model in Audiology, a shift from the medical model of practice to a more holistic and integrated model of service delivery that encompasses all areas of life into the assessment and management process.

Conclusion: A cohesive, integrated referral system and collaboration between professionals and caregivers are often the dictators of the assessment and early diagnosis of the hearing loss. A service delivery model that incorporates all aspects of life is therefore recommended within the profession of Audiology. The argument for a change in the current service delivery model in Audiology is supported by the evidence in the narratives obtained in this study. Individual's with a hearing loss are seeking for alternative means of healing and it is negligent and divisive to disregard the interconnectedness of the medical, psychological, social and spiritual facets that affect the individual being seen by an audiologist. The diversity in South Africa must be embraced and incorporated into the healthcare service delivery model to ensure that the individual with a hearing loss is receiving contextually based services that are appropriate and necessary. Training of future audiologists must include multicultural and multidisciplinary areas as audiologists need to be equipped for success when they are faced with areas that are not familiar to the current medical model of practice. Healing is multidimensional and clinical practice in the field of Audiology must consider and include the aspects of healing that are relevant to the individual seen. A proposed case history section was developed from the evidence obtained in this study. The section allows the audiologist to explore religious and spiritual beliefs of the individual with a healing loss and his/her family. This study is one of the first studies that explore the relationship between medicine, religion and spirituality however these areas have been intertwined

for centuries. The findings and recommendations in this study will assist audiologists in managing individuals in an integrated holistic manner.

Keywords: Healing, Supernatural, Hearing loss, Audiology practice, Alternative Practices, Biopsychosocial-Spiritual Practice.

Declaration

I declare that this thesis has been written by myself and is my own work. The work has never been submitted to any other university for degree or examination purposes. The references and sources used within the write up of this thesis have been acknowledged in the study.

Dhanashree Pillay

July 2017

Signature: _____

Dedication Page

This PhD is dedicated to my parents and grandparents: *The Pillay and Reddy families.*

They were unable to pursuit further studies yet they played a vital and practical role of schooling me in LIFE.

A legacy of hard work and perseverance can only come from a strong support structure. Things that didn't break us, only made us stronger!!

Dedicated to Perindhren Ronnie & Premilla Pillay and Vatharajiloo (Teddy) & Salachie (Sally) Reddy

Dedicated in the memory of Alfred Benny & Soranathammal (Runga) Pillay

Acknowledgments

Be Still and Know that I AM God as I can do all things through Christ who strengthens me as Nothing is Impossible with God.

~ Psalm 46:10, Philippians 4:13 & Matthew 19:26

- **The above-mentioned verses have breathed LIFE in every millisecond of this PhD. I thank God for the wisdom, determination and perseverance to conduct this study. His Grace was more than sufficient to carry me through this process.**
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- **To my beloved nephew Chazaq whose smile lights up my world no matter how intense the PhD process has been. Your presence is greater than you know; I stand expectant to see your LIFE unfold. To my unborn niece Sarah, the joy of knowing that you are on the way has brought an expectation for a blessed and happy future after this PhD process. Growth, Love and Happiness. My love for the both of you can only grow stronger as we do LIFE together.**
- **Thank you to my extended family that has always been there to support and distract me in a good way. I acknowledge your contribution in shaping the person that I have become.**
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- **To my colleagues who continued to challenge my thoughts and decisions throughout this PhD process. Your questions, knowledge and support have created a stronger study with a great**

significance for our South African context. The depth of this body of knowledge was shaped by your contributions and I truly appreciate that.

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List of Abbreviations

ENT: Ears Nose and Throat Specialist

WHO: World Health Organisation

ANC: African National Congress

ICF: Classification of Functioning, Disability and Health

HOH/D: Hard-of-Hearing/Deaf

NICU: Newborn Intensive Care Unit

SNHL: Sensorineural hearing loss

PIP: Proximal Intercessory Prayer

CAH: Complementary and Alternative Healing

Preamble

Storytelling aptly describes narratives, hence when writing up this dissertation I considered the way I would tell the stories of the participants without losing the essence of who they are and the contexts from which they emanate. I also considered the reader as an explorer of the individual narratives and the overall story. The reader as an explorer will be following a systematic trail of information that will finally lead to an understanding of my thoughts. Conclusions were made based on relevant and trustworthy literature that interact, supports or disagrees with the data that I collected. Ultimately the information will provide the reader with a conversation starter with the participants based on the sharing of their narratives. Hence the researcher and the reader will weave through this understanding while exploring the events described. A brief description of what is entailed in each chapter is presented.

In chapter one the reader will initially be orientated to my personal insights and reasons for pursuing a dissertation within the area of supernatural healing and Audiology despite the history of antithesis notions of healing in relation to science, religion and spirituality.

Chapter two then provides the reader with an insight into the setting of this study within the diverse South African context. The theoretical background and models that underpin this study, in chapter three provide a map of the direction and stance that I chose to follow as a researcher. The reader can then expect to be informed about key literary areas that tie into the study in chapter four. This chapter discusses and critiques the relevant areas that form the literature review of this study. Chapter five provides the reader with the methodological buttress that was followed throughout the planning, implementation and analysis of the data.

In chapter six the reader can expect a presentation of the results obtained and a critical discussion of these results in relation to the existing practices and literature. Thereafter chapter seven provides the reader with theoretical and practical evidence for a way forward towards an integrated and holistic model of care in Audiology. The conclusion of this dissertation is presented to the reader in chapter eight, where the reader as the explorer will follow the argument of how the aims of this study were realised. The implications, limitations and research ideas that arose from the new data in the current study are also presented in chapter eight. The personal reflections section, within this study refers to the writer as ‘I’ however the reflections that pertain to the researched data refer to the same writer as

'the researcher'. The culmination of my thoughts throughout this PhD journey is a fitting end to this study but a fantastic way to begin my future as a PhD researcher, scientist and Audiologist.

Chapter 1: Orientation and Introduction to this Research

1.1 Personal Insight and Outlook When Embarking on this Thesis

I decided to pursue a career in Audiology based on the shared experiences of family members, more specifically my dad, who had experienced continuous bouts of ear related difficulties. Countless ENT visits and ear surgeries are accounted for in his life. Living in close proximity to an international airport emphasised the sense of hearing and the communication needs that I realised as being vital for social and psychological interactions with family and friends. My dad's medical diagnosis allowed me to view a hearing loss though a medical lens however I soon realised that hearing plays a major role in the psychosocial aspects of my life as well. Socially music is one of my biggest passions and having a good 'ear' is necessary as the language of unspoken sounds that come from guitars cannot be compared to any human voice. For me, hearing is vital to appreciate the intricacies of pieces of deep praises that are sung in adoration of one's joys in life, be that God's love, relationships or life in general. I was fascinated with the sense of hearing from a young age.

As an undergraduate student, I thoroughly enjoyed my Audiology studies and pursed the career to the fullest, initially working in rural Kwa-Zulu Natal during my year of community service where I was privileged to serve indigent and underserved individuals residing within the heart of rural areas and I loved that year of my career. I was involved in the Red Cross Air Mercy Services and when we would land a chartered plane on the top of the mountains of Bethesda, we were received with such love and appreciation that one would even feel like a celebrity at times. This unique service delivery system allowed for scarce skilled doctors and therapists to provided services to people within their context. I remember one visit where the chickens were running around outside as we arrived and after we setup the hearing screening station and began to go about our duties then the same chicken was served as my lunch. In any other situation, one might be tempted to say that you are not hungry but when you are exposed to and are knowledgeable about the high levels of poverty within a developing country then you cannot refuse the offering of thanks from the people who may have sacrificed their own lunch so that you can eat, and share their appreciation.

During these visits to rural communities it was evident that individuals, who had problems with their ears, were seeking any remedy that was available to them. I saw an array of foreign bodies in the ears of individuals such as crushed marigold leaves and flowers, sand, pastes made from herbs, seeds and

beads. All these methods were used in the attempt to alleviate ear aches or infections within the ear. The question that plagued my mind was 'where were these individuals obtaining such treatment or instructions from?' How do we then manage, respect and modify the methods in which we practice with a more holistic, integrated and supportive model of care for the individual with a hearing loss? At that time, I was instructed by the Ears Nose and Throat Specialist (ENT) to ignore the other methods being used and to focus on my assessment and management related to my scope of work. In hind sight, I now realised how disjointed an approach of care we, as the medical team, were providing. I recognise however that our fear of the unknown might have limited our desire to explore methods that are alternative to the ones that we had learnt in an ideal and structured environment at the University, which were often based on the developed contexts. Furthermore, the world of knowledge only recognised this ideal as science. The seed of exploration was thus planted in my thoughts as I started to grapple with my understanding of the diversity that existed within the different cultural, religious and spiritual beliefs within the South African context. My interest grew as we visited these sites once a month, as we were only seeing approximately 10 percent of the inhabitants. So where were the others going to for assistance and what procedures were followed when the 'medically' trained individuals were not available?

Regardless of the lack of published or documented evidence of alternative and augmentative treatment methods to restore ear health, these indigenous practices were present however the 'medically trained' practitioners were reluctant to engage with what they termed 'rudimentary' form of care. Over the years in practice from rural to urban and private to public sectors I have seen aspects of religion, culture, belief systems and practices of individuals shape the journey taken when a medical need arises. The medical advisors were not always the first port of call for a large number of patients. Patients would not openly admit to seeking alternative advice as they assumed that the medical advisors, including the audiologists, would not be interested in those aspects and would discredit the alternative forms of practice.

As an audiologist, I would only be alerted to possible alternative methods of care that were used after I saw the evidence during the otoscopic examination. The suspicions about audiologists doubting the alternative practices used by individuals with a hearing loss might have been correct, as Audiology followed a precise medical model approach. A recent shift towards family-centred and patient-centred approaches has allowed for emerging shifts within audiological service delivery. Changes in audiological care are beginning to emerge and are moving towards considering the medical and psychosocial factors that affect the individual with a hearing loss, hence a more holistic approach.

However, the spiritual factors are still not fully adopted as a mandatory area of exploration when assessing and managing a person with a hearing loss. The most important factor for me as an audiologist at this point is, patient benefit and management therefore I have taken it upon myself to always consider the possibility of medical, psychosocial and spiritual humanistic factors when practicing as a professional. I might not have known then how to accommodate those indigenous practices with my medical approach but I am motivated now to document the experiences of patients and to explore modifications of patient care that might be necessary.

The stories of supernatural methods of healing and restoration of a permanent hearing loss and other medical diseases and illnesses intrigued me as it seems contrary to the medical results. The stories were generally told in places of worship such as churches and there seemed to be no medical explanations or reasons in some of the cases that I was exposed to at church. Being a Hindu who converted to Christianity I am fairly knowledgeable about the theology and practices of both religions and I have seen the sick seeking spiritual guidance for illness and diseases within both religious practices. My curiosity about the lived experiences, of individuals who believe in healing and having undergone personal healing, motivated my research within this area. My bias at the forefront is that I have personally seen and been involved with individuals who seek alternative supernatural means to heal diseases and illnesses. I do not have a hearing loss and I have not been healed of a hearing loss however I would like to provide healthcare that is respectful, accommodating and well-integrated. Care that allows the individual with a hearing loss to discuss their experiences, beliefs and practices, as I believe that an integrated model of audiological care will lead to a family-centred service provision instead of a disease and illness centred approach. I strive to present and interpret the narratives of participants through both the etic and emic perspectives. My personal exploration of the supernatural healing and curing has uncovered varying definitions, view-points and standings that relate to healing, in the last century. However, for this dissertation, healing is discussed in relation to the South African context.

1.2 Introduction to Healing in Context

There is a differentiation between ‘curing’ and ‘healing’ and these terms need to be understood before considering religious beliefs. The term ‘curing’ is used when someone is relieved of a physical symptom or sign of a disease while the term ‘healing’ is a used to describe an experience of restoration and manifested wholeness and wellness that is spiritual and intangible, which involves the body, mind, spirit and soul (Young & Koopsen, 2010). The focal point of this study is the healing and restoration of

hearing and not the 'curing' of hearing even though participants in this study might have used the term 'cure' in their narratives.

The need for an understanding of multicultural practices of treatment options and management methods is imperative in our diverse society in South Africa. The objectivity and impartiality of the audiologist plays a significant role in the outcome of the rapport and progress with the individual with a hearing loss. Evidence is clear, that a successful treatment plan for hearing impaired individuals in South Africa cannot repudiate the incorporation of cultural beliefs and practices, tradition and customs with respect to alternative healing methods. Without documented experiences of healing occurrences devoid of medical intervention, there is no supporting evidence to highlight the need to explore other methods of care for individuals with a hearing loss. The acceptance and implementation of an integrative intervention model is likely to go unpractised until there is trustworthy evidence to support the need to change within the current scope of practice.

'*Good health or a healthy individual*'(Boorse, 1975) is difficult to define as all individuals have some form of abnormality, even on a minor level such as tooth decay. Health is described as:

> *The kind of health that men desire most is not necessarily a state in which they experience physical vigor and a sense of well-being, not even one giving them a long life. It is, instead, the condition best suited to reach goals that each individual formulates for himself. (Dubos, 1987, p. 278)*

As audiologists, we can however candidly say that we classify an individual as *healthy* if there is no illness or disease present. The WHO defines health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*(WHO, 1995). The WHO principles of ultimate or ideal health are detailed as:

- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States.
- The achievement of any State in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.

- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.
- Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

Normality of health is determined by comparing one's state to pre-established normal values of parameters such as weight, height, blood counts, level of hormones, blood pressure and heart rate (Helman, 2014). Healing and rehabilitation are the focal points of a medical profession as the restoration of good health is the aim. The accomplishment of good health is also the aim of *'Folk medicine'* which describes any method that contrasts with the medical treatment provided by doctors in a conventional setting (Kirkland, 1992), these include traditional healers, religious faith healers and natural healers.

Science, religion and spirituality have been debated for centuries. In the early 1960's literature describes that the mixture of the scientific field of medicine and supernatural healing as 'that dangerous field, placed between theology and medicine, that no one has dared thoroughly to explore' (Bonser, 1963).

There are limitations to scientific information hence the exclusive reliance on science to make sense about humanistic behaviour is like "asking Siri on my iPhone to cry for me when I get lost" (Kim, 2015). Scientific knowledge has a pertinent place in the understanding of the world however human behaviour has an equal place. Patient assessment and management have traditionally focused on the scientific medical model of detecting and curing a disease, facilitating a narrow focus on the physical needs, without considering the patient holistically (Segal, Gerdes, & Seiner, 2010). Patient care however operates both in the temporal and the spiritual realms (Bramadat, Coward, & Stajduhar, 2013). The spiritual aspect of patient care is argued by some researchers as alternative practices, while others see it as complementary to the temporal management of the patient (Blanchette, Imamichi, & McLean, 2001). More inclusive models of patient care are becoming favourable as diversity of patients and health practitioners becomes more evident. An inclusive model of patient care is the ecological model for health promotion which focuses on the environmental causes of patient behaviour and

considers the intrapersonal factors, interpersonal processes, institutional factors, community factors and public policy (McLeroy, Bibeau, Steckler, & Glanz, 1988).

Medical care is beginning to reclaim the spiritual roots that were initially a vital aspect of patient care (Puchalski, 2001) thereby amalgamating the medical aspects as well as the psychosocial aspects of the individual being treated. The sociology of healthcare and human development is significant in the management of patients as areas such as illness, current social changes and health are considered (Clarke, 2010). Healing, spirituality and divine intervention have been explored in Psychology (Miller, 2012), Psychiatry (Incayawar, Wintrob, Bouchard, & Bartocci, 2009), Dentistry (Ayer, 2005) and in Medicine (Lee, Lin, Wrensch, Adler, & Eisenberg, 2000) however there is minimal evidence available within the field of Speech Therapy and Audiology. Research indicates that every culture has a history of some form of healing practices (Moses, 2011) so we can assume that hearing impaired individuals are seeking alternative care even though individuals do not explicitly provide this information to the audiologist.

1.3 Summary

My personal reflections and outlook have been the driving force in the pursuit of this study. My unique and particular experiences shaped my decision to endeavour to complete a study in an area that is uncomfortable to most healthcare service providers. Science and spirituality are not isolated entities and their symbiotic relationship is greater than researchers wish to acknowledge. My attempt to illustrate the interconnectedness of the supernatural realm in the lives of individuals with a hearing loss is the beginning of future contributions of studies that follow suit. Healing is multidimensional and its effects on the individual's life cannot be calculated. Therefore, this study focuses on the narratives and lived experiences and not the scientific proof of healing. The concept of healing is changed and modified by the individual's experiences within a specific context. The South African context is by far one of the most well-known in the world due to history of segregation, apartheid and oppression. The historical influence of religion is substantial in shaping the current state of affairs in South Africa. This study is based within the unique and diverse South African context therefore the ensuing chapter two illustrates: The role of this research within the South African Context.

Chapter 2: The Significance of this Research within the South African Context

2.1 Introduction

South Africa forms part of the geographical landscape within the continent of Africa. The country is infamous for its unique history of apartheid which led to political oppression, racism, inequality and chastisement (Maylam, 2017). The commencement of the struggle towards democracy cannot be dated however the official demise of apartheid in South Africa began in 1994 with the election of president Nelson Mandela (Coombes, 2003). The years leading up to 1994 saw key events such as policy implementations, freedom fights and boycotts that moulded the current South African climate in 2017 (Maylam, 2017). It is with this context in mind that this study needs to be understood. The current study is in the field of Audiology within the health sector of South Africa however it is impossible to understand the current situation without delving into the history that shaped the present health sector within a vibrant new South Africa in 2017.

The colourful and difficult history of South Africa and her people is documented from the effects of the western invasion and colonisation of the South African land and indigenous populace at the time (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Maylam, 2017). South Africa's history of apartheid, which means *apartness* in Afrikaans (Kothari & Mehta, 1984), is complex and multi-faceted. The facets that either shaped or were shaped by apartheid include religion, politics, education, liberation, economics and inequality through racial segregation (Bond, 2003; Coovadia et al., 2009; Maylam, 2017; Price, 1986). The following sub-sections will present a summarised view of the history of South Africa that has shaped the current state of affairs. Despite the major influence of apartheid in South Africa, the researcher chose not to present South Africa's history with sub-sections that refer to pre and post-apartheid as South Africa existed as a country that was full of potential prior to it being 'found' by European settlers in the 1400's. The researcher cannot argue that the English and Dutch literature about South Africa became more prolific since the 1400's and there are more references to support research findings post-1400. Nevertheless, it must be noted that archaeological findings in South Africa date prehistoric rock illustrations back to 30 000 years B.P (Before Present) (Wendt, 1976). We may not be able to understand and reference the knowledge within these rock illustrations for research purposes however there is evidence that some form of knowledge sharing had transpired from one generation to the next pre-1400. The San and Khoi-Khoi inhabited the geographical region of South Africa millennia before the European settlers 'discovered' the country (Smith, 1990).

The presentation of the history of South Africa in this study will follow a date timeline from the 1400's due to the sequence of documented dynamic changes and influences available.

2.2 South Africa: 1400 - 1700

Bartolomeu Dias, a Portuguese sailor, was the first explorer in 1488, to document his findings of his 'discovery' of South Africa (Clarke, 1973). The need for a quicker sea route to the Far East, namely India, was the premise for the exploration route around the present Cape Town (Clarke, 1973; Curley, 2012). The spice trade between Europe and Asia via the Cape route, by The Dutch East India Company (DEIC) between 1488 and 1652 was the process that ignited the colonisation of South Africa (Curley, 2012). In 1952 Jan van Riebeeck a commander within the DEIC, establishment a Dutch fort at the Cape. The fort was built to provide rest, shelter and food for passing Dutch sailors on route to India (Colony, 2017; Curley, 2012; DeVilliers, 2006; Hall, 2006). The concept of the fort was based only as a refreshment station for passing ships. Food and supplies were brought in from Europe and this process became a burden as the trade route increased in popularity. The DEIC decided to relocate Dutch farmers called Free Burghers to cultivate the land which was occupied by the indigenous Khoi-Khoi populace (Hayden, Hopkins, Macrea, & Beighton, 1980).

The farmers grew in number and were expanding their farms despite the end of their contracts with the DEIC, they were now infringing on more land from the Khoi-Khoi (DeVilliers, 2006; Maylam, 2017). The farmers became permanent residents in the Cape as the DEIC granted them independent from their contracts. The Dutch farmers were joined by German and French nationalities who began to inhabit the Cape (Johnson, 2007) as these individuals fled from Europe. Jan van Riebeeck who controlled the area at the time, brought in slaves from the Far East, namely India, Malaysia, Indonesia to work for the European occupants in the Cape (Colony, 2017; Johnson, 2007). The history of settlement in the Cape, with its already diverse population of Dutch, French, German, Eastern and African decents, led to the formation of two unique groups of individuals who were called the Cape Coloureds and the Cape Malays (Davids, 1990; Mason, 1991). The present day South African Afrikaans White race group is an outcome of the original Dutch settlers (Johnson, 2007) with the inclusion of the interracial children from the slaves and the Dutch inhabitants. The first political figure, the Governor of the Cape settlement, was Simon van de Stel who was of mixed-race (Young, 2016). The Dutch farmers brought with them the belief systems that were inherited from the Calvinist Reformed Church of Netherlands (van Wyk, 2016). The significant influence of Calvinism in South Africa will be explored in later texts of this study.

2.3 South Africa: 1700 – 1900

South Africa's population began to grow and diversify further after the British influence in 1795. The British seized the Cape through European political circumstances between the French and the Dutch (Ashkanasy, Trevor-Roberts, & Earnshaw, 2002). The control over South Africa changed hands again the early 1800's when the Dutch reclaimed the country however after 1806 the British were in control again. The British however allowed the Cape colony to remain and function under the existing Dutch structures, which created an identity-independence from the British Empire as a whole (Bradford, 1996). This set in motion the establishment of Roman-Dutch identity within the South African context. Conflicts arose between current occupants who were the Dutch descendants (Dutch-Mixed race group who are ancestors of the present Afrikaans White race) and the British in 1806, due to the banding of the Dutch language in South Africa (Etherington, 2014; Van Rooyen, 2000). The animosity grew between the two groups which resulted in the Dutch descendant faction (Voortrekkers), of the white population in South Africa at the time, breaking away and migrating to inland areas of the country (known as the Great Trek) (Van Rooyen, 2000). In the 1820/30s the British inhabitants, the 1820 Settlers, in South Africa grew as a results of forced relocation from Britain (Mesthrie, 2002).

The influx of the British led to further exploration and domination of South Africa, namely Natal along the coast, due to the landscape which was ideal for a sea port (Mesthrie, 2002). The Voortrekkers and the British discovered more indigenous inhabitations as they explore South Africa. They encountered the Zulus on the Natal coastlands and the Xhosas inland (Afọlayan, 2004). The movement of the Voortrekkers away from the British did not lessen the hostility within these white population groups (Ashkanasy et al., 2002). The Voortrekkers became increasing agitated with the British language law changes; it affected the original Dutch influenced religious beliefs, schooling, justice and governance in South Africa (Afọlayan, 2004). Apart from the hostility resulting from linguistic factors, the British ruled to abolish slavery in 1838 in South Africa, to the disfavour of the Voortrekkers (Davenport & Saunders, 2000).

The next South African era was affected intrinsically and extrinsically by two wars (First and Second Boer War, Crimean War, Bapedi Wars), friction (Great Fish River clash, Battle of Blood River) and the signing of treaties and legislation. The fight for land and dominance became the secondary reason for friction after the discovery of diamonds in South Africa in 1867 (De Kiewiet, 1966). By the late 1800's South Africa was producing 95% of the diamonds in the world. The primary rationale for land ownership was the resources available within the land (Williams, 2011). The discovery of gold in the

Transvaal in the 19th century highlighted the lucrativeness of becoming a White inhabitant in South Africa (De Kiewiet, 1966). Gold and diamond seekers from all around the world started to relocate to South Africa in hope of finding these resources. Mines and industries were built, jobs were created and the infrastructure developed as a consequence of the gold rush (Marks & Rathbone, 1982). The economic and investment shift began in South Africa at this point. Industrialisation in South Africa also led to the revitalised friction in 1899, between the British and the Voortrekkers (Boers) as the British demanded that the white foreigners (who were brought into the country as labourers) were allowed to vote (Marks & Rathbone, 1982; Nasson, 2002; Williams, 2011) thus giving the British an advantage in numbers. The British demands evoked the second Anglo-Boer war.

2.4 South Africa: 1900 – 1989

The second Anglo-Boer war resulted in the deployment of British troops to South Africa from the British colonies around the world (Van Heyningen, 2009). The war took many lives and allowed for an internal conflict to grow within the black South African population, as they were coerced by the Voortrekker Boers and the British, (Claassen, 1999) to take sides in the war (Warwick, 1983). Disease, illness and death became numerous in the concentration camps during the war (Van Heyningen, 2009). The signs and symptoms of 'white-on-white' apartheid was evident however apartheid did not fully manifest itself due to the peace treaty (Treaty of Vereeniging) that was signed between the two white groups, in 1902 (Davenport & Saunders, 2000; De Kiewiet, 1966). The birth of formalised South African legislation, treaties and decrees occurred at the Union Buildings in Pretoria in 1925 (De Kiewiet, 1966; Maylam, 2017). The union of the different White 'owned' areas then formed the Republic of South Africa which was headed by Louis Botha and Jan Smuts (Robert, 2008). The Voortrekker Boers preferred their own Afrikaner leader and formed the National Party (NP), in turn electing Barry Hertzog as their leader in 1914 (Claassen, 1999; Sussman, 2006). The word 'apartheid' was recorded for the first time in a speech by Jan Smuts in London in 1917 (McClintock & Nixon, 1986) and he became the South African Prime Minister two years later. The power shifted from the British rule to a White Afrikaner National Party (NP) rule in 1924 and the population in South Africa were categorised into racial and ethnic groups under NP rule (Beinart & Dubow, 1995; Coovadia et al., 2009; Davenport & Saunders, 2000).

Changes began with the implementation of a series of legal policies related initially to segregation then to apartheid in South Africa. The racial and ethnic divisions that were mandated by policy, led to key events in South Africa. The history of South Africa between 1924 and 1994 played a significant role in

the formation of the New South African Republic. Table 2.1 provides a detailed timeline account of policies and the changes that occurred in South Africa under apartheid rule. The table also provides a systematic flow of the significant events and people who shaped the history of the South Africa of today.

Table 2.1 Detailed Timeline Account of Policies and the Changes that Occurred in South Africa under the Apartheid Rule.

Year	Policy or Significant Meetings	Significant People, Outcomes and/or Events
1913	**Land Act**	'Petty Apartheid' Act of the segregation based on racial discrimination (Clark & Worger, 2016; Lipton, 1986).
1943	**The establishment of the African National Congress Youth League (ANCYL)**	Leaders of the ANCYL included: Walter Sisulu, Nelson Mandela and Oliver Tambo (Beck, 2013)
1947	**The Three Doctors Pact**	Naicker, Dadoo and Xuma connected the African National Congress (ANC), the Transvaal Indian Congress (TIC) and the Natal Indian Congress (NIC) (Digby, 2007; Flint, 2006).
1948	**Afrikaner National Party (NP) won the Elections to govern South Africa**	NP leader DF Malan immediately implemented apartheid policies after the elections. The proposed the ideology of apartheid became a reality under the NP leadership. The only association black people were allowed to have with white people, was being a servant discrimination (Clark & Worger, 2016; Lipton, 1986).
1949	**Prohibition of Mixed Marriage Policy** **The ANCYL overthrew the conservative leadership of the ANC**	The Act was established to keep the racial groups separate without the opportunity to have interracial families. (Clark & Worger, 2016; Jacobson, Amoateng, & Heaton, 2004) The ANCYL combined advocated for mass campaigns which were designed to pressurise the government in number. Open defiance and resistance was advocated. Riots, strikes, boycotts and protests were planned (Carter, 1963).
1950	**Group Areas Act**: 'Grand Apartheid' and political separation replaced 'petty apartheid' and segregation (Goldberg, 1993). South Africa was partitioned and people were segregated into racial groups and placed into specific areas.	Geographic separation of race groups was a political tactic by the NP to claim ownership of the land. 'Whites Only' signboards were placed on beaches, parks, transportation, buildings, hospitals, schools and universities.
	Immorality Act	This Act played a role in forbidding interracial families and the mixing of religious beliefs. Sexual relations with someone of a different race was a criminal offence (Sisk, 2017).

	Population Registration Act	Identity cards for everyone over the age of 16. Race was stipulated on the cards to enforce segregation (Posel, 2001).
	Suppression of Communism Act	This Act was established as the ANCYL become more pronounced in determination and vigour. Nelson Mandela, Walter Sisulu, Albert Luthuli and other ANC, Indian Congress and Trade Union Chiefs were vetoed under this Act. They were banned from public meetings and confined to their homes and surrounding areas (Clark & Worger, 2016). Banning of the South African Communist Party and anyone who the government labelled as 'communist'. Punishable by 10 years in prison
1951	**Bantu Building Workers Act and Native Services Levy**	White employers were forced to pay for proper housing structures for black workers in white cities (Lipton, 1986).
	Prevention of Illegal Squatting Act	Shackland slums were abolished to stop black individuals from residing close to the cities (Dixon & Reicher, 1997).
	Bantu Authorities Act	Bantustans was the premise, so a separate government structure for Black was formed. Within the 'reserves' there was the establishment of tribal authorities of chiefs and headmen. The leaders were however required to form part of the Afrikaner National Party and failure to comply meant a discharge from service (Ntsebeza, 1999).
1952	**Pass Book Law**	Non-White individuals were resisted in movement and were not allowed onto the streets after dark. They needed to carry the pass at all times (Jenkins, Niparko, Slattery, Neely, & Fredrickson, 2004). ANC, South African Indian Congress and the Coloured People's Congress gathered
	Joint Planning Council Meeting	The result of the joint planning council demanded that DF Malan repeal current legislation, with no avail. The Defiance Campaign was launched and government was forced to relax its apartheid legislation (Lodge & Nasson, 1991). In December 1952: Nelson Mandela, Walter Sisulu and 18 others were tried under the Suppression of Communism Act (Clark & Worger, 2016).

1953	**Reservation of Separate Amenities Act**	Public amenities were not to be used interracially. The façade of separation was removed as it became lawful that people of different races are treated unequally (Durrheim & Dixon, 2001).
	Bantu Education Act	Education that trained Black people to work as subordinates to White people. Mission schooling which was of equal stand for all race groups, was replaced with the unequal and inferior Bantu Education system (Shepherd, 1955).
1954	**Native Resettlement Act**	Containing the movement of Black people into the cities.
1955	**The Congress of the People was held in Kliptown to accept the Freedom Charter that the ANC had approved. The Freedom Charter presented the vision of a just and non-discriminatory racial society** (Hudson, 1986)**.**	The Congress was almost concluded when the police stated that they suspected treason and they recorded all the names of the people who were present.
	The Black Sash was formed	An organisation of white women who fought against the removal of Coloured voters from the Cape voters roll (McClintock, 1991).
1956	**Riotous Assemblies Act**	The government prohibited disorderly gatherings to avoid meetings that were assumed to be a threat to governance (Kahn, 1943).
	The Federation for South African Women was founded by Lilian Ngoyi and Helen Joseph	On the 9th August the women marched to the Union Buildings to protest against the Pass Law (Walker, 1991).
1959	**The Pan African Congress (PAC) was established from disgruntled ANC members** **Bantu Investment Corporation Act**	Capital was transferred to the homelands to create jobs and infrastructure with the premise that black people and the homelands will in the future be cut off from South Africa (Blausten, 1976).
	Extension of University Education Act	Separate Universities with different stands were established for each race group. Students could enrol at universities that were not allocated to their own race group. This became the breeding ground for student activism with educated, socio-economically similar, like-minded and determined individuals (Carby, 1992).
	Promotion of Bantu Self-Government Act	Separate territorial governments in the 'homelands' which were on the outskirts of the country. The plan was to exclude these homelands from South Africa in the future so the support for their own government was evident (Waetjen, 1999).

1960	**1960 Referendum of Independence from the British Commonwealth. The Republic of South African was established.**	
	Sharpeville Massacre	The PAC called for a black demonstration and crowd gathered outside the Sharpville police station. The police opened fire on the crowd, killing 69 and injuring 186 people. The police stated that the crowd had trampled down the fences and damaged property therefore they opened fire (Matthews, 1989).
	The Banning of the ANC and the PAC	The Sharpville Massacre led to the government decision to ban the ANC and PAC however it also led to the approval of Mandela's Guerrilla Tactics Plan (M Plan). In 1961 the militant tactics were adopted by the ANC (Johns, 1973).
	Unlawful Organisation Act	This Act outlawed certain groups that the government deemed to be a governmental threat
1961	**Coloured Peoples Communal Reserves Act** **Urban Bantu Councils Act:**	The Urban Bantu Act was a way to curtail the birth rates by keeping the men away from the families. Men were allowed to work in the urban areas however the women and children must stay in the homelands (Brown, 1987).
	In December 1961 the first, ANC M-Plan under the MK military wing, sabotage occurred. There were many other sabotages that followed	Lilliesleaf in Rivonia became the headquarters for the underground ANC. The banned ANC called for negotiations between different ethnic groups (Houston, 2004). Umkhonto we Sizwe (MK) planned to sabotage tactical state structures.
1962	**Sabotage Act**	August 1962 saw the arrest of the Nelson Mandela
1963-1964	**Lilliesleaf was raided and many MK and ANC leaders were arrested in July.** **The Rivonia Trial then began in October.**	Some of the individuals arrested included Govan Mbeki, Walter Sisulu and Ahmed Kathrada. In 1964, eight were found guilty for terrorism, sabotage and planning to use guerrilla warfare to invade the country. Goldberg was sent to a Pretoria prison and the remaining seven were exiled to Robben Island. The Lawyer Bram Fisher was soon arrested and tried (Dick, 2007). The Government had now shattered the activist movement. However, the International criticism of the apartheid government evoked sanctions against South Africa.

	Coloured Person's Education Act	The Department of Coloured Affairs was in control of the education system for Coloured people (Shepherd, 1955).
1965	**Indian Education Act**	The Department of Indian Affairs was responsible for the education system for Indian people (Shepherd, 1955).
1967	**Terrorism Act** **The Soweto Uprising Began** **Physical Planning and Utilisation of Resources Act:**	The aim to relocate the black people to the homelands was the driving force of the redirected resources to the homelands. The development stopped in the cities and started in the homelands (Lipton, 1986).
	The annual National Union of South African Students (NUSAS) symposium at Rhodes University saw student leaders being housed at different located based on race.	The Black students were reignited to fight the inequality that they faced on a daily basis, in all spheres of life. The South African Students Organisation (SASO) was constructed (Watermeyer, 2006).
1970	**The Black Consciousness Movement (BCM) started. The NP's apartheid policies were again challenged** **Trade Unions and the SASO under Steve Biko (a medical student) became the force behind the (BCM)**	BCM was the main organisation with sub-organisations that were formed under its umbrella to fight the apartheid system (Hirschmann, 1990).
1973	**The Black Allied Workers Union was formed illegally** **The Black Peoples Convention was formed**	Labour wage strikes began in Durban in 1973 until 1974. Black trade unions were not allowed however they were formed and they filled the gap that formed when political parties were banned (Moodie, 2002).
	Bantu Homelands Citizens Act	Black individuals were no longer citizens of South Africa but they became citizens of one of the homelands. Only four homelands accepted the 'false' independence (as they were still controlled by the apartheid government) citizenship: Venda, Bophuthatswana, Transkei and Ciskei.

1974	**Afrikaans Medium Decree**	This policy was despised, especially due to Afrikaans being the 'language of the oppressor'. The use of English and Afrikaans on a 50/50 basis outside the homelands.
1976	**School strikes and boycotts in Soweto began and continued until 1977** **June 16th -18th Strike in Soweto** **The death of Steve Biko**	June 16th: Police opened fire on protesting students in Soweto and 23 were killed. Overall there were over 200 deaths in the region. Steve Biko was arrested in August 1976 under the Terrorism Act and died in prison September 1977 under police brutality. All BCM activities were thereafter prohibited by the Minister of Justice (Wilson, 2012).
1977-1980	**The lack of medical care given to Steve Biko and the growing international irritation with Apartheid lead to disconcerted global population.** **Beyers Naude left the Dutch Reformed Church who were pro-apartheid and formed the Christian Institute that brought black and white people together. Beyers Naude was often detained for his criticism of apartheid. He became a general secretary of the South African Council of Churches (SACC)**(De Villiers, Weisse, & Anthonissen, 2004)**.** **In 1979 Black Trade Unions were legalised: FOSATU and COSAS. Principles were based on The Black Consciousness Movement** (Maree, 1985)**.** **Local white and international pressure started to build on the apartheid government. South African products and**	Foreign countries started to impose stricter sanctions on South Africa. The United Nations Organisations imposed an arms embargo. Trade Union solidarity created a strong force and voice against apartheid and inequality. The young black populous in South Africa became more fervent in a stance that 'liberation before education' White voters (15%-20%) voted for the Liberal Progressive Party with Helen Suzman (Hackland, 1980). Helen Suzman publically criticised apartheid and played a role in permitting a public stand against the apartheid government. The South African Communist Party led by Joe Slovo , writers namely Breyten Breytenback, Andre Brink and Alan Paton apposed apartheid (Wieder, 2013). Internationals sporting federations in Cricket, Rubgy and Tennis began to ban and boycott South African interaction. This was difficult for a country that was proud of their sporting ability (Booth, 2003). International cultural figures, entertainers, actors and singers began to publically criticise the apartheid government.

	trade was banned or restricted. Participation is sporting events were affected. Ordinary people in countries around the world protested publically against South Africa.	
1982-1984	**School and Work boycotts**	There was a large number of strikes in 1982 (Marais, 2001) estimated to be around 394 strikes with 141571 workers in 1982. In 1984 South Africa experienced the longest and biggest stay-away (Clark & Worger, 2016). There were 469 strikes in 1984.
1985-1986	**The government declared a State of Emergency** **COSATU was formed**	1985: A meeting was held between white business leaders and ANC leaders in Zambia which brought about the formation of COSATU. In 1986 a fight against apartheid led by COSATU, further strikes were held. The lack of skilled white labourers forced the government to education Black, Coloured and Indian individuals (Marais, 2013).
	The Swedish Prime Minister Olof Palme supported the ANC in his keynote speech against apartheid	The Swedish PM stated that apartheid must be eliminated as it cannot be reformed. Olof Palme was murdered a week later (Nussbaum, 2004).
1989	**The Mass Democratic Movement (MDM) was formed between COSATU and the UDF.**	The MDM arranged campaigns and marches against the segregation of hospitals, schools and beaches.

The literature presented in the timelines above is a collection of the key major events that shaped the New South Africa. The context of a research study plays a significant role in the understanding of the underpinnings that have framed the findings of the study. This study focuses significantly on religion within the supernatural occurrences therefore it is incumbent to take the reader, as an explorer in this study, thorough the deeper religious influences in history of South Africa.

2.4.1 The Role that Religion (Christianity) Played in the History of South Africa

Critics and social analysts in the 1970's and 80's were unable to understand the South African dynamics at the time, due to the lack of religious inclusion (Enquist, 1979). Social scientists payed little attention to religious forces of Christianity, beliefs and theology when analysing the social forces that shaped South Africa (Gruchy, 1986). The lack of the inclusion of the role of the Church in South Africa in the 1980s appeared 'strange' as one sector in the church was pro change and one sector appeared to do everything in its power to stop the changes that democracy would bring (Gruchy, 1986). When delving into the religious history of South Africa, Calvinism and its effects on apartheid is a popular documented belief (De Gruchy, 1986; Du Toit, 1985; Gruchy, 1986; Moosa, 2000; van Wyk, 2016).

Calvinism is a theological tradition that emphasises the power of God that works in the world (politically, socially and economically) (Gruchy, 1986). John Calvin was a Christian theologian whose interpretation and teachings of the bible became a denomination of Christianity after his death. In the 17th century (1917) the Synod of Dort in the Netherlands determined the true marks of Calvinism. The Dutch settlers in the Cape belonged to the Reformed Church of Netherlands and they brought with them the doctrine of election under Calvinism (Gruchy, 1986).

The Calvinistic doctrine appeared to have undergone many modifications that were based on the changing religious, political and social situation in the world. Various forms of Calvinism arose from the modifications; a single principle of Calvinism was used as a foundation for most sects of Calvinism thereafter additions were made that were not originally included in John Calvin's theology. Writers in the 1970s and 1980s indicated that the evolution of Calvinism, in all probability, would not be owned by Calvin as it differed greatly from his original thoughts, he never intended for his theology to become a denomination in Christianity called Calvinism (De Gruchy, 1986; Du Toit, 1985). Dutch Calvinism was a modified form of the original doctrine and literature

argues that it is not a faithful representation of the novel theology of John Calvin (De Gruchy, 1986). The Gereformeerde Kerk was founded in South Africa in the 1860s and this church sect was faithful to Calvinism and took theological direction from Abraham Kuyper (1837-1920) for the interpretation of the belief (De Gruchy, 1986). The Dutch Reformed Church, in South Africa is another White Afrikaans Calvinistic denomination of Christianity, without the Kuyperian influence (De Gruchy, 1986; Du Toit, 1985).

It is a superficial to view Calvinism as the only driving force of the Afrikaner individuals who shaped apartheid (Du Toit, 1985). One argument against the roots of Calvinism being the only driving force behind the apartheid belief, is the inherent belief within a nation, to think that they are on a 'chosen, divinely ordered mission' (van Wyk, 2016). Hence domination of land and resources still occur in the present era, racial oppression dictated the domination in the past with different variables dictating oppression in the current era. Afrikaner Calvinism is not akin to the principles and beliefs of an authentic Calvinistic tradition that was evident in the primitive Trekboers (Du Toit, 1985). The religious influences in South Africa may have shaped the past and will continue to shape the future; therefore we should not ignore this vital component in all aspects of life.

2.5 South Africa: 1990 – Present Date in 2017

The state of affairs in South Africa in the 1980s and 90s was a consequence of the apartheid regime that was based on the economic, ethnic and religious differences amongst its diverse populous (Gruchy, 1986). The South African legacy is multidimensional and individuals who live through apartheid, regardless of age, race, religion, nationality, gender or socio-economic status have a unique perspective of the events that occurred in the history of South Africa. The apartheid governance of separation ironically became the vehicle to unite and solidify the South African Black population in its fight against inequality and oppression.

Post-apartheid the South African population became famously known as the 'rainbow nation'(Woods, 2004) due to the acknowledgement of an array of culturally, linguistically and racially diverse individuals (Afọlayan, 2004; Zuberi, Sibanda, & Udjo, 2016) who make-up the human landscape of South Africa. The estimated population statistics in 2015 indicated that approximately 54 960 000 individuals reside in South Africa (Africa, 2015). South Africa encompasses nine provinces with four predominant racial groups, namely the Black African

(80.5%), Coloured (8.8%), Indian/Asian (2.5%) and White (8.3%) (Africa, 2003, 2015). The life expectancy for persons in South Africa was estimated to be at 62 years in 2015 in comparison to 52 years in 2010 (Africa, 2010, 2015). The increase in life expectancy over the last 5 years can be attributed to the implementation of the social development initiatives that have targeted macro-economic stability, increased access to basics service such as electricity, water, social security and healthcare services (Fedderke, 2006; Triegaardt, 2014).

Despite the initiatives of empowerment and upward mobility of the previously disadvantaged individuals in South Africa, the country has a long road ahead in terms to true equality and the fair distribution of resources. The journey from segregated oppression to apartheid, leading to democracy with freedom has impacted the service provision in South Africa, across all sectors. The progress towards equality in South Africa continues as the decolonisation of the systems are tackled at present (Sisk, 2017). The apartheid South African government did not foresee the abolition of apartheid; hence the infrastructure capacity was proportionate to the white race only. Democracy highlights this point as there is a shortage of housing, education, jobs and a struggling economic and health system, despite the freedom afforded in 2017.

Globalisation has led to the integration of diverse people, economies, cultures and political practices (Midgley, 1997) around the world. The last decade has seen the complexities of globalisation due to the advances in technology, trade and communication (Triegaardt, 2014). The global trend to increase social development and social security had an effect on the emerging democracy in South Africa post 1994. The South African Constitution that was established post-apartheid, prioritised for a just and equitable society (Constitution & Devenish, 2005). The fair distribution of wealth is not a linear process; it is a long term dynamic and conscious process within all sectors of the country (Lombard, 2014). The World Bank classifies a country based on the wealth of a country in relation to the disparity between the rich and the poor within the population (Bank, 2015). In 2012 South Africa was rated as a country with unequally economic balance in society however in 2016 the World Bank stated that a turning point in the economy of South Africa is possible (Bank, 2016). This slow turning point may be the steps of change that was predicted in 1994, a change towards a more integrated and fair society. A prediction for a society that may not have an equal distribution of wealth; however one that allows for the equality opportunity to gain wealth and education. There are nevertheless mixed reactions and thoughts about the progress of change in South Africa.

Literature also indicates that there is are growing discrepancies between the rich and the poor in the South African population regardless of the macrosocial positive changes that have occurred (Lombard, 2014).

Social development and progress towards the fair distribution of wealth that focused on equality; access to food, water and electricity, was evident in the early stages of democracy within South Africa (Fedderke, 2006). Absolute poverty has been reduced in South Africa after the introduction of planned social change, as the government social grants were introduced to support poor and disabled individuals (Mayosi & Benatar, 2014). The social grants in South Africa attempted to bridge the poverty gap created by a corrupt apartheid government. Social grants aim to promote social cohesion, inclusion and integration within a society (Patel, 2016) and the Mandela regime began the process of social change.

Social support was able to decrease absolute poverty however relative poverty has become worse as the top 10% of the South Africans still earn 58% of the total national annual income (Chirinda & Zungu, 2016). The inequalities in wealth distribution and unemployment has led to the rich getting richer and the poor getting poorer, the result of being poor is the limited access to health care, food and the increased susceptibility to illness and disease (Blustein, Franklin, Makiwane, & Gutowski, 2017; Fields, Cichello, Freije, Menéndez, & Newhouse, 2003; Triegaardt, 2014).

Apartheid dictated through policy that well-funded and established healthcare service delivery and education remain restricted to the minority White race group in South Africa pre 1994 (Bond, 2003; Price, 1986) while poor services if any were provided to the majority of the population who were Black African and Indian/Asian.

Access to healthcare in South Africa has improved post-apartheid; however the increased burden on the public healthcare system, that was not equipped for the influx of patients, has placed many hospitals in a state of crisis (Von Holdt & Murphy, 2007). Poor infrastructure, underfunding and mismanagement are the causes of a burdened healthcare system in South Africa (Von Holdt & Murphy, 2007). Patients have better access to healthcare however the effectiveness and quality of healthcare is under scrutiny in the South African context (Moonsamy, Mupawose, Seedat, Mophosho, & Pillay, 2017). The South African healthcare system is plagued by a higher burden of disease within a growing population, who depend upon a struggling healthcare system with a lack

of doctors (Coovadia et al., 2009; Harris et al., 2011; Mayosi & Benatar, 2014; Von Holdt, 2010). South Africa has incurring the highest costs to train medical doctors at the greatest loss of investment as the locally trained doctors emigrate (Mayosi & Benatar, 2014). The influx of people migrating into South Africa adds to the overburdened healthcare infrastructure and services (Vearey, 2014). The prevalence of diseases and virus such as tuberculosis and HIV/Aids in South Africa has burdened the healthcare system.

Democracy has afforded equal access to resources however there is still a lack of cohesion between people in South Africa. The focus on westernisation has negated the significant influence of the diversity in culture, religion and spirituality in South Africa. The medical model focuses on the development of western medicine and procedures, however the global trend towards the acceptance of diversity, calls for a healthcare model that integrates areas of diversity into the healthcare service provision. The diverse South African population requires a healthcare model that allows for the inclusion of factors that represent South African languages, culture and beliefs.

2.6 Summary

The history of legislated segregation in South Africa has led to distrust and a lack of tolerance between the different cultural and racial groups. The foundations of the laws in South Africa favoured a specific religious belief system and negated to incorporate the diversities within the populous. The reversal of the racist apartheid legislation was the beginning of change towards a more equitable service provision in healthcare. New democratic legislation is starting to consider the social determinants that affect health and the practical implementation of the laws (Mayosi & Benatar, 2014) within the diverse South African context. The democratic South Africa is still on a journey towards equality and there should be deliberate changes in the healthcare system to allow individuals to express thoughts and feelings about alternative healing methods. A need for a holistic model of healthcare is evident as it is already supported in the South African constitution (Constitution & Devenish, 2005). The current study attempted to provide evidence for the development and implementation of a holistic care model in the sector of Audiology, within the South African context. This study motivates for a shift from the current medical paradigm of healthcare service delivery towards a more integrated and holistic model of practice. The ensuing chapter discusses the theoretical underpinnings of this study.

Chapter 3: Theoretical Framework

3.1 Introduction

The theoretical framework in the current study is centred on an integrated model of healthcare in Audiology that will include the medical, psychological, spiritual and religious beliefs of the participant. The current study was conceptualised from a need to change and transform the current medical model structures of assessment and management methods in Audiology to a more integrated and holistic healthcare model. The long standing medical model approach has been adopted by audiologists in South Africa and is no longer beneficial to all areas of healthcare. The patient dynamics have changed over the past 20 years in South Africa; therapists and patients were usually from the same culture and race in the past as a result of the apartheid segregation regime. However, the abolition of apartheid in South Africa has resulted in a diverse therapist and patient complement. The constitution of South Africa since 1994 has necessitated the change in healthcare provision, irrespective of class, creed, race or ethnicity (Constitution & Devenish, 2005). A stand-alone medical model of care no longer meets the needs of the diverse South African population as psychosocial and spiritual aspects play a large role in the lives of many South African communities. The inclusion of psychosocial and spiritual aspects of care into medical care is becoming vital in the holistic management of patients globally.

The following paragraphs provide an explanation of the key models of healthcare service delivery that were utilised in this study, namely the medical model, the biopsychosocial model and the biopsychosocial-spiritual model. These models will be defined and explained in relation to this study.

3.2 The Medical Model

The health care of individuals has relied predominantly on fighting the disease or illness from a medical perspective (Bandura, 1998) the illness or disease is nevertheless always attached to a human being. Even though the medical model ensured that the patient was treated medically and restored to ‘good health’, the quality of life of the individual over the past 30 years has been highlighted as an area of concern (Ferrans, Zerwic, Wilbur, & Larson, 2005).

3.2.1 International Classification of Functioning, Disability and Health (ICF)

The ICF is a scientific method created in the 1980's to understand health and its related issues, outcomes and determinants. The system was devised to facilitate commonality between health care workers, policy-makers, researchers, medical professionals and people with disabilities (WHO, 2013). Despite the relevance and necessity for such a classification system to standardise the understanding of disability and its effects, the system does not cover influential factors such as religion, gender, race and socioeconomic status of persons with disabilities, in a detailed manner (WHO, 1948, 2013) . The ICF is continually utilised in the healthcare system however the service provision within this system has become dynamic and it is starting to include other facets of the patients' life into its service provision.

The holistic-patient-focused biopsychosocial models are becoming a favourable tool for the understanding and classification of individuals with disabilities as it provides a complete picture of the medical and psychosocial influences (Brown, Bonello, & Pollard, 2005). This is supported by the need to humanise medicine in the last few years as narrative constructions of illness and disease are explored (Charon & DasGupta, 2011). Audiologists build relationships and rapport with the individual with a hearing loss, during case history taking and feedback sessions through the use of narratives; however what significance do these narratives hold unless they are used to manage the individual holistically.

3.3 Integrated Models

In the medical model of healthcare, the sole focus is on the disease and the management thereof. Recent trends in healthcare provision have been shaped by more patient focussed care rather than disease focused care. These models of care include the medical, psychological and spiritual aspects of the patients' life into the service delivery process. The inclusion of religious practices and spirituality are the key aspects that differentiate between a medical model of care and the biopsychosocial-spiritual models of care. Evidence of the exploration of spirituality and healing in the medical world started to emerge in the early 1980's and a range of terminology was used synonymously during the time of exploration. Gardner (1983) provided the following terminology, when attempting to understand and document the supernatural and spiritual events that occurred in medical practice: *miracles, wonders, signs, power of God and benevolent magic* were used.

The prominent models of care that are more inclusive and holistic include Bronfenbrenner's biopsychosocial model, Bandura's social cognitive theory and the biopsychosocial-spiritual model.

3.3.1 Bronfenbrenner's Model: Biopsychosocial/Ecological Model

This research will use the ecological model as one of the main frameworks when developing a suitable service delivery model for the field of Audiology. The ecological model considers the individual, the environment and the public thus providing a complete overview of the hearing impaired individual and the external influences. Bronfenbrenner (2009) divided the environmental influences on behaviour into micro-, meso-, exo- and macrosystem levels, as per Figure 3.1.

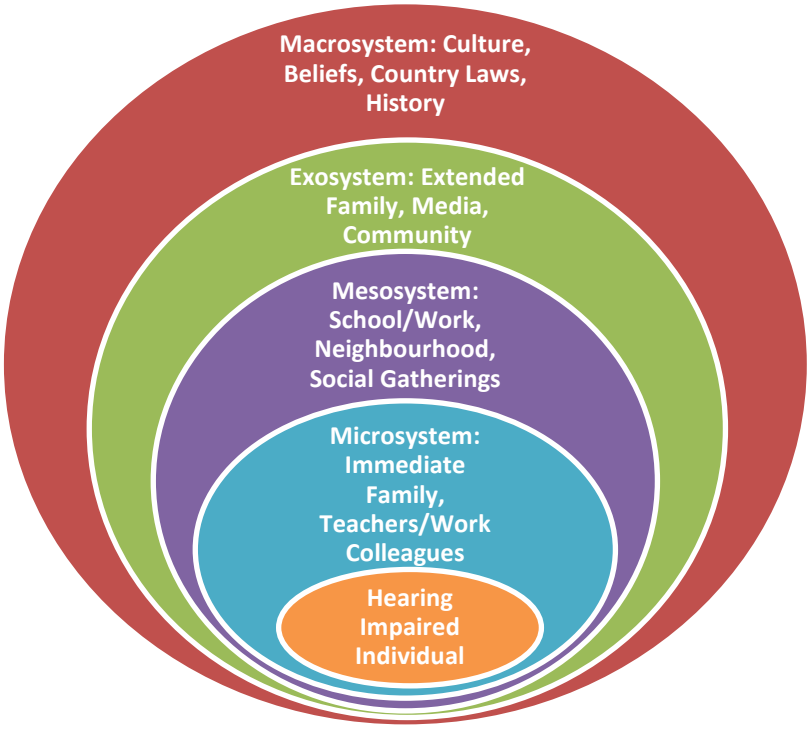


Figure 3.1: Environmental Influences on Behaviour

Holistic care in Audiology should aim to consider all aspects that influence the life of an individual with a hearing loss. Consideration of the microsystems which relate to face-to-face encounters of influence, the mesosystems which are the various settings where these interactions occur, the ecosystems which refers to forces within the various settings that have an external influence on the individual and the macrosystems are the cultural beliefs and values of the individual (McLeroy et

al., 1988). This study considered all four environmental influences with its key focus on the macrosystem of cultural beliefs, religious beliefs and values. The ecological model is essential when researching the social science contexts as behaviour is viewed as being affected by and affecting the environment (McLeroy et al., 1988). The current study is based largely on the ecological model as a framework, in addition to being detailed according to the social cognitive theory, as the relationship between the events or event leading up to the healing process are described.

3.3.2 Bandura's Model: Social Cognitive Theory

Human behaviour is shaped and moulded by internal or environmental influences however people are able to self-organise, reflect and regulate their thoughts and actions on a personal level (Bandura, 2001) hence there is a cause and effect relationship for every action or event on a personal level in an individual's life. Figure 3.2 depicts how human nature is influenced by the environment, behaviour and personal determinants.

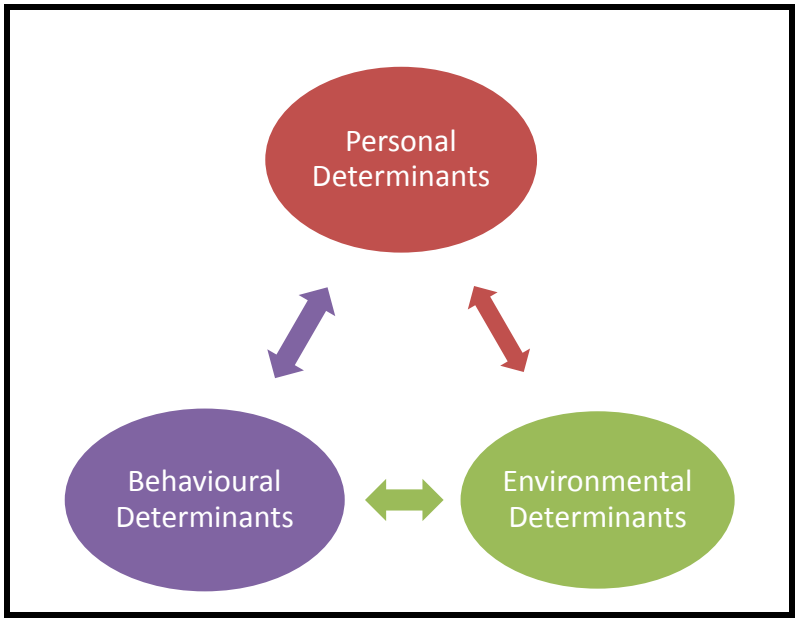


Figure 3.2: The Causal Relationship that Shapes the Human Nature (Bandura, 2001).

The causal relationship depicted in Figure 3.2 illustrates the human capacity for symbolisation which allows a person to comprehend life events and the environment to form ideas and thoughts that will affect every aspect of their life (Bandura, 2001). Various major life changing and

memorable events in the life of a human being such as births, deaths, marriages, celebrations or achievements, can shape the way life is viewed and lived but this can also be influenced by daily media including the morning news, radio or television advertisements.

Despite the changes and influences from the world, each individual has personal standards of morals and values that serve as an internal regulator for reshaping ideas or actions based on the circumstance (Bandura, 1991). Social theory models have agents that intentionally influence the individual's life; these agents could be a direct personal agency, proxy agency or a group agency (Bandura, 2002). The actions of others are role-players in decisions taken, as people very rarely influence their own lives. Hence with healing and rehabilitation there are proxy or group agents involved such as religious leaders, therapists, doctors and significant others, and these individuals play a major role in the well-being of the individual. Dewey's model of learning supports Bandura's social-cognitive theory as both indicate that new patterns of behaviour can be acquired by direct experiences of healing or through observation of healing in other individuals (Bandura, 2001; Englewood, 1984). By understanding the human psychosocial relationship, the researcher documented the narratives obtained from individuals who reported a supernaturally healing of a sensorineural hearing loss.

When evaluating and managing a patient, medical professionals should consider the patient's lifestyle, family, vocation, disease or illness, values and religious beliefs (Ferrans, 1990, 1996) in order to provide a holistic and effective service to the patient. Individual differences of values and beliefs will determine how one reacts or responds to situations; impairment may have different effects with different people based on individual preferences, values and beliefs (Wilson & Cleary, 1995). Religious beliefs and practices are the biggest influences in an individual's reactions to life events including illness and disease. Ellison and Levin (1998) postulate, that spirituality is one of the key strengths in personal wellbeing. Religious and spiritual aspects of a patient's life can be freely discussed between the healthcare practitioner and the patient during narrative sessions of case history taking and feedback session. Narrative medicine can be an effective way to acquire information about all aspects that influence the patient's life.

3.3.3 Narrative Medicine

Healthcare practitioners deal with cultural differences, emotions and social factors on a daily basis (Mattingly, 1998) and this usually challenges the medical framework that is dominant. There is a need to use the evidence that already exist within a setting with therapy discourse as rich narratives are present that could be incorporated in a beneficial manner for the patient's care. Caron cited in Kim (2015, p. 17) fittingly states that "A medicine practised with narrative competence will more ably recognise patients and disease, convey knowledge and regard, join humbly with colleagues, and accompany patients and their families through the ordeals of illness. These capacities will lead to more humane, more ethical, and perhaps more effective care".

3.3.4 Biopsychosocial-Spiritual Model

Greaves, (2002) states that the biopsychosocial model may have transformed patient care in the positive direction however the model fails to interconnect the scientific and humanistic areas such as religious practices and spirituality. Parents of Hard-of-Hearing/Deaf (HOH/D) children state that early intervention is beneficial however the excitement and joy of a new-born was replaced by anxiety related to the diagnosis (Young & Tattersall, 2007). A model that aims to diagnose a hearing loss as soon as possible in conjunction with simultaneously support for the well-being of the parents is vital. The biopsychosocial-spiritual model of care is closer aligned for holistic healthcare as it incorporates further aspects of the family life into the assessment and management of illness and disease.

Holistic care within a multidisciplinary team in the South African healthcare context consists of a medical doctor, physiotherapist, occupational therapist, speech and audiologist and dietician (Baroch, 2003). A study conducted by Sulmasy (2002) supports the holistic biopsychosocial-spiritual model of care as patients stated that they would like their spiritual needs to be considered when they are being managed by a health professional. A holistic model of healthcare should include significant role-players in the patient's spiritual community. Individuals such as a religious leaders, teachers, caregivers, best friends could be included (Balboni et al., 2007).

McLeroy et al. (1988) define 'community' in three ways, namely:

- as a mediating structure to which the individual belongs
- the relationships amongst groups in a defined area
- as a geographical term

The mediating structure of community was vital for this study as the community was a source of social resource and social identity (McLeroy et al., 1988) that is required by the HOH/ D individual. (Griffin, 2013) stated that integrated models of support and care will shape the child's future as well as the future of country as a whole.

A study conducted by Wilkinson, Gcabashe, and Lurie (1999) revealed that individuals who were diagnosed with tuberculosis (TB) were compliant with treatment resulting from the support of traditional healers within the community.

3.3.5 New Medical Cosmology

The researcher included the new medical cosmology under the section of integrated models as there are concepts within this cosmology that can add value to the development of a holistic healthcare model in Audiology. A new medical cosmology is not a different model of healthcare but it provides a wider view of medicine in comparison to the medical paradigm view that is restricted to scientific ideas (Greaves, 2002) is suggested. This view is fairly new and will gain momentum if it is feasible and if healthcare practitioners buy into the vision and are willing to change. The new medical cosmology is not a new model of healthcare but a renewed way to view healthcare. (Greaves, 2002, p. 82) describes the difference between a medical cosmology and paradigm as:

(i) Cosmology will be taken to include moral and cultural as well as scientific and technical matters (or in shorthand arts as well as sciences).

(ii) Cosmology will be used to refer to both theory and practice, whereas paradigm is principally used in relation to theory.

(iii) The historical replacement of one dominant paradigm by another in terms of "paradigm shifts" which usually take place relatively rapidly (often in a period of a few years), whereas dominant cosmologies change much more slowly, over decades or centuries.

According to Greaves (2002) the features of a new medical cosmology should include:

- Redefinition of health-related conceptions that lead to changes in the goals that are set out for better healthcare.
- Definitions and boundaries of health care and medicine, such as 'good health' and 'diseased'.
- The reconstruction of knowledge that is related to medicine as there are various influencers involved in the development thereof. Individuals who are diagnosed with a disease or illness, families, medical practitioners and society at large will provide a unique perspective that adds to the body of knowledge in medicine.
- The inclusion of healing and healer in all its forms within society. The multifaceted definitions must be included.
- Humanities being a fundamental area in medical education as the humanistic component of healthcare and patient co-operation are more significant than the diagnosis and treatment of a disease.
- The delineation of roles and responsibilities of the health practitioner verses the patient.

Literature provides the strengths and weaknesses for healthcare models that exist (Henningsen, 2015; Oliver, 2017; Sallis, Owen, & Fisher, 2015). The trend towards a holistic model of care does not remove or negate the medical aspects within the medical model of care. The additional facets that are added onto the medical model have always aimed to enhance patient care.

Figure 3.3 illustrates the modified facets that have been suggested by various authors over time.

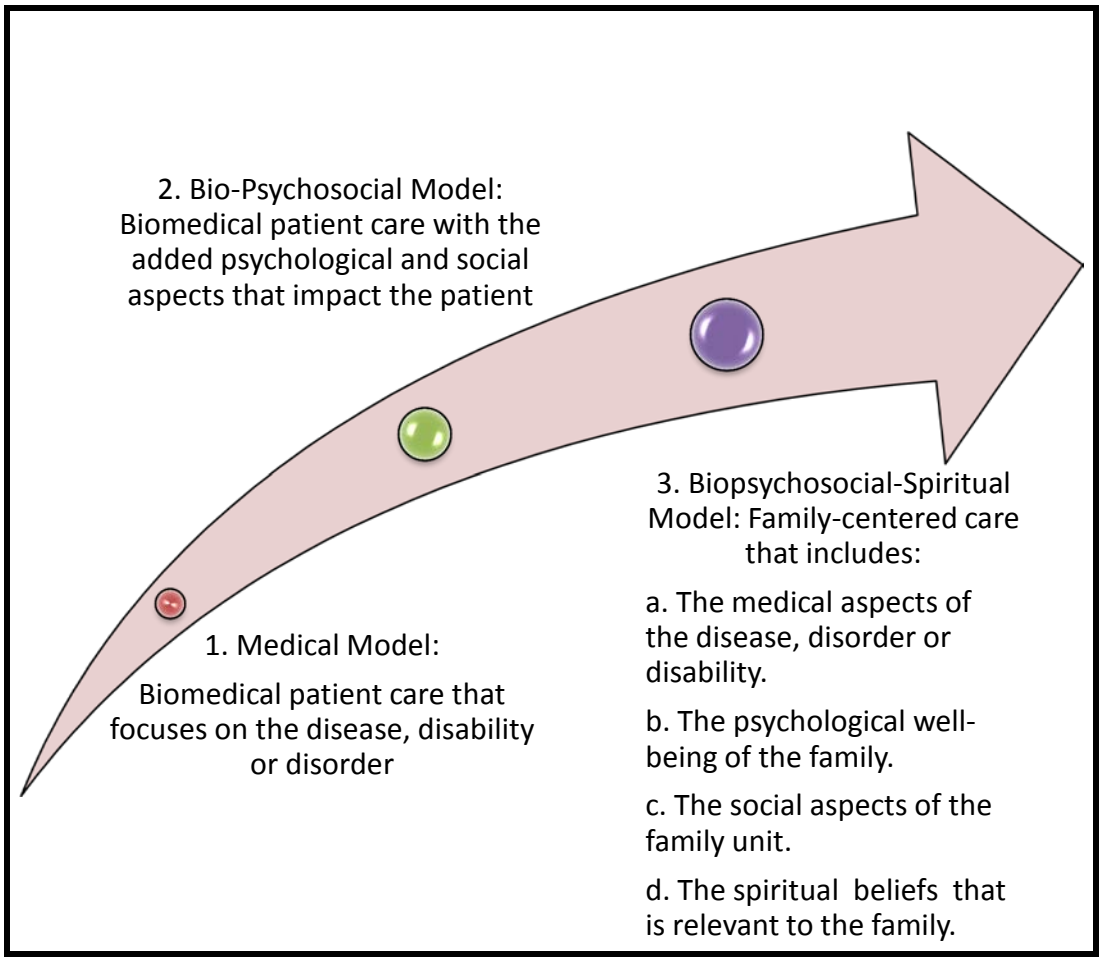


Figure 3.3: Modification from the Medical Model to the Biopsychosocial-Spiritual Model

Psychosocial considerations for the HOH/D child and family

An integrated model of audiological care may consist of the site visits (Douglas, 2014) for parents' who need to choose between a school for the Deaf, school for the disabled and a mainstream oral school. Parents seek for support from someone who would allow them to talk and not someone who wants to fix their problems (Griffin, 2013).

The expectation of 'fixing' the hearing loss needs to be discussed in detail with the parents (Young & Tattersall, 2007) to ensure the maximum capabilities of the child is realistically harnessed. In the United States of America (USA) a family resources coordinator is available to assist parents with the various decisions that are required for a newly diagnosed baby (Griffin, 2013).

Parents of hearing impaired children need someone to listen to their stories. It is necessary to provide the parents with time to understand process and discuss the decisions that will be taken and the implications thereof.

Interaction among families who also have a HOH/D child can provide encouragement and support (Hong & Turnbull, 2013). In the USA there are 'Parent to Parent' support programs and parents of children with disabilities, delays and health needs can grow and encourage each other in a holistic safe environment (Griffin, 2013). The incorporation of teachers and therapist into support programs on a regular consultative basis can be a start of an inclusive and diverse child focused model of care. Other support role players may include a:

a. *Genetics Counsellors*

The diagnosis of a hearing loss is emotionally draining and the inclusion of a genetics counsellor would be beneficial as the support will be provided to the parents from the initials stages (Douglas, 2014). Initial support for parents can ensure that well thought-out decisions are made for the benefit of the child and family. A geneticist in Canada describes how a mother gave birth to a baby who was diagnosed with Down Syndrome:

> *I met the mother in the Newborn Intensive Care Unit (NICU). The NICU paediatrician had disclosed the result the previous day. Her husband was not present at our meeting. The mother spoke slowly and alternated between tearing up and staring into space. I felt she was sad and somewhat numb. I asked how she was feeling and she answered "bad" (Douglas, 2014, p. 696).*

The child's success in life is dependent on the parents' decisions and self-esteem (Prakash, Prakash, Ravichandran, Susan, & Alex, 2013). Counselling is not a once of procedure and parents with a hearing impaired child would need ongoing support as grief can be re-activated at different stages in the child's life (Douglas, 2014).

b. *Psychologist*

A study conducted by Young and Tattersall (2007) found that parents were in a synchronous state of grief, due to the diagnosis of a disability and a state of relief at the early diagnosis. Kim and Park are parents of two Deaf boys, in a study conducted by Hong and Turnbull (2013).

These parents stated that their frustration was relieved in their faith in God despite the many enjoyable moments that were sacrificed. Parents will react to the diagnosis in a unique and personal manner and should be allowed the freedom to go through their own psychological process (Young & Tattersall, 2007).

Mothers of children who have disabilities present with higher stress levels than mothers with children who do not have these diagnose (Prakash et al., 2013). Pre and post-natal depression is evident due to the stress of having a baby (Van den Bergh, Mulder, Mennes, & Glover, 2005). The added diagnosis of a hearing loss can increase the severity of depression and the unsupported mother is left in a vulnerable state (Prakash et al., 2013). There is a need for a psychologist within the healthcare team that is involved with an individual with a hearing loss.

c. Audiologist

Financial burdens do occur when a child is differently abled (Hong & Turnbull, 2013), thus the inclusion of a social worker as a member in the team is recommended. In South Africa parents are faced with the high costs associated with purchasing hearing aids, special education and medical services (Swanepoel, Störbeck, & Friedland, 2009). Strategies to combat hearing loss and the consequential cost in South Africa has included an increase in hearing screenings, efficient management of middle ear infections, a state tender hearing aid price list which is more affordable to the individual who is not covered by the private medical aid system (Baltussen & Smith, 2012). Despite the efforts to fight against the effects of a hearing loss on the individual and the country's economy, it is evident that over two-thirds of individuals with a hearing loss reside in developing countries such as South Africa (Tucci, Merson, & Wilson, 2010). Developing countries such as South Africa have limited financial resources and strained healthcare systems that cannot cope with the increasing burden that is caused by illness, disease and disabilities. The burden of the increasing cost of assessment procedures to detect a hearing loss and the management costs of hearing aids is shadowed by the need for basics supplies of food and clean water (Kiyaga & Moores, 2003). The role of the audiologist is significant when assessing and managing an individual who is suspected of having a hearing loss. The need to holistically integrate aspects of financial burden into the service delivery is vital so that the individual with the hearing loss obtains the best possible care.

The multidisciplinary team can support the family from a medical, psychological, social and spiritual stance however families do face negative reactions from the community.

3.4 Summary

The current study aims to build on the existing models of care within the field of Audiology. There are strengths and benefits to the medical model of care however there are large voids within the models as described above. The steps towards an integrated model of care is the focus of this study as the narratives of healing experiences are documented statements of participants that use alternative means when a hearing loss exists. The documentation of these events allows the opportunity for audiologists to consider ways to include patients' spiritual and religious beliefs into the practice of Audiology. The following literature review chapter provides the reader with imperative facets that makeup the basis for the current study.

Chapter 4: Literature Review

4.1 Introduction

Traditional healing, spirituality, culture and religion are major dictators in the lives of South African individuals. There are over 80% of individuals in South Africa seek alternative methods of practice (WHO, 2001). Patient care must integrate all relevant aspects of the patient's life into the holistic management program that is provided. This current study aimed to document the lived experiences of individuals in South Africa that have sought and have been impacted by supernatural encounters that relate to Audiology. The current research aimed to obtain qualitative data with thick descriptions, analysis of narratives depended on the categories that emerged. Audiological studies have predominantly focused on quantitative normative research which shaped the strong medical model as a focus of patient care. Recently studies such as the current study have grown in popularity as the shift to holistic healthcare is developing. The qualitative thoughts, feelings and perceptions of patients and therapists have gained as much value as the quantitative measures that were previously researched.

The ensuing sections with regards to illness, disease, religion, culture, healing and spirituality are discussed as they were previously isolated from medical care despite the foundation of medical care being rooted in cultural and religious practices. There is a dearth of research into the mechanisms and experiences of deaf individuals who have experience healing through supernatural means. The lack of the inclusion of spirituality and religion in medical training and practice is one of the biggest contributors to avoidance to discuss these pertinent aspects with patients (Best, Butrow, & Olver, 2016). The growth of new age religions and healthier more spirit focused lifestyles demand a change in the manner in which hearing impaired individuals should be seen in Audiology. This study's central feature is a permanent hearing loss that is supernaturally healed therefore the literature review commences with a description of the global burden of disease, leading into the specific procedures of identification, assessment and management of a hearing loss. The concepts of culture, religion and alternative healing practices are also presented in the literature review. The need for an integration of areas such as healing, spirituality and religion into the healthcare service delivery model becomes evident at the end of the literature review.

4.2 The Global Burden of Disease and Illness

Disease is defined scientifically as a chemical, anatomical or physiological change that manifests in ill-health (Humber & Almeder, 2013). A disease becomes an illness when it has incapacitating effects on the individual (Boorse, 1975). In the scientific paradigm, diseases are abnormalities in the functioning of the body organs and systems (Eisenberg, 1977) and they are named as pathological entities such as tuberculosis, otitis media or diabetes (Helman, 1981). Disease is 'something an organ has' and illness is 'something a man has'(Cassell, 1978), thus indicating that the illness is the man's experience, perception and description of ill health while the disease is the cause of the ill health.

4.2.1 Major Illness and Disease: Causes and Contributing Factors

Cancer, HIV(AIDS), Cardiovascular disease, Ebola and Marburg fevers are some of the major illnesses to affect and destroy mankind (Ayles et al., 2009). These diseases have no boundaries or border restrictions, affecting any race, gender or ethnicity. Over the past decades infection has increased due to illegal drug usage, rapid world travel, sexual transmission and environmental decay (Karlen, 1996) consequentially affecting the good health of the population. The leading causes of the global burden of disease in high income countries are non-communicable diseases such as unipolar major depression, adult onset hearing loss and alcohol use disorders while in low-income countries there was a higher prevalence of lower respiratory tract infections and diarrhoeal diseases (Mathers, 2008). Poverty, poor hygiene and unhealthy diets are contributors to the susceptibility of the major diseases affecting the population (Spicker, Leguizamon, & Gordon, 2007) however diseases and disorders such as hearing loss, diabetes and visual difficulties may have genetic association that may be linked to a family history (Sharpe & Carter, 2006). Every disease has a prescribed regime for the healing or rehabilitation process. The individual has the choice of which healing avenue to pursue when diagnosed with a disease. Some individuals seek medical advice, while others seek alternative measures and there are some individuals who may choose not to seek any advice. Such decisions are often influenced by the individual's cultural and religious practices.

South Africa's biggest healthcare burden to date is the human immunodeficiency virus (HIV). It is estimated that 11.2% of the South African population is HIV positive (Africa, 2015). The history of

HIV management in South Africa is not a glorious one, where the denial from government with regards to the prevalence of HIV led to a slow reaction response to managing the virus in 2003 (Mayosi & Benatar, 2014) thus creating a burden on the economy and healthcare service delivery in South Africa. In relation to the current study, a hearing loss also presents a noteworthy effect on the healthcare system in South Africa.

There are a vast number of illnesses and diseases, ranging from mild to fatal outcomes of disease. For the purpose of this study, the auditory system and hearing loss are the focus areas; therefore the following sections provide a detailed discussion of hearing loss in relation to spirituality and healing.

4.3 Hearing Loss

Hearing loss the hidden disability is regarded as the number one disability in the world (Cohen, Labadie, & Haynes, 2005) thus a significant proportion of the world's population is affection directly or indirectly by this communication hindering disability.

4.3.1 The Diagnosis of a Hearing Loss

A hearing loss may be congenital or acquired. Congenital hearing loss is predominantly inherited via genetic transmission as the mother may have been exposed to drugs or infections that would have affected the foetal development (Falvo, 2013). An acquired hearing loss maybe progressive or sudden and it can occur anytime in the lifespan of an individual and may occur due to infections such as otitis media or trauma and noise exposure (Stach, 2003). A sudden hearing loss has an instantaneous onset and arises without forewarning of decreased hearing. When an idiopathic sudden hearing loss occurs, the degree and configuration will vary from person to person however the type of loss is usually sensorineural. A sudden sensorineural loss is typically secondary to trauma, viral infections, vascular, metabolic or caused by an inflammation. Additional causes of a hearing loss may include otitis media, cytomegalovirus, premature birth, noise exposure, ototoxicity amongst an array of causes (Ross & Fowler, 2008).

Universal new-born hearing screening and the early identification of a hearing loss has been a global priority in Audiology since the early 1990's (Leo, Mincarone, Sabina, Latini, & Wong, 2016; Tharpe & Seewald, 2016). The early diagnosis of a hearing loss will reduce the effects of a hearing

loss on the speech and language development of a child, thus having a positive impact on the country holistically. The time delay between the parental suspicion of a hearing loss and the diagnosis of a hearing loss is still a concern for the South African audiologist (Swanepoel, Johl, & Pienaar, 2013). Hearing screening and early identification of a hearing loss is only available in 7.5% of the public healthcare facilities in South Africa, resulting in less than 10% of new-borns being screened for a hearing loss (Swanepoel et al., 2013; Theunissen & Swanepoel, 2008). The delay between suspicion and diagnosis coupled with the limited resources available in the healthcare sector, is evidence of the disproportion between policy and practice.

There is a lack of documented statistics for the incidence and prevalence of a hearing loss within the South African population. There are pockets of specific research data available that presents snapshots of the prevalence of a hearing loss with specified groups. One such study was conducted at the Audiology clinic at the University of Pretoria, which revealed that three in every four children that were assessed at the clinic presented with a hearing loss (Swanepoel et al., 2013).

Despite the cause of a hearing loss, the most drastic effects on communication are seen in individuals with sensorineural hearing losses. The diagnosis of a hearing loss has an effect on the individual and the family at large. Parents of a baby who has been diagnosed with a hearing loss may respond in three stages according to Stein and Jabaley (1981):

- An initially expression of anger. This is usually directed at the professionals who diagnosed the hearing loss.
- Anger towards the child as the existence of a hearing loss cannot be denied.
- Acceptance of the hearing loss, coping and adaptation behaviours start to develop.

An integrated supportive model of care should be in place to succour the family unit during this potentially emotional situation.

Prakash et al. (2013, p. 43) provide the following guidelines for audiologists to consider when counselling the parents, after a child is diagnosed with a hearing loss:

- the need for understanding empathy and the skills to convey these qualities to the parents,
- the need to build up parents' feelings of self-efficacy and competence in undertaking the myriad tasks involved in parenting a child with a cochlear implant or a hearing aid,
- the importance of flexibility in responding to families' changing needs,
- the importance of continuing efforts to provide prompt back-up services in case of equipment breakdown and
- the necessity for ongoing communication between the professional and children's teachers.

(Douglas, 2014, p. 698) describes strategies to assist families when they are faced with the emotional reactions following the diagnosis of a child with a disability. These strategies can also be used by audiologists to improve on the holistic and integrated services that are required when a child is diagnosed with a hearing loss:

- Identify resource to assist the parents
- Provide a safe, non-judgemental and support space
- Provide some hope for the families
- Discuss the emotions felt by the parents and encourage them to see this as a normal process
- Name and explain the details of the hearing loss (causes, type, anatomy)
- Explore the spiritual beliefs of the family
- Identify their understanding and meaning for the hearing loss
- Compliment the parents on their strength and resilience
- Encourage therapeutic writing

Parents can either, according to Robert A Neimeyer and Sands (2011):

1. *fit the implications of the loss into their previous understanding of the world and of themselves, essentially maintaining consistency in their identity and the way they see life or*
2. *create a new narrative and understanding or*
3. *contact spiritual leaders and support structures.*

In South Africa, there is an effective family support program called HI HOPES (Home Intervention – Hearing and Language Opportunities Parent Education Services), which was established at the Centre of Deaf Studies at the University of the Witwatersrand in 2008, for families who receive the diagnosis of a hearing loss. South Africa has the benefit of the HI HOPES program that is uniquely designed to support parents and families who have children with hearing loss. The primary aim of the HI HOPES program is to inform and equip parents of infants with a hearing loss ((Storbeck & Calvert-Evans, 2008). The key focus of the program is to provide each family with a parent advisor who will assist with information in the following areas:

- acceptance of the child's disability
- language assessment
- communication option: Spoken language, Signed Language and SimmComm (signing and speaking)
- hearing aids
- daily routines to maximise language acquisition
- cochlear implants
- play and concept development
- speech therapy
- literacy

Parent advisors are matched to meet the needs of the family with special consideration of age, communication mode, religious views and gender (Storbeck & Calvert-Evans, 2008). The consideration of biopsychosocial and spiritual aspects is evident in the pairing of families and parent advisors. Audiologists in South Africa are frequently from a different race or culture of the family (Louw & Avenant, 2002) therefore the HI HOPES program assists in bridging the

communication gap by matching the family with a parent advisor that can meet their communication needs. Education is important of all children however children with a hearing loss need support for optimal performance at school. Reed, Antia, and Kreimeyer (2008) states that HOH/D children perform above average in school when:

- *The family has high expectations*
- *Parents are involved*
- *Parents are knowledgeable*
- *Parents are frequently communicating with teachers*
- *The infrastructure of the school meets the needs of the students*

The diagnosis of the specific type of hearing loss will direct the audiologist towards the most suitable rehabilitation option for the child.

4.3.2 Types of Hearing Loss

There are three major types of hearing loss. These include a conductive hearing loss (a hearing loss which may result from pathologies of the outer and middle ear), a sensorineural hearing loss (a hearing loss caused by damaging of sensitive structures of the inner ear) and a mixed hearing loss (a hearing loss resulting from the combination of conductive and sensorineural pathologies) (Willems, 2003). The hearing loss may occur at birth or during the individual's life. The sensorineural hearing loss is detailed below as it is the focus of the current study.

- *Sensorineural hearing loss (SNHL)*

Permanent cochlear or retrocochlea damage resulting in a permanent SNHL may be associated with presbycusis, ototoxicity, injury, trauma, diseases and congenital aspects (Møller, 2006), with irreversible damage to the hair cells in the cochlear structure. An irreversible loss of hearing sensitivity is called a permanent threshold shift (PTS) and there is no cure for permanent sensorineural hearing losses (Eddy, 2013; Tanner, 2007). A SNHL can range from mild to profound in severity however any degree of severity will impact the communication ability of the individual. The cause of a sensorineural hearing loss can be either 'sensori' which indicates that the cochlea is affected or 'neural' which indicates that there is retrocochlea damage. The rehabilitation for a sensorineural loss includes amplification or surgery.

4.3.3 Rehabilitation of a Hearing Loss

4.3.3.1 Medical Rehabilitation

The widely used medical model of care in Audiology focuses on the medical management of a hearing loss. Prior to rehabilitation, finding a cure was the ultimate goal when considering any medical pathology. In 1999 the United States government launched "*Wise Ears: It's a noisy planet campaign"* to educate the public about the preventative measures available to protect the hearing mechanism (Schraer-Joiner, 2014). Good hearing is taken for granted until something goes wrong and help is sought (Dalebout, 2009) despite the awareness campaigns that are available. Prevention should assist in decreasing future diagnosis however it does not provide assistance to the individual with a current hearing loss (Burkey, 2006).

Medical methods to repair and restore a conductive hearing loss include a tympanoplasty, removal of a cholestatoma or antibiotics however there is no method available for restoration of a sensorineural hearing loss. Conversely, a sudden hearing loss develops over a few hours or days with idiopathic causes (O'Malley & Haynes, 2008) however it may spontaneously recover. A retrospective study of 83 participants who reported a sudden hearing loss in Turkey established that participants were all treated medically upon consultation. The participants were hospitalised and treated with: 10 days of bed rest, plus medical intravenous treatment with pentoxifylline20 mg/day, heparin 5000 U/day, methylprednisolone 1 mg/kg/day (tapered down over two weeks), ginkgoglycosides 28.8 mg/day and papavarine HCl 120 mg/day (Ceylan et al., 2007). Evidence of recovery was seen in all participants however there was no correlation between prognostic factors between patients. A previous study of Cogan's Syndrome participants who experienced a sudden hearing loss, indicated that participants treated with a regime of corticosteroids (prednisone and methylprednisolone) showed an improvement in hearing within 14 days (Haynes, Pikus, Kaiser-Kupfer, & Fauci, 1981). The above-mentioned studies provide evident for the restoration of a sudden hearing loss with the use of medical intervention. The participants in the current study were individuals' who had a permanent hearing loss that was not sudden, therefore the evidence from the study in Turkey cannot be applied to the individuals in this study. However, the researcher acknowledges the possibility for the restoration of a sudden sensorineural hearing loss.

Rehabilitation of a permanent hearing loss under the medical model will conventionally include amplification with the use of a hearing aid or cochlea implant. Presently there is no surgical method available to replace the permanent damaged hair cells of the cochlear. Technological and surgical development have grown drastically in the last century in relation to hearing loss as the advancement in hearing aids has transcended all knowledge of hearing aids in the past. At present the hearing impaired population have the option of hearing aids that connect wirelessly to the television and cellular telephones (Dalebout, 2009) however the technology will never replace a fully functioning hearing system.

According to Eddy (2013) there is no cure for a sensorineural hearing loss. From a medical model perspective, audiological rehabilitation is the only option for individuals with a permanent hearing loss. Assistive devices can provide the individual with a hearing loss, with enhanced speech reception but falls short of providing 'normal' hearing. The surgical advancement of cochlear implants is driven by the desire to accomplish 'normality', this has encouraged audiologists and scientists to proceed with further modifications to the cochlear implant system in the last 30 years (Møller, 2006). Although it is not a 'cure', the cochlear implant has made significant in-roads in this direction (Eddy, 2013). International research focuses on hearing aids and implant technology, which is continuously developing, as the aim of successful audiological intervention is a priority for the audiologist. A study conducted in the USA and Europe, looked at the technological advancement of Otologies Middle Ear Transducer (MET) ossicular implants to assist with a sensorineural hearing loss (Jenkins et al., 2004). This study consisted of 282 participants who underwent a surgical procedure to implant an electromechanical stimulation device into the middle ear to assist with the amplification for the ear with a hearing loss. Participants in the USA were excluded if there was a conductive or a mixed hearing loss, this criterion is consistent with this study. Surgical implantation of any nature comes with risks (Dunn, Tyler, Oakley, Gantz, & Noble, 2008) and this procedure was performed via a post-auricular incision, thereafter a 1cm deep hole is made in the incus and an aluminium oxide transducer probe is inserted. Eight weeks post-surgery the individual with a hearing loss, is fitted with a button audio processor. This study indicated that neither the hearing aids nor the Middle Ear Transducer restored hearing to normal levels however both methods worked similarly to improve hearing results. The methodology and aims of the study in the USA differ from the current study however the results provides a support for the need to establish if there are alternative methods to managing a hearing loss. The results from the above-

mentioned study reiterates one of the vital facts in this study, the inability to medically restore hearing to normal limits without the use of a device or surgery.

4.3.3.2 Alternative Rehabilitation

Despite these medical advances, people continue to seek alternative means of intervention, believing in supernatural healing to improve or cure a permanent hearing loss and its symptoms. Medically it seems impossible to re-grow damaged cochlea inner hairs, despite medical research and attempts by researchers (Vernikos, 2004). Individuals are therefore seeking other methods to manage the hearing loss which justifies the need for audiological service delivery models that will integrate these methods into the session with a patient. In relation to Audiology there is minimal published international research relating to alternative methods to manage a hearing loss. Culture plays a significant role in the way disability is viewed by an individual (Salas-Provance, Erickson, & Reed, 2002) and most cultures have been influenced by science and the medical assessment and management of illnesses and disease. Complementary and alternative methods of management for medically diagnosed illnesses and disorders are becoming more popular in society.

Brown, Mory, Williams, and McClymond (2010) conducted a study in Mozambique on hearing impaired and visual impaired individuals who were receiving complementary and alternative medicine. The researcher created the term Proximal Intercessory Prayer (PIP) which involved prayer through touching or laying on of hands. Participants in this study were recruited from Christian church meetings at Iris Ministries in Pemba, as Iris leaders are reputable for being ‘specialists’ in praying for the visually impaired and the hearing impaired. Proximal Intercessory Prayer was customarily conducted on the blind and deaf in designated areas of the church, leaders would place their hands on the head of the individuals or hug them and pray for the healing to come from God and for evil spirits to depart in Jesus’ name. The prayer could last between five minutes to half an hour, thereafter individuals would be asked to confirm the healing and if it was successful then it would be tested, consisting of the repetition of verbal phrases heard or the counting of fingers from a distance.

The study in Mozambique included 11 hearing impaired participants (18 ears were tested). The hearing assessment pre and post PIP was conducted on site using a handheld diagnostic audiometer, the researchers stated that the environment was noisy due to the nearby crowd and this affected the

testing procedures. Statistical differences were found pre and post hearing assessments; however the article does not provide details of the specific differences. The assessments were limited to certain frequencies due to time constraints however the improvement seen at the test frequencies validates the need for further studies to be conducted. The methodology of the study in Pemba and this study has traits that are similar, as the participants needed to have hearing loss to participate in both studies. There was also a need for a supernatural or alternative method of restoration of hearing. Participants in the Pemba study had prayer and the laying on of hands as their alternative method which is similar to participants in this study. The different between the current study and the Pemba study is the medical evidence to confirm the restoration of healing. This study focused on the physical restoration as much as the psychosocial experiences of the individuals who report of a healing. Furthermore, a different design in the methodology was used in the current study.

Another study was conducted in the field of Speech Pathology and Audiology in Brazil, utilizing forty members from different generations in a Hispanic family. Within the Hispanic culture beliefs regarding the causes of illnesses may include; improper dressing, the *mal de ojo* (evil eye) causes conjunctivitis or other diseases, dreams during pregnancy, past sins, accidents or trauma. There are various treatment options and home remedies used within the Hispanic culture which include holy water, candles, medicinal tea and purification rituals performed by *curandero* (spiritualistic healer). Participants in the study stated that individuals were disabled dues to folk beliefs such as 'the mother making fun of a disabled person, or due to an earthquake, God's Will, a spell on the mother, the pregnant women saw a dead person, work of the devil and the lack of faith in God'. The research explored the treatment methods used by participants when an individual had a hearing loss, participants were asked 'how would you cure a hearing loss?' and answers included; visits to the ear doctor, audiologist, prayer, volcanic oil, smoke from garlic/tobacco, insertion of garlic cloves/leaves or urine. This study revealed that the majority (92.5%) of the participants would consult a *bruja* (witch) for advice when disability is a factor in the family situation. The researchers in Brazil found that even though 95% of participants stated that religion was important, 27% would not turn to the priest for help, thus seeking alternative methods to cure the disability.

Another study conducted in the USA in 1984 stated that treatment for a sudden hearing loss remained controversial and regimens consist of diuretics, anticoagulants or corticosteroids (Byl, 1984). This study by Byl (1984) monitored 225 participants with a sudden onset of hearing loss,

each participant was monitored over 8 years and the hearing status was monitored as the treatment was taken and the therapy conducted. It was evident that all progress made in terms of recovery was a gradual process and no instantaneous healing or restoration of hearing was reported. A study was conducted on 41 participants who were diagnosed with an idiopathic sudden unilateral hearing loss. Participants were divided into four groups with different treatment procedures; prednisone tablets, placebo tablets, carbogen inhalation or room air inhalation. Treatment was received for five consecutive days and hearing assessments were conducted pre-treatment, on the 6th day and a follow-up between 14-90 days later. Participants showed improved hearing however there were no differences between the different treatment methods (Cinamon, Bendet, & Kronenberg, 2001). The study indicated that improvement was seen despite the management method utilised thus postulating that healing occurred due to factors that were related to the person's belief in restoration or spontaneous recovery.

Rehabilitation, according to medical sciences, is said to be the only option to improve hearing and communication for individuals with a permanent sensorineural healing loss. Thus, the current study, as there is a need for a study that looks at the alternative practices in addition to the technological and surgical practices, used by individuals in South Africa, when they are faced with a hearing loss of this nature.

Hearing loss is a communication disorder that affects the everyday life of a person. The type and severity of the hearing loss will prescribe the expanse of impact, on the quality of life of the individual and their family. Healthcare for the Deaf and hard of hearing is predominantly the responsibility of the audiologist. The focus of patient care has historically relied on the medical model of service delivery in Audiology; however there is a proposed shift in care, towards a more integrated family-centred model of care that incorporates all facets of healing into the management of the individual.

4.4 Healing

Healing is not, as it is often characterized, a "making whole." Rather, healing, in its most basic sense, means the restoration of right relationships. What genuinely holistic health care means then is a system of health care that attends to all of the disturbed relationships of the ill person as a whole, restoring those that can be restored, even if the person is not thereby completely restored to perfect wholeness. A holistic approach to healing means that the correction of the physiological disturbances and the restoration of the milieu interior is only the beginning of the task. Holistic healing requires attention to the psychological, social, and spiritual disturbances as well. (Sulmasy, 2002)

4.4.1 Physical Healing

4.4.1.1 Supernatural healing: Culture, Religion and Spirituality

Supernatural healing is the belief that healing is as a result of interception from a *Supernatural Being, form* or *God* that will heal the disease, disorder or illness through prayer, fasting or rituals (O'Connor, 1995). Healing is thus obtained through *a miracle* which is defined as an extraordinary event or events that lead to the curing, restoration and wholeness of the individual (Crosley, 2004).

Varghese (2010) provides a succinct statement to portray the relationship between religion, spirituality and health care "Prayer is an important postulate and practice in all religions. Science and religion are two important immersions in one's life; they are like the two sides of the same coin. Scientific claims are open to testing and verification. Religious claims cannot be proved and verified; they are to be experienced. Faith is the cornerstone of all religions.

Ranger (1982) wrote about a community in Ethiopia who were given gospel books. The community started to believe in the miracles in the literature in the absence of teachers, when the missionaries visited the site again they found evidence of healings every day. The Ethiopian community believed in what they were reading and they practiced their beliefs and the consequences were evident. The missionaries stated that the miracles were seen as the people believed without any formal teaching, a missionary would have taught the people that the literature was not to be taken literally (Ranger, 1982). The above-mentioned story indicates that spirituality is an individual decision and the consequences of a person's belief may be limitless as it is based on their desires.

Any attempt to scientifically prove religious tenets will be a wild goose chase. Just because religious experiences cannot be proved as per the accepted scientific standards, it does not mean that they are not real or important. Religious experiences are fundamental to the person who experiences them. Therefore, religion and spirituality are important in the field of Psychiatry. When we try to understand our patients; we must explore their religious orientations and practices. This however has been ignored all along.

The Facets of Culture

Culture is defined as the custom, civilization, and achievements of a particular group of people (Miller, 2012). With respect to the proposed study, cultural backgrounds of the participants may differ, as the focus of the study is on the event that caused the supernatural healing hence culture, race or gender are not defined variables. The etic and emic factors that influenced the data obtained, was considered in the interpretation and discussion of the data.

Etic vs Emic Factors Related to this Study

Etic/Emic factors play a role when researching individuals and cultures. According to Ten Have (2007) the traditional *emic* descriptions state that a participant must be analysed by the principles and definitions that are used within the specific culture. The *etic* descriptions state that the analysis is conducted on a universal level which is based on the analysts or the observers' point of view. However these traditional definitions are problematic in the study of current day religious life and practice (Jørgensen, 2008) as the researcher may not always affiliate with the study population. The presentation of narratives within the current study will be provided from the *emic* or insider view however the analysis of the data collect will invariably include an *etic* or outsider interpretation as the researcher cannot belong to all the cultures that may participate in the study. Hence the participants' quotes and stories will be presented verbatim ensuring that the cultural content is unchanged and the analysis of the information will be based on the researcher as the observer.

Cultures vary within dynamic social systems (Bandura, 2001) thus leading to individuality and uniqueness of belief systems and practices. In Africa, South Africa has the most ethnically, culturally, and linguistically varied population, with its 11 official languages, with each perhaps belonging to a specific culture (Afọlayan, 2004). The South African multicultural population has

four major cultures that includes the different Black South African cultures such as the Nguni, Sotho and Tswana cultures (Afọlayan, 2004); the South African White: English, Portuguese, Italian and Afrikaans culture, among others, the varied South African Indian cultures, and the South African Coloured cultures. Inadvertently yet not exclusively, the cultural groups are largely race bound in South Africa, because of the Apartheid era. Thus, highlighting the need for this study so that a deeper understanding of the non-medical practices within this diverse South African society, can be achieved. Individuals from each culture will view, respond and react to disease, illness and healing in a different manner, with religion being the biggest influencer.

We live in a multicultural spiritual society and most people accept a spiritual aspect in their lives as they seek to obtain a meaning to life (Bandura, 2003) therefore health care for individuals should consider the person as a whole and not only as a medical entity. The history of patient care indicates that the majority of patients are assessed and managed under a medical model which focuses on the doctor or therapist's education and knowledge when assisting the patient.

Culture is not the same as religion despite the interchangeable use of these terms in society. The cultural aspects shape how one lives his everyday life and how he views the world (Steiner, 2016). Religion shapes a deeper aspect of the individual's life, having an effect on morals and ethical principles that are based on belief systems (Phillips, 2016; Wainwright, 2017). A person is influenced by culture and religion in every aspect of life and decisions are based on the foundation of understanding on a personal level. The next section describes how the world's major religions shape society.

The World's Religions

Religion is defined as a belief system based on knowledge of specific teachings (Kunin, 2003) that can exist from centuries ago or from a few years ago. Old-Age and New-Age religions of the world may vary from Judaism, Christianity, Hinduism, Islam, Atheism, Buddhism, Cosmology and Kabbalah (Chryssides, 2001; Smith, 2010).

Religions in South Africa

In South Africa cultural, linguistic and belief systems shape the current cultural-medical paradigm; of which, traditional healing is a vital aspect (de Andrade & Ross, 2005). Religious beliefs

influence the individual's beliefs and practices regarding supernatural intervention and healing. The South African constitution allows for the freedom of religion and the right to practice ones religion (Lipton, 2002) and this ensures that the diverse South African population are given the freedom to practice any of the world's religions such as Christianity, Hinduism, Islam and Judaism (Melton, 2014).

According to the 2011 census, 79.8% of the South African population belong to the Christian faith, while the rest of the population indicated that they belong to one of the traditional religions such as Hinduism, Islam, Judaism, Buddhism, Confucianism and Rastafarianism (Africa, 2003). A minority indicated that they don't belong to any religion or they chose not to indicate a religious preference (Lipton, 2002). The highest ranking faiths in South Africa, based on the number of individuals who follow it, are thus Christianity, Hinduism, Islam and Judaism (Hendriks & Erasmus, 2005). Christianity is currently the faith that is dominant in South Africa and in many parts of Africa (Mangaliso, 2001). Religious views and rituals play different roles in different cultures. Race does not equate to a specific culture however in South Africa a person may have specific cultural beliefs and religious beliefs based on the ethnic group that they belong to (Sewpaul, 1999).

Beliefs, spirituality and religious practices hold significant value to individuals; hence the inclusion and integration of the above-mentioned areas are vital in holistic healthcare. The incorporation of factors that influence the patient from a psychosocial perspective is common factor throughout this study, so as to validate the need for an integrated model of service delivery. *Supernatural healing* in this study is discussed according to the four most commonly practiced religions in South Africa - Christianity, Hinduism, Islam and Judaism.

- *Christianity*

Christians believe in the triune God: The Father, The Son and the Holy Spirit. When individuals proclaim Jesus as their Lord and Saviour then the believer is 'filled' with the Holy Spirit of God (Jenson, 1999). The Christian belief reveals that the Holy Spirit is the agent for healing and testimonies are used to support the belief that the healing is a Godly intervention at work (Dyrness & Karkkainen, 2009). Faith healings are believed to occur through prayer and the *laying on of hands* (Christensen & Kockrow, 2013). Christians believe that disease and illness are not from God

and believers practice the physical *laying on of their hands* onto the sick person while praying for the power of God to move through them and heal the individual (Cuffy & Farnsworth, 2013).

The bible provides various encounters and events of divine healing and restoration, sight and hearing are common in the healing and restoration process. The literature however considers the healing physical and spiritual, restoration of the body as well as the spirit. One encounter of the Apostle Paul in the book of Acts in the Bible indicates that there was a loss of vision and a divine healing and restoration of sight. Apostle Paul had an encounter of divine healing which changed his spiritual understanding and belief (Hamm, 1990). Blindness in this case was seen as a physical blindness and lack of sight however refers to spiritual blindness, which was seen as a lack of belief and trust that Jesus was the son of God (Hamm, 1990).

Healing within the Christian faith became a contentious issue. MacNutt (1974) noted that the Church was sceptical of the reports on healing as was the medical world, therefore a panel was formed to assess the genuineness of the supernatural healings. The panel, after inspection and research, concluded that certain extraordinary phenomenon of healing does occur therefore the church accepted the concept of supernatural healing. In the early 1970's a 'miraculous' healing was seen in Newcastle in the United Kingdom (Gardner, 1983). The case of healing involved an infant who was diagnosed with advanced alveolitis with no response to medical intervention. The infant was discharged with a 'hopelessly' prognosis as the disease was rapidly progressive. The parents were consulting with Professor Webb who advised the parents to attend a healing service at the Heaton Pentecostal church in the community. The medical model of care had exhausted its attempts to provide services for the restoration of health to the infant therefore the parents considered supernatural healing. Five days after the prayer service, the infant appeared happier and progressed to full recovery and health (Gardner, 1983). There was no way to prove that the prayer service resulted in the healing however doctors had no doubt that this was the work of God (Gardner, 1983). The current study is not aimed at proving that the healing was a work of God however it vital to accept and respect the beliefs and experiences that are evident in the lives of patients.

Research in Brazil found that there are cases of illness with supernatural causes that are treated in part by medical means and there are natural causes of illnesses that are treated by supernatural means (Ngokwey, 1989). This notion relates to this study as it sought to document the narratives of individuals who received a healing via supernatural means. Faith healing institutions in Feira de

Santana (Brazil): the *Rezadores* Catholic faith healers and the Protestant church known as the *Church of Miracles* were researched (Ngokwey, 1989). The study looked at the specificity of illness, diagnosis and management procedures in each institution. The management aspect was congruent with this study as it pursued cases of supernatural intervention to heal the hearing loss.

The intervention from a rezadores is known as *rezas* is most effective in the areas that medical doctors cannot diagnose or treat. The rezas will include the following (Ngokwey, 1989):

a. The verbal affirmation of an event involving Jesus, Mary, a Saint and a sick individual.
b. The invocation of God
c. A short description of the illness the person is presenting with.
d. The exorcism of the illness.

The rezas are ended with Catholic prayers such as Ave Maria. These rezas are conducted to facilitate the divine intervention of healing for specific illnesses. The practice of rezas, are more prominent in the rural areas of Brazil due to the large number of rezadoras and the acceptance and belief in supernatural intervention. Brazil being similar to South Africa in areas such as levels of economic status, unemployment, development, religiosity, rural communities and education levels, allows the researcher to predict similar outcomes in the narratives within this study. Patients sought healing through rezadores faith healers as they were dissatisfied with the biomedical services, as doctors do not tell patients exactly what they have and what caused it (Ngokwey, 1989). The exorcism of the illness illustrates the supernatural element of the reza, as the unwanted illness is treated as if it is an entity embedded in the patient's body and it is commanded to leave, rezadoras may expel it into the *'waves of the sea'* so that it can never return to harm the patient again. The biblical story of Jesus casting out demons from a man, where the demons were cast into pigs that drowned in a river is (KingJamesVersion, copyright 1998) comparable to the treatment of expulsion that is performed by rezadoras.

Patients in in Brazil stated that they seek healing from rezadoras as they have a *'special power from God'* that enables the rezadora to perform effective rezas. It is not only the prayers or words alone that bring about the healing, it is the *'gifted power or charisma'* within the rezadoras that activates the prayer to perform the healing. One type of traditional faith healer in South Africa is a sangoma and they can be likened to rezadoras in Brazil therefore the findings of the currents study are

expected to be analogous. Rezadoras have no special training or initiation to indicate that they are practicing rezadoras, the *'gift of power'* is innate and may be groomed by another rezadoras. Sangomas are initiated into practice by other sangomas who are governed by the traditional healers' bill in South Africa. Rezadoras are usually titled by their dominant secular profession while South African traditional healers may function solely as a sangoma. Patients will test the rezas efficacy and give a testimony of the *'power at work'*; rezadoras usually do not charge for their services but may accept donations or candles (Ngokwey, 1989).

The Church of Miracles in Brazil was found to assist individuals with health difficulties on a broader scale; individuals sought healing for physical or mental illness, financial, social or professional issue (Ngokwey, 1989). The Church of Miracles belief system states that any illness or disease is a cause of *Candomble* and *Umbanda* specialists who are devil agents and *orixas* and *exus* are manifestations of the devil which are used to harm people. The supernatural relation to this study is evident, as the participants in the current study were expected to proclaim that a supernatural event occurred to produce a healing. The individuals', who attended the Church of Miracles, usually consulted other medical institutions for a medical diagnosis however individuals are less concerned about labelling the difficulty as they are concerned about eliminating it. The medical diagnosis was used by the Church of Miracles to validate the claims of a miraculous healing. Cured testifiers at the Church of Miracles presented medical bills, x-rays and prescriptions to validate the inability of medical assistance to cure the disease (Ngokwey, 1989). The pastor-healer at the Church of Miracles focused on natural and spiritual aspects of the healing to claim a better quality of life for the individual who sought a healing. This study does not aim to verify or validate the claims of healing as there is a broader understanding of the word 'healing' that underpins the interpretation and discussion of the narratives, as healing is not limited to physical healing. This study does however aim to verify that the participants were initially diagnosed with a permanent sensorineural hearing loss, though the evidence of a previous audiological examination.

The method of healing at the Church of Miracles in Brazil focused on prayer and faith, the pastor-healer either prayed for individuals or for the congregation. The pastor-healer calls out the names of the diseases or chaos then he affronts the evil spirits that are causing the infirmities and commands them to leave the person's life and body in the name of Jesus-Christ. Anointed oil or water may be used to bless the individual who sought a healing at the Church of Miracles, and in some cases the

oil allowed for *'invisible surgery'* of the affected body part, so that divine healing and restoration are achieved. Divine healing powers at the Church of Miracles operated over far distances; therefore individuals may receive their healing over the telephone or the television (Ngokwey, 1989). The present study relates to the events at the Church of Miracles as the claims of supernatural healings are similar to the claims of healing by participants in this study. The participants in this study are matched to congregants of the Church of Miracles in terms of the socio-economic status and the avenue of healthcare that was sought. It was indicated that the majority of individuals seeking spiritual healing were from lower socio-economic backgrounds and the assumption could be that they were not able to afford medical care, so they sought pastoral care (Ngokwey, 1989).

A study was conducted on a faith healing sect in Indiana (USA) called Faith Assemblies (FA), the religion was founded by Hobart E. Freedman in 1963 (Hughes, 1990). Faith Assemblies believed only in faith healing and discouraged the use of any medical care. The present study did not aim to access participants who solely believed in the supernatural and not the medical aspects of care. The use of medicine, for healing in the FA was seen as unbelief in God and a lack of faith in the blood sacrifice in the death of Jesus for the atonement of ill health (Hughes, 1990). Faith Assembly members practiced healing through procedures such as fasting, prayer and the laying on of hands. The sick individual was asked to declare that Jesus has healed them and satan will leave the body, after the confession there cannot be any conversations about pain, illness or medicines with any other person (Hughes, 1990). This study also aimed to describe any faith based procedures that were used to heal an individual of a hearing loss, which is similar to the FA methods. This statement from Freedman cited in Hughes (1990, p. 108) describes his own healing using this method: "When I claimed healing from a heart ailment several years ago on the basis of God's promise in Isaiah 53:4-5, disposing of my medicines, I neither looked nor felt healed for many months. Several times during this period satan caused the symptoms and pains to return; but in each instance, I refused to accept the symptoms (or evidence of the senses), resisting satan with the promises of God. As I daily confessed what God's Word said about my condition (I Pet. 2:24), and refused either to confess how I felt or what I saw in the mirror, then gradually my condition came more and more to be in harmony with what God's Word said about it, until finally my healing was fully manifested".

Many believers of this religion died as a result of the lack of medical care for treatable illness (Hughes, 1990). Parents of children who died were tried and convicted for the deaths due to neglect or reckless homicide. The members started to change and question their belief when the founder himself died of multiple illnesses such as arteriosclerosis, diabetes, gangrene and heart issues. The negation of medical care with the sole focus on supernatural healing, led to the death of many individuals with curable diseases and imprisonment of the parents (Hughes, 1990). The reliance only on a belief system can have negative consequences on the believer if the advice given conflicts with the laws of the country (Hughes, 1990). In the current study, the mismanagement of a permanent sensorineural hearing loss is not fatal however the psychosocial and development consequences are life altering.

Another study conducted by Espinosa, García, Stevens-Arroyo, Busto, and Lloyd-Moffett (2009), states that in 1937 Francisco Olazabal contributed to the birth of ten Protestant and Pentacostal denominations in the United States of America, Mexico and Puerto Rico, largely due to his ability of charismatic faith healing. Olazabal's wife was healed from a sickness after he and the church elders prayed for her healing, this moment strengthened his belief in divine healing. The healing event that occurred is matched to the expected healing narratives in the present study. The healing ministry of Olazabal grew and at an annual convention in Houston when "Olazabal's evangelistic healing ministry was reignited by the alleged healing of the twelve-year old 'deaf and dumb' daughter of Mrs. Guadalupe Gomez. He had never before performed, what was in the minds of his followers, such a great and obvious 'miracle'. Rev. Homer Tomlinson, one of Olazabal's closest Anglo-American friends, stated that, from this was a new beginning for his faith for healing." (Espinosa et al., 2009, p. 602).

There is vague reference to evidence of the healing event of a Deaf and mute child; and the article did not provide specific details of the event. The current study aimed to document the details of the occurrence of the supernatural healing and the consequences thereof with hearing impaired individuals. Hundreds of people were divinely healed of blindness, deformities, tumors, rheumatism, deafness and other diseases in 1931 at the Spanish Harlem campaign (Espinosa et al., 2009). The relationship between the Spanish study and the current study is apparent as deafness was divinely healing during the Spanish Harlem campaign. Despite the thousands of divine healing claims of individuals across the Americas, some individuals indicated that they were prayed for but

they did not receive the healing expected and Olzabal's response was "it was God's prerogative to heal, I am simply a vessel through which God manifested his healing power, nothing more" (Espinosa et al., 2009, p. 606). The present study did not focus solely on the physical healing of a hearing loss, it also allowed for non-physical psychosocial healing. Olzabal's healing ministry on the American continents was envisioned as one that had no racial, denominational or gender boundaries which is akin to the criteria in the current study.

Developing countries like Brazil have similarities to South Africa therefore the expectations are similar when researching comparable areas such as healthcare (Espinosa et al., 2009). The present study matched studies in Brazil and the USA, in respect to rural traditional healers, religious institutions and other religious beliefs that are believed to affect or heal the sick individual. Beliefs affect the physical, mental and emotional state of a person and literature of previous studies have considered and incorporated the findings into integrated management plans. Research illustrates that there is an interest in supernatural healing however the focus on physical healing dominate literature, hence swaying indirectly to the medical aspect of physical restoration. There has been minimal evidence of studies relating to supernatural hearing within the field of Speech Pathology and Audiology, reiterating the need for a study akin to mine, which aimed at documenting the healing occurrences within the diverse and unique South African population. An integrated management plan is necessary when individuals with a hearing loss provide narratives of supernatural physical and psychological healing.

- *Hinduism*

In Hinduism, believers called Hindus see live events, including blessings and hardships, as a result of karma. Karma is the law dictated by the 'good and bad', that individual may do to others which in turn is given back to them (Bhardwaj, 2015). When '*good things'* are done then *'good things'* are reaped as a reward from God, when '*bad things'* are done then curses or bad circumstances are reaped. Karma however does not only refer to the present life but it also refers to past lives that the soul has lived (Ghose, 2007). Hindus believe that wholeness and good health are related to the aligning of *chakras* or energy centers, the consciousness and the body functions should be at an optimum state and equilibrium (Young & Koopsen, 2010). Fasting, chants and water rituals are performed to seek retribution from God for the healing of illnesses and disease (Baumgarten, Assmann, Stroumsa, & Stroumsa, 1998). The current study focuses on aspects such as prayer,

fasting, rituals and events that lead to a supernatural healing; these aspects are evident in the Hindu faith. The belief of healing is documented in literature however there is a dearth of research and documentation of supernatural healings in the Hindu faith.

- *Islam*

In Islam, believers called Muslims (Braswell, 2000) see illness and disease as God's will and as a compensation for sins (Ross, 2007) as the infliction of the illness or disease will be a stronger incentive for the believer to turn to God in repentance (Suyuti, 1999). Illness is as a trial or blessing from God, there is an imbalance in one's self, i.e., the soul, the intellect, the desire and the link between the body and soul (Abdullah, Saini, Sharip, & Shaharom, 2016). Illness and disease are seen as God's test so that the individual's faith can be proven to God (Sachedina, 2005). Muslims who require healing will seek assistance from a moulana, a hakeem or a gift healer in Islam (Ross, 2007), they will seek prayer over the sick person and thus seek God for healing. Despite the evidence that Muslim individuals believe in supernatural healing, there are no documented studies of healings within the field of healthcare however there are studies to indicate that Muslim individuals seek for supernatural means to cure an illness (Abdullah et al., 2016).

- *Judaism*

In Judaism, the Jewish believer refer to the prayer book of Israel, called the *Tefillah*, when a believer has an illness or disease and prayers are made to God for healing as he is the only one who can heal. Jews believe that healing is one of God richest blessings (Spiegler, 2007). Jewish individuals believe that Adam and Eve disobeyed God and severed the relationship between man and God and caused disequilibrium, thus life is now seen as good or bad, sick or health, rich or poor (Spiegler, 2007) therefore only God can restore the equilibrium. Individuals are allowed to consult physicians as this does not constitute a lack of faith, maintenance of good health is key to the believer (Rosner, 2007).

A study in Israel found that conflicts may arise when the patient and therapist belong to different cultural, religious or ethnic backgrounds (Witztum & Buchbinder, 2001). Orthodox Jewish individuals believed that *'the best of doctors go to hell'* therefore medical intervention for illnesses and diseases were avoided (Witztum & Buchbinder, 2001). The battle between medical

practitioners and faith in divine healing was bridged by some rabbinic leaders as they stated that doctors are used by God to be his instruments (Witztum & Buchbinder, 2001). Thereafter patients were freely seeking medical advice when required. The strong faith in God to heal a sick person in Judaism is evident in literature however there is a scarcity of documented studies of healing.

God is a universal term shared by all religions regardless of the beliefs or practices. Literature indicates that medical practitioners have documented cases of medical recovery of patients who were unsuccessful with medical care and they deem 'God' as the healer. A case in 1975 provided the history of a trainee medical practitioner who was diagnosed with meningococcal septicaemia with meningitis; she was at the point of death and was also diagnosed with Waterhouse-Friderichsen syndrome (Gardner, 1983). There was no record of survival for such a diagnosis and the patient was deteriorating rapidly. Prayer groups around the community gather to intercede for her healing without disability and they believed that God had answered the prayer. Simultaneously there was a sudden improvement in the patient's health and in 48hours there was a complete restoration of health. There was not medical reason for the recovery however doctors deemed the case as 'unique' and 'the one that got away', however the patient and her friends ascribe to their belief of a supernatural healing of God (Gardner, 1983). The alternative methods of healing must be explored as there is value in documenting and considering methods that are different to the medical care of the patient.

Traditional Healing: Complementary and Alternative Healing (CAH)

A traditional healer is "someone who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal, and mineral substances and certain other methods based on the social, cultural, and religious background as well as the prevailing knowledge, attitudes, and beliefs regarding physical, mental, and social well-being and the causation of disease and disability in the community'' (Pretorius, De Klerk, & Van Rensburg, 1993). An abundance of global literature indicates that individuals of various cultures and backgrounds use traditional healing interventions in conjunction with Western interventions (Domene & Bedi, 2013; Moodley, 2016; Munthali, Mannan, MacLachlan, & Swartz, 2016; Oulanova & Moodley, 2016; Siwela & Jansen, 2016).

Complementary and alternative healing and therapy cannot be specifically defined due to its large spectrum of practices, however it is shaped by culture and refers to the *'other practices'* in relational to allopathic medicine (Singh, Raidoo, & Harries, 2004). CAH practices are global and the methods of practice are unique to the country, culture and religious affiliations of the individuals who seek CAH. A study in Brazil revealed that there are alternative practices such as the S*eicho-no-Ie* Japanese-born movement which involves the reading of scared books and monthly magazines (Ngokwey, 1989). Literacy is therefore a necessity and followers are found to consist of professionals who are predominantly White regardless of the Japanese origin of the religion. S*eicho-no-Ie* is based on the 'enlightenment of humanity' therefore no religion is excluded and there is a premise that all religions lead to one Universal God. S*eicho-no-Ie* describes illness and disease as manifestations of the mind therefore the mind creates it (Ngokwey, 1989). S*eicho-no-Ie* promotes good health rather than the elimination of disease or illness and indicates that each individual has the power to heal himself. The religion was founded by Dr Masaharu Taniguchi who was healed from sickness; he received the code of practice through divine revelation during mediation (Ngokwey, 1989). *Seicho-no-le* states that individuals must find their *'true self*', the emphasis being on good family relationship and a positive emotional state resulting in good health. Ngokwey (1989, p. 524) states that the basis of the teaching is illustrated as: "Be reconciled with all the things of Heaven and Earth. When you are so reconciled with the Universe, everything will be your friend. When the Universe becomes your friend, nothing can harm you. If you are wounded by something or reached by germs, or lower spirits, that is proof that there is no reconciliation between yourself and all the things of Heaven and earth".

George Berguer cited in (O'Reilly, 2000) describes religion as *"a struggle with destiny; it is directed towards an end, towards an aim; the devotee is in search of something, he follows a plan."* An exploratory study of 176 individuals practicing spiritual healing compared to 137 individuals utilising primary health care, in Baltimore revealed that faith healing and prayer persists in Western culture irrespective of the advancement is scientific medicine (Glik, 1986). The favourable choice of alternative medicine has been evident since the early 1980s, a study in Britain found that 86% of general practitioner trainers had positive attitudes with regard to alternative medicine such as hypnotherapy, acupuncture and faith healing and 18% were using one or more of the methods at the time of the study (Reilly, 1983).

Religious belief systems and culture play a significant role in the patient's perspective during the diagnosis of an illness or disease. This study concentrated on documenting the alternative approaches to medical management that is used by individuals with a hearing loss in South Africa.

Complementary and Alternative Healing in the South African Context

Complementary and alternative healing (CAH) is evident in South African Black Traditional healing practices, Mind-Body intervention and Herbal medicine. The South Africa cultural-medical paradigm features the traditional healer as they are intrinsic to the shaping of individuals perceptions of health matters (de Andrade & Ross, 2005). Traditional healers may serve as a priest, councillor, doctor and psychiatrist (Puckree, Mkhize, Mgobhozi, & Lin, 2002). Traditional healers are sought by 60-80% of the African population (Sukati et al., 2005) making traditional healing an integral component of health care.

Two unpublished studies conducted by undergraduate students at the University of the Witwatersrand, found that individuals seek advice and management from traditional and religious healers in South Africa (Moolla & Pillay, 2016; Serooe & Pillay, 2016). Muslim healers in South Africa have expressed a desire to work collaboratively with audiologists however there is no clear line of communication to assist with the integration of the medical and traditional methods used (Moolla & Pillay, 2016). There is evidence that audiologists in South Africa are reluctant to ask the patient about traditional healing as the audiologist has a lack of expertise and training in the area (Serooe & Pillay, 2016).

The Traditional Health Practitioners Bill in South Africa was developed to support and strengthen the patient care beyond the medical condition (Richter, 2003). In South Africa there are various categories of traditional healers within different religious circles and these include herbalists, faith healers and diviners (de Andrade & Ross, 2005). There are three categories of Black traditional healers in South Africa, the *'Izinyangas'* are the herbalists, the *'Sangomas'* who work within the supernatural sphere and the *'Faith healers'* who integrate Christian beliefs and traditional practice (Pretorius, 2001). Singh et al. (2004) documented the prevalence and utilization of Complementary and Alternative Medicine (CAM) within the South African Indian population. Through face-to-face interviews, the researchers in South Africa found that spiritual healing and herbal/natural medicines were popular in the Indian population, allopathic medication was utilised concurrently with the

CAM. Chronic illnesses such as diabetes, hypertension, arthritis, stress, backaches or skin disorders are managed through CAM (Singh et al., 2004) however there was no evidence relating to hearing loss, which is the focus of the present study.

CAM is based on a referral system from other CAM users or by advertisements that are seen in magazines and newspapers (Singh et al., 2004). There is a need for a supportive relationship between the medical model and the ecological model (Singh et al., 2004), as CAM is becoming popular amongst South Africans. The study conducted by Singh et al. (2004) is restricted to the South African Chatsworth Indian population and therefore the findings are not generalizable. The strong cultural background of the Chatsworth Indian community probably led to the use of prayer as a major source of healing, it is noted that the proportion of Christians, Hindus and Muslims utilising spiritual healing was similar (Singh et al., 2004). Thus, rehabilitation of any hearing related issue within the South African population may include assistance from traditional healers. The current study did not focus on a specific culture or religion in South Africa, which correlates with the study by Singh et al. (2004). CAM is documented as a common practice for the South African population however in relation to the present study it was noted that none of the participants in this study used CAM to manage a hearing loss. Culture may dictate religious practices but spirituality tends to be a personal and individual choice.

Spirituality

Literature does not provide a clear definition of the term spirituality and it is inappropriate to assume that spirituality is synonymous with religion or culture (Dyson, Cobb, & Forman, 1997). Published work on spirituality agrees that spirituality is an individual process that is ongoing, it is dynamic and it reflects and expresses the human spirit (Meraviglia, 1999). Spirituality encompasses the integration of the mind, body and spirit of the human-being (Reed, 1992). The relationship between oneself, the world and God is directed by the spiritual dimensions of one's life (Meraviglia, 1999). Literature in Psychology, Logotherapy, Theology and Sociology provide contrasting views on the meaning of spirituality. Psychology describes spirituality as the self-actualisation and expression of the person's internal desires while Logotherapy by Viktor Frankl describes spirituality as the discovery and pursuit of the meaning for life (Batthyany, 2016; Pargament, 1997). In literature, Theological research in the area of spirituality generally include participants who hold Christian beliefs (Bown & Williams, 1993), a belief in the relationship with a

higher spiritual being or creator. Religiosity and spiritualism are seen as synonymous terms when considering the Theological definition of spirituality. Sociology's opposing definition indicates that spirituality is an institution, collection, gathering or participation of people instead of an individual's search for meaning to life (Dyson et al., 1997).

Spirituality in healthcare has been discussed and researched significantly in the field of nursing and there is an abundance of literature concerning healthcare and spirituality in nursing. Literature in nursing from the early 80's indicates that theorists in the field such as Roy (1984); Watson (1985) and Sims (1987) were instrumental is pioneering the integration of spirituality into the care of patients with nursing. The concept of spirituality in this study will include the mind, body, spirit, world and the belief in a God or higher-being. Healing is a complex concept and researchers cannot ignore the non-physical aspects of healing that affect the psychosocial well-being and quality of life of the individual.

4.4.2 Non-Physical Healing

Culture, religion and spirituality shape the way human-beings relate to healing and to the world. Spirituality plays an all-encompassing lead role in the outlook one has in life. God or a higher being is held accountable for the positive and negative events in life. People of all religious and cultural backgrounds seek support in their Gods through prayer, fasting and sacrifices. When disability, illness and disease enter a family situation, God is sought for help in many households. The individual and his/her family who is impacted by the illness may seek for a physical healing however non-physical forms of healing are also a focus of prayer. A South African study documented the interaction between individuals of Zulu ethnicity and their ancestor spirits when a psychosocial distress occurred (Crawford & Lipsedge, 2004). The Zulus would seek physical and non-physical help from their ancestors who are deemed to be God's subordinates. Participants in another study by Crawford and Lipsedge (2004) would shop around for a medical practitioner who provided them with advice that aligned with their belief system. The support for the current study is evident from the findings of Crawford and Lipsedge (2004) as individuals who are suspected of having a hearing loss in South Africa may also look for an audiologist who will accept and support the belief systems of the family. Non-physical healing pertains to the social, emotional and psychological areas of the individual's life. Healing that occurred internally, in the mind and spirit in isolation or in conjunction with the healing of the body. Coping with the diagnosis of an illness is

supported by a spiritual and religious affiliation (Al-Azri, Al-Awisi, Al-Rasbi, & Al-Moundhri, 2014) however the medical team can integrate aspects of the individual's belief into the healthcare provision as there is evidence that families will seek for spiritual advice when a medical diagnosis is made. Ghazali and Abbas (2017) emphasises the need for holistic care by creating 'healing environments' to support physical and non-physical healing.

The exploration of an integrated service delivery model of care in Audiology that includes the medical, psychosocial and spiritual aspects of the patient's life is necessary for holism within the field. A shift in focus is essential for the effectiveness of an integrated service delivery model to be evident. A shift in healthcare that values the experiences of individuals and their families, a change from a provider focus to person-centred/family-centred focus (Leatt, Pink, & Guerriere, 2000). There are various global advocates for a holistic family-centred service delivery models in healthcare (Cannon, 2017; Hussey & Kennedy, 2016; Jolley et al., 2017). An Australian study found that audiological service provision appear to remain therapist-centred as three quarters of sessions commenced began with a biopsychosocial interaction but 80% of the sessions ended with a biomedical interaction (Meyer, Barr, Khan, & Hickson, 2017). The challenge of change rests with individuals within the profession. Model (1994) states that challenges are opportunities, South Africa has its portion of challenges, specifically within the healthcare sector. There is an opportunity to constructively engage with the challenges in the South African healthcare sector and thus develop a stronger service delivery healthcare model.

The way forward towards a more effective service delivery model in Audiology, in South Africa depends on the overall transformation of all aspects that affect the profession (Moonsamy et al., 2017). Aspects such as the training of professionals, clinical practice and research are areas of opportunity to strengthen the profession of Audiology in South Africa. There is a need to consider the physical and non-physical healing that occurs when consulting with an individual with a hearing loss and his/her family. The biopsychosocial and spiritual aspects that are intertwined determinants of the individual's life must be incorporated into the audiological care that is provided.

There is a need for studies that explore the field of Audiology in the South African context. The number of studies are growing however there are minimal studies that related to the psychosocial aspects of culture, religion and spirituality that influence the family system when where a person is diagnosed with a hearing loss.

4.5 Rationale for this Study

4.5.1 Listening to the Patient's Perspective: Shifting the Paradigm of the Medical Model in Audiology to an Integrated Family-Centred Model

The current research contributes to the controversial area of discussion, namely spirituality as a factor in healthcare, as it is one of the first studies conducted in this area. The results from such a study maybe a rare discussion due to the debate of the interaction between the scientific and the spiritual worlds, two areas that are usually on either ends of the spectrum when considering illness, disability and rehabilitation. Effort however is required to document and discuss the many areas of ignorance that relate for patient care in Audiology (Model, 1994). Areas that consider the non-technological factors that affect the individual with a hearing loss, such as values, beliefs and preferences.

The current study is original in Audiology and may evoke dialogue and assist in establishing a channel of dialogue between the scientists and spiritual leaders. The current trend in patient management is adapting the medical model to ensure that the social aspects of life are incorporated into the rehabilitation of the patient (Doel & Shardlow, 2009). This trend therefore justifies the need for such a study to amalgamate the medical methods or rehabilitation to the social and spiritual aspects of the individual's life. By embracing beliefs and views that are new, old, different and unproven will be a challenge however the need arises to understand the possibilities of alternative or complementary means of managing a hearing loss and its effects, and hence providing a holistic view of the client.

The feasibility of such a study has challenges however the benefits of such of a study should not be ruled out. The current medical model of service delivery in Audiology inappropriately isolates the personal context from the management of the hearing loss, which is unjustified for the diverse context of South Africa. The South African 'Rainbow Nation' has facets of diversity in every area of life; some of these facets are unique to the context that is based on the history of the country. Diversity in South Africa is a result of a unique populous that is shaped by different racial groups, religions, languages, cultures, spiritual beliefs and practices. Linguistic diversity is one area that is evident as there are eleven official spoken languages in South Africa and audiologists who fail to account for this difference will hinder the management of the patient. The failure to adapt to the

diverse South Africa populous may create a barrier to the success when managing a hearing loss as communication between the audiologist and patient can be affected. It is essential to consider the diversity of the South African population so as to provide contextually appropriate healthcare services to hearing impaired individuals. Information obtained in this area will be one of the first in the field of communication, more specifically in Audiology in the diverse South African population. This study will be the first to explore the area of supernatural healing and hearing loss and the data collected from such a study should open the door to further studies in the field of Audiology and specifically best practice.

Literature supports the need for a model of service delivery in Audiology that considers the macro- and microscopic details in the life of an individual with a hearing loss. A model that accounts for the global variables that can affect a person as well as the individual's idiosyncrasies and values (Model, 1994). A model of service delivery in Audiology that uses a wide lens of focus, that encompasses more than the hearing loss, must consider the person as a whole. Holistic family-centred, culturally appropriate interventions have shown a high success rate when managing hearing loss (Madell, 2008). It is essential for audiologists to consider the issues and measures that affect the hearing impaired individual as a functioning-whole (Model, 1994). The family-centred viewpoint includes the medical as well as the social and cultural aspects of the individual's family unit (Bowden, 2010) thus providing a holistic intervention plan. A need arises for a study, such as this, that assesses and documents the narratives of individuals who report that they have been supernaturally healed of a permanent hearing loss. The diversity in culture, religion and beliefs within the South African populous highlights the significance of the current study, which allowed for the exploration and appreciation of South African diversity.

There are undocumented claims of supernatural intervention, healing and cures that have produced a total recovery of health-related issues. The on-going research in the area of hearing restoration has indicated that a cure does not exist, however this contradicts the claims of individuals who state that permanent hearing loss has been cured. Paucity in research exists that focuses on the links between supernatural healing and a permanent hearing loss. This study may contribute to the growing body of evidence based holistic treatment practices in Audiology as the medical and spiritual aspects are considered during the rehabilitation of hearing impaired individuals. The outcomes of this study may shed light on this unexplored area of intervention, when treating hearing impaired individuals.

Aspects of healing are centred on the restoration of health through divine intervention (Morvillo, 2009) however science provides a sceptical view of this spiritual healing that occurs (Graham, Litt, & Irwin, 1998).

4.5.2 An Integrated Audiological Care Model of Service Delivery

Policy makers and system planners in developed countries are determined to have healthcare services that meet the needs of the country at a macro, meso and micro-level (Strandberg-Larsen & Krasnik, 2009). The process of change is dependent upon the collaboration of sectors within government, education, health and the general population. South Africa is rapidly developing in its political and socio-economic status, which forces a change on the healthcare service provision from a medical paradigm to a more holistic and integrated paradigm. The change in healthcare that is positive will require the definition of the concepts that are targeted.

The concept of integrated healthcare service delivery is dynamic. Literature focuses on ‘integrated care’ or ‘integrated health system’ however the information is predominantly disease specific (Leatt et al., 2000). There is a dearth of literature pertaining to the performance of a well-run and functioning holistically integrated system. Integration within healthcare involves more than a healthcare provider who treats a patient who has an illness. The concept of integration is broadly classified as functional integration, physician integration and clinical integration as per Table 4.1 (Shortell, Gillies, Anderson, Erickson, & Mitchell, 1996; Shortell, Gillies, Anderson, Mitchell, & Morgan, 1993).

Table 4.1: Types of Integration

Functional Integration	Physician Integration	Clinical Integration
Definition: Support functions and Activities.	Definition: The physician is economically linked to the system, uses its facilities and actively participates in the system.	Definition: Continuity of care, coordination of care, disease management, good communication and smooth transfer of all information between role-players.
Examples: Finances, Human resources, Marketing, Strategic planning and policies.	Examples: Development of medical staff, group practices and serving on boards and committees.	Examples: Holistic care of the patient and all aspects related to the well-being of the patient.

There is a need for an integrated model of service delivery in Audiology and the current study focuses on the clinical type of integration without disregarding the other two types of integration. Clinical practice in Audiology is the emphases of this study as the narratives of participants provide a motivation for the development of an all-encompassing integrated service delivery model. A model that considers the collaboration of services, service providers and systems within healthcare and governing bodies (Leatt et al., 2000) is required. A system literature review entitled ‘Doctors discussing religion and spirituality (R/S)’ was conducted 2016. The 2016 study aimed at identifying all the online research articles that pertained to doctors and their practice in relation to spirituality and religion (Best et al., 2016). The systematic literature review set out to answer the following questions: ‘Do doctors report that they ask their patients about religion and/or spirituality and how do they do it? According to doctors, how often do patients raise the issue of religion and/or spirituality in consultation and how do doctors respond when they do? What are the known facilitators and barriers to doctors asking their patients about religion and/or spirituality? (Best et al., 2016). Table 4.2 provides a succinct summary of the findings of 61 papers that were identified with respect to the questions that were outlined by Best et al. (2016).

Table 4.2: A Summary of Research Findings of 61 Papers

Questions	Relevant Findings
Do doctors report that they ask their patients about religion and/or spirituality and how do they do it? Thirty-four papers addressed this question.	- Raising the topic of R/S in medical practice was reported as infrequent and inadequate. - During case history, 66% of doctors never ask about R/S. - Spiritual history-taking was reported by 33% of doctors. There was little evidence of a standardised tool. - The FICA (Faith, Importance, Community, Address) tool was recommended to assist healthcare workers who need support when discussing R/S with patients. - The tools used had a Judeo-Christian bias which negatively affected the use as its use was deemed as 'cultural imperialism.' - Doctors stated that they silently prayed for their patients (89%) however the overall view on R/S and prayer was: It must be approached with sensitivity, integrity and should not impose on the patient's overall well-being.
According to doctors, how often do patients raise the issue of religion and/or spirituality in consultation and how do doctors respond when they do? Twenty-six papers addressed this question.	- Eighty-three percent of doctors stated that they encourage their patients' own R/S practices and beliefs. - Prayer is requested in 56% of consultations, at the instigation of the patient and not the doctor. - Patients raise R/S when there is medical uncertainty or conflict. - At least 66% of doctors indicated that they would try to change the topic of conversation when R/S was broached by the patient, 44% stated that they would never discuss R/S even if the patient asked.
What are the known facilitators and barriers to doctors asking their patients about religion and/or spirituality? Forty-three papers addressed this question.	- Prior training of doctors was the strongest facilitator to approaching the areas of R/S and spiritual care with the patients. - Doctors mentioned that sensitivity, patience, tolerance for ambiguity and sensitivity to one's own spirituality is vital. - Doctors who discussed R/S with patients had a strong intrinsic and extrinsic belief that R/S was an important part of life. - Family physicians stated that R/S did not conform to the reductionist medical culture as these areas may pose unanswerable questions. - Some doctors did see the discussion of R/S as part of holistic care. - Barriers included: the lack of time, insufficient knowledge and training, personal discomfort, professional scope of practice being blurred, differences in belief or unbelief, imposing on the patient, lack of financial reimbursement, lack of scientific evidence related to R/S, disapproval from colleagues. - Medical training devalued the importance of R/S care and stressed 'curing' and not 'caring' as the medical role.

Table 4.2 provides insight into the global reality of the association of the areas of religion and spirituality in relation to the world of a medical doctor. The literature reveals clear facilitators and barriers to the inclusion of the patient's religious and spiritual beliefs into healthcare. The desire for spiritual guidance from a patient perspective is focused on the receipt of holistic care from all sources in a multidisciplinary manner rather than a doctor who provides all the support (Best, Butow, & Olver, 2014). Global healthcare trends indicate that services are becoming more explicit, accountable, holistic and family-centred (Model, 1994) which encourages the parallel shift in the field of Audiology, hence a motivation for a study such as this.

Literature focuses on techniques or models to assist the audiologist during the rehabilitation process. The models are aimed at changing the behaviour of the individual with a hearing loss, towards a hearing loss or a hearing aid. A trans-theoretical model of intentional behaviour change was discussed in relation to hearing aid user's behaviour towards the amplification (Babeu, Kricos, & Lesner, 2004). The stages of change and the process of change in the trans-theoretical model are vital constructs that can be similarly applied to the change in behaviour that is required from an audiologist. Despite the target groups being different in the current study and the study by Babeu et al. (2004), the stages of change are constant for the audiologist who will have a change in behaviour during the shift from a medical model mind-set to an integrated model mind-set. The foundations of the trans-theoretical model and its application to the changes required in Audiological service delivery are presented in Table 4.3.

Table 4.3: Stages of Change Required in Audiology

Stages of Change	Application to the Audiologist (Changes required)
1.Precontemplation	The Audiologist has no thoughts or plans to change the service delivery within the diverse South African population.
2. Contemplation	Awareness is created and the Audiologist is cognisant that the current medical model of hearing healthcare is creating a problem.
3.Preparation	The Audiologist has recognised that the medical model of care is not meeting the needs of the diverse population. There are thoughts about ways to create a more holistic, integrated model of care.
4.Action and Maintenance	The Audiologist practices and maintains a service delivery model that incorporates all areas of the individual's life into the holistic care.

Table 4.3 provides basic steps of the stages of behaviour modification that are required from the audiologist. The profession of Audiology is rooted and has its foundations embedded in the constructs of the medical model and basic steps are necessary to motivate the audiologist to begin to engage with the concepts that need integration. Concepts that warrant engagement such as spirituality, religion, beliefs and values should be included. Hence the need for this study that explored the narratives of hearing impaired individuals and the evidence obtained can be a motivation for the integration of these concepts into the service deliver model in Audiology.

International efforts towards an integrated healthcare model are emerging and South Africa is in need for of its own model that encapsulates the diversities that exist. Leatt et al. (2000), outlined the following key ideals that can be adopted in the design of an integrated model of service delivery in Audiology:

- Focuses on meeting the health needs of the community
- Matches service capacity to meet the community's needs
- Coordinates and integrates care across the continuum
- Has information systems to link consumers, providers, and payers across the continuum of care
- Provides information on costs, quality, outcomes and consumer satisfaction to multiple stakeholders
- Uses financial incentives and organisational structures to align governance, management, physicians and other providers to achieve objectives.
- Is able to continuously improve the care it provides

The ideals listed above are relevant for the South African context therefore the current study was required so as to provide the evidence for a change in service delivery methods in the audiological context. The audiologist should consider the quality of life of a family with a child with a hearing loss. The following quality of life domains should be considered during audiological care (Schalock, 2000):

- Emotional well-being
- Interpersonal relationships
- Material well-being
- Personal development

- Physical well-being
- Self-determination
- Social Inclusion
- Disability related rights

Model (1994) provides the audiologist with the following approaches that could assist in the implementation of holistic service delivery:

a. The Continuous Quality Improvement Approach: This approach stresses the importance of continually evaluating and improving the services provided to the individual with a hearing loss. There is a need to clearly depart from the technology-driven and authoritarian care models in Audiology to a family-centred, better quality of life model.
b. Program Evaluation (PE): The PE approach allows for the macroscopic view of service provision. It looks at the interaction of variables and it assists in the understanding of the conceptual and procedural relationships that exists in the field. This approach looks at the processes in Audiology and the context. Program evaluation reaches beyond the clinical criteria into the lifestyle and quality of life aspects of the individual's life.
c. Decision Analysis: Audiological care is essentially a problem solving, goal-orientated process. However, it is imperative to analyse the relationships between the audiological, psychological and social structures that affect the individual with a hearing loss.

The above-mentioned approaches can add value to the service provision in Audiology however there is a lack of evidence in literature that indicates the need for change from the current disease focused medical model of service delivery, to a model that holistically integrates the individual's beliefs, culture and spirituality. This study becomes essential as it adds to the body of knowledge and provides evidence of individual's experiences that need to be incorporated into the overall healthcare of the individual with a hearing loss.

Audiology is traditional viewed as a blend of diagnosis and therapy (Model, 1994) and the abovementioned approaches enable the audiologist to consider the structures that are beyond the medical realm. An all-encompassing model of service delivery reaches beyond the diagnosis and therapy as it incorporates the psychosocial and spiritual aspects into the care. An integrated family-centred model of care will provide holistic support to a hearing impaired individual who is seeking hearing healthcare (Babeu et al., 2004).

4.6 Summary and Research Question

There are currently no documented scientific cases in South Africa that indicate that an individual has regained hearing supernaturally after being diagnosed with a permanent hearing loss. Hence the value of this study that focused on exploring the experiences and perceptions of supernatural healing within the South African context. In relation to this study, there was no attempt to prove or disprove the reported healing and restoration but it aimed to record the narrative of the participants' experience of the supernatural intervention and healing process retrospectively. Thus providing evidence that can motivate for an integrated service delivery model, that includes aspects like spirituality and beliefs within healthcare in the South Africa context. The argument in this study is that a holistic service delivery model, compared to the current medical model, better accommodates the needs of individuals with a hearing loss who are seeking alternative ways of restoring hearing in a South African context.

The Research Question was thus:

What are the narratives of individuals who report that they have been healed of a permanent sensorineural hearing loss through supernatural intervention?

Chapter 5: Methodology

5.1 Introduction

This chapter provides an in-depth description of the aims, procedures, instrumentation and ethical considerations that were undertaken in the study. The foundations of a good study rest on the details and planning of the methodology of the study.

5.2 Research Aim and Objectives

The main aim of this study was to document the narratives of healing experiences of individuals who reported a supernatural healing of a sensorineural hearing loss.

This study aimed to fulfil three main objectives and three sub-objectives:

- Main Objectives

- to identify the recurring themes within the narratives of participants who reported a healing, with the purpose of deconstructing the aspect of healing amongst participants.
- to describe the cultural, religious, spiritual and social influences that impact the individual with a hearing loss.
- to design a proposed working Audiological Model: An Integrated Model of service delivery in Audiology

There were 3 sub-objectives:

- Sub-Objectives

- to document the diagnosis of the sensorineural hearing loss.
- to identify the 'turning point' event or events that caused the reported healing.
- to explore the influences of the healing on the participant's life.

5.3 Research Design

This study was an exploratory case-study design within a qualitative paradigm. 'The function of a research design is to ensure that the evidence obtained enables us to answer the initial question as unambiguously as possible' (De Vaus, 2001). This study was thus exploratory as supernatural

intervention has had limited theoretical analysis and is an area of undocumented occurrences in South Africa, particularly within the context of Audiology.

A sound understanding of human behaviour and the rationale for such behaviours becomes evident in a qualitative study (Wisker, 2007) hence the current study aimed to document each participant's experiences of a supernatural encounter, shaped by culture, religion, spiritual and societal influences.

Audiology is known for the diagnosis and quantification of the degree of a hearing loss however the qualitative aspects related to Audiology are equally important. Especially within the diverse South African context where there are contextual variables such as language, culture, religion and beliefs that can impact the medical management of a hearing loss in a purely medical model of service delivery. The medical model advocates for a quantitative approach as research tends to focus on the numerical prevalence and incidence rates or the quantifiable relationships that exist (Engel, 1989). The qualitative aspects in healthcare play an equally significant role as indicated in the current study. The biopsychosocial-spiritual model focuses on holistic care of the individual thereby considering the qualitative aspects that play a role in the care of an individual.

Qualitative methods allow for the holistic consideration of factors that affect the individual's life in context (Sileo, Kintu, Chanes-Mora, & Kiene, 2016). The psychosocial humanist effects of a hearing loss cannot be merely quantified, as the effects have a significant impact on the individual's life. These effects need to be described in a qualitative manner to aptly understand the individual's experiences. The use of a qualitative methodology is vital in a study that has a focus on 'storyteller or narratives'. Audiology in South African has been affected by the history of apartheid and the new healthcare policies post-apartheid, that allow for easier access to services that are not equipped to provide those services. There is a need to provide audiological services that are relevant to the South African context (Khoza-Shangase & Michal, 2014), therefore the use of a qualitative method in this study is apt to understand the narratives of the experiences of hearing impaired individual's within the South African context.

A qualitative methodology allowed the researcher the opportunity to explore the deeper meaning behind the narratives that are reflective on the diverse South African context. The personal experiences of participants in this study required the use of a research design that fully captured the thoughts, feelings and perspectives in a way that illustrated the humanistic elements within the

narratives. A qualitative research design allows for the presentation of direct quotes from the narratives obtained, hence one of the benefits of using this method in the current study as the participant's voice is seen in its natural utterance (Pitney & Parker, 2009).

The qualitative reports of supernatural healing within this study are based on the lived experiences and perspectives of the participants however these unique experiences within the South African context, will have an impact on the service delivery requirements in the field of Audiology. Hence the use of qualitative methods allow for the exploration and interpretation of the lived social experiences (Green & Thorogood, 2013) , as with participants in this study. Qualitative research methods favour the holistic approach of research, which is of importance in this study, as the researcher is expected to explore how the ontological and epistemological perspectives of participants impact the service delivery in Audiology (Hesse-Biber & Leavy, 2010).

5.4 Sample

5.4.1 Sampling Procedure

Snowball sampling was employed on the participants in this study in order to identify individuals who shared a similar experience (Babbie, 2013). The access to the sample was not restricted to a specific environment or setting thus no direct permission was necessary. Letters of information and request for participants were mailed to religious leaders. Verbal communication also occurred between the researcher and religious and spiritual leaders, in an attempt to recruit participants.

5.4.2 Description of the Participants

The target number of participants was between 7 and 10, due to the depth of information required as well as the uniqueness of the area being researched. Narrative researchers should select limited participants to have adequate information to answer the research question (Jones, Brown, & Holloway, 2012). Participants in this study were purposefully recruited from places of worship as religious leaders were contacted to identify individuals who report a healing of a hearing loss. The current study aimed to obtain a fair distribution of participants from the major religious groups in South Africa, representing its religious diversity, but the sample depicted six Christian participants and one of the Hindu faith, as depicted in Table 5.1.

Inclusion and Exclusion Criteria

Participants included in this study lived in South Africa and they met the following criteria:

- Diagnosis of a hearing loss: Participants were diagnosed by an audiologist with a sensorineural hearing loss of any degree either unilaterally or bilaterally and proof of the assessment, in the form of an audiogram was available.
- Gender: Male or female participants were eligible for candidacy for this study as it is not gender specific however there were six females and one male participant. There were two additional female participants who were mothers to participants in this study.
- Race: Race groups were not restricted from participation and there was a varied distribution between the 4 predominant races groups that encompass the South Africa population. There were two Indian participants, two Black participants, two White participants and one Coloured participant, as described in Table 5.1.
- Age: Participants from any age group were accepted into the study however parental consent and participant assent was obtained for participants who were younger than 18 years. This study included two participants who were younger than 18 years of age.
- Religion: Participants from any culture, religion or belief system were included in the study.

Participants were excluded from this study if:

- The person reported a healing of a temporary healing loss. The audiogram results were used to validate a permanent sensorineural hearing loss therefore individuals who presented with a hearing loss that was not congruent with this study, were excluded.

The demographics of the participants in the current study are presented in Table 5.1. There were seven participants in the current study, with the inclusion of two mothers.

Table 5.1: Demographics of Participants in this Study

Participant Number	Age in Years	Gender	Race	Religion	Onset and Laterality of the hearing loss	Severity of the hearing loss
1	27	Female	White	Christian	At Birth and Bilateral	Severe to Profound
2	37	Female	Coloured	Christian	At Birth and Bilateral	Severe
3	22	Female	Black	Christian	At Birth and Bilateral	Severe to Profound
4	25	Male	Indian	Christian	At Birth and Bilateral	Severe to Profound
5	17	Female	Black	Ancestor Beliefs	At Birth and Bilateral	Severe to Profound
6	20	Female (Mother was also Interviewed	White	Christian	At Birth and Bilateral	Profound
7	16	Female (Mother was also Interviewed	Indian	Hindu however was healed by a Pastor	At Birth and Bilateral	Severe to Profound

5.5 Data Collection

5.5.1 Instrumentation: Interviews

"I *think it sometimes gives us a sense of certainty that we are human when we hear that people far away have the same feelings and problems that we have and that they are troubled by the same things. We realise that humans have so much in common. This is where the power of interviewing is situated."(Henning, Van Rensburg, & Smit, 2004, p. 51).*

A semi-structured interview was used in this study to obtain narrative data from individuals who reported to have experienced supernatural healing. A semi-structured interview is a versatile method to approach sensitive topics (Miles & Gilbert, 2005), such as supernatural healing in this study. Narrative data is 'powerful and rich' and 'transcends time and space' (Connelly & Clandinin, 1990; Kim, 2015, p. 8). The semi-structured interview began with an open-ended question that allowed the participant to narrate his/her experiences of the reported healing process. The use of follow-up open-ended questions allowed for a data collection process that did not impose pre-existing ideas on the participant (Shekedi, 2005), however the questions probed for further details on the narrative that was provided. The researcher asked additional follow-up questions if necessary to guide the process however these were rare occasions (Appendix G).

"In our interview society our lives are permeated with interviews for employment and workplace promotions, for therapy and counselling and of late also very much for edutainment and self-improvement via the mass media" (Henning et al., 2004, p. 51). This study used a narrative inquiry during the semi-structured interviews as society is familiar with this manner of communication which facilitated a more naturalistic data collection process. The participants were having a storytelling session during the interview which was less formal and allowed for the freedom of realistic conversation to occur.

5.5.2 Procedures

5.5.2.1 Narrative Inquiry: Participant

The researcher interviewed all the participants, so that there was a direct involvement and immersion into the data collection phase which provided the researcher with the ability to interact with the data from an etic standpoint (Ten Have, 2007). Human beings are story telling organisms

as we live storied lives (Connelly & Clandinin, 1990) hence a narrative inquiry documented the lived experiences of these participants. Naratology is used across fields such as drama, art, psychology, linguistics and education (Connelly & Clandinin, 1990). The lived experiences of participants in this study were documented using narratives. The participant was the storyteller, in narration of the events that occurred. The words used to express thoughts and feelings of these participants shaped their identity on a personal and social level (Conle, 2000).

5.5.3.2 Recording of Narratives

Informed consent was obtained from all participants prior to the recording of interviews (Appendix H). The interview sessions were audio and video recorded to ensure that the information was captured accurately and controlled for timing so that the rapport between the researcher and the participant was maintained throughout the interview (Holloway, 2005). The data was transcribed and analysed soon after the interviews. The video recording allowed for the observation and documentation of non-verbal cues and language that were not focused on during the interview.

5.5.3.3 Pilot Study

The pilot study was conducted to determine if the research tool was effective in obtaining the necessary information for this study. The validity of the research process was also verified through the pilot study (Kelley, Clark, Brown, & Sitzia, 2003).

The participant was verbally recruited as a referral from a friend of the researcher who was aware of the research title. The participant was provided with the information letter prior to him granting his consent to participate in the interview. The participant indicated when and where would be convenient for the interview and the research made the appointment for the interview. Upon the interview, the participant provided a written consent for participation; he also provided permission for the video and audio recordings. The participant indicated that he would obtain a copy of his audiogram for the researcher. The results of the pilot study were not included in the main study data.

The participant was a South African male who was diagnosed with a profound sensorineural hearing loss at birth. He is over the age of 18 and works as a laboratory technician at present. The participant attended a school for the Deaf as a child and he reported a partial healing in one ear.

The time taken to complete the interview was noted to be sufficient to obtain the data that was required. The set-up of audio and video recording devices was also assessed. The participant was able to understand the opening question with ease and the narrative flowed smoothly throughout the interview. There was no need for the researcher to probe with additional questions which provided an assurance of the appropriateness of the research instrument. It was noted that the proximity and direction of the video and audio device play a vital role in obtaining clear utterances for transcription.

During the interview, the researcher attempted to write down notes for reference at a later stage however this affected the rapport during the session and the researcher decided to abandon this method of recording for the interviews that followed and there was a solely reliance on the audio and video recordings for the transcriptions. The transcriptions were completed in no more than a few days after the interview so that the information was fresh in the researcher's mind and the mannerisms and non-verbal clues were documented. The question was open-ended and the outcome was suitable for the present study. There was a significant delay in obtaining the audiogram however this did not affect the data collection of the narratives required.

Main Study:

The interviews for the main study were conducted over five calendar months as participants resided in different provinces in South Africa. Appointments for the interviews were set up in advance and the transportation and accommodation were arranged in the relevant provinces. The procedure for the main study followed that of the pilot study, including any identified changes needed.

5.6 Data Analysis

5.6.1 Working within the Qualitative Paradigm

The researcher attempted to move from the positivist manner of merely coding and categorising data into *content* based information (Henning et al., 2004) to a thicker way of analysing the data acquired into *content and manner of utterances.* The interview process required the participant to convey a narrative of the healing process and/or event. The researcher was aware that the *'realness'* of the full context and impact of the healing may be fragmented due to the recollection of this short snippet of the participant's life (Henning et al., 2004). Qualitative data yields substantial research output if the data is analysed for its content as well as its context, as it is more effective to report not only on *what* is being said but also on the *manner* in which the participant provides the evidence

(Henning et al., 2004). Hence the researcher's choice of analysing both *content and manner of utterance* provides a deeper discussion of the data obtained in this study.

The researcher transcribed the interviews as this allowed for a deeper engagement with the data from the onset of data analysis. A researcher who engages in the transcription process is humorously described as attempted to enter into the 'rite of passage to researcher-hood while having fun flirting with the data to become an independent narrative researcher' (Kim, 2015). The notion of 'flirting with data' intrigued the researcher as the summarized version of Phillip (1994) cited in Kim (2015) stated that flirtation exploits the idea of surprise and curiosity; it creates a space where aims or ends can be worked out; it makes time for less familiar possibilities; and it is a way of playing with new ideas without letting these new ideas be influenced by our wishes.

This summary describes the way the researcher tackled the narrative data collected during the interviews and specific ideas and themes that emerged were unfamiliar and unexpected. However this added a different dimension to the study and allowed for a rich interpretation of concepts of *Identity, Culture and Integrative Patient Care.* The analysis of narrative data provided an interpretation of the way in which participants understood and made meaning of their lives and experiences through a storytelling session (Kim, 2015).

5.6.2 Methods of Analysis

The main purpose of interview data is to identify *inter-subjectivity* and to determine what society perceives, feels and does in relation to specific subject areas that are directed by the researcher (Henning et al., 2004). The narrative data obtained was first unpacked by using a narrative inquiry into the *context* of main event which was the supernatural healing and thereafter the *content* associated with the participant's life before and after the event was analysed and discussed into themes that were common. All inquiries need a description and all descriptions must be interpreted (Sandelowski, 2000). Therefore a narrative inquiry captured the stories and ideas of the participants and their stories were analysed and interpreted (Mitchell & Egudo, 2003), using an interpretative approach as the participants experiences were studied within their context while considering their subjective meaning to the context (Willis, 2008). The interpretative approach within this study focused on words rather than numbers (Kim, 2015) when analysing the participant's utterance. A narrative inquiry was chosen for the current study as it supported the interview method of data collection and it is a method that is a "perfect hybrid of research and art" (Kim, 2015 P1).

5.6.2.1 Narrative Inquiry

Narrative analysis was used in this study to break down the individual stories from the extended account that was grouped into the content and context (Wells, 2011) of the participant's record of the supernatural healing. A narrative inquiry allows for the understanding of meaningful human experiences that are informed by human actions and events (Kim, 2015) and thus in this study the reported supernatural healing process is the focus. (Polkinghorne, 1988, p. 6) states that narrative inquiry is to 'make explicit the operations that produce its particular kind of meaning, and to draw out the implications this meaning has for understanding human existence'.

Therefore, in this study the supernatural healing event and all the individuals involved had meaningful roles to play in the participant's life and in a broader view there are implications of this for the move towards a holistic management system of hearing impaired individuals in Audiology. When narratives are the centre of human research studies then the focus will inevitably be to develop our understanding of humanity (Kim, 2015) as in medical care the patient's narratives have an epistemological function when building up knowledge (Hunter, 1986).

There are however limitations to such a method of analysis, the researcher was aware that the narratives are context-sensitive and are based on the participants ability to reiterate the event and its meaning with an individual bias. The participants were in control of the details of the narratives even with the follow-up probing questions, as the realm of meaning was unique for each participant's experience. Despite the challenges of data analysis using a narrative inquiry, the researcher decided to acknowledge the prospects of participant bias. The researcher determined that the information obtained would allowed for the engagement in aspects of care and management from a different perspective that permits for a better understanding of the individual with a hearing loss as a whole, rather than a diseased focus perspective.

The narratives within this study were analysed in accordance with the relationship between the person and the social experience of supernatural healing (Connelly & Clandinin, 1990). Cultural and contextually relevant information were analysed in a framework that adopted the following structure:

Structuring the Narrative: Scene and Plot

Scene: Refers to the place where the individual experiences the event or action. The scene is influenced by culture, social context and other individuals. Descriptions of the environment, decorations in the room, context of the event and ambiance will be evident in the *story telling* process. This assists the story teller to provide a detailed picture of the story being told.

Plot: Every story has a beginning, middle and an end which is bound by temporal sequence. A story is a collection of narratives that are structured (Kim, 2015) to describe events or situations. Most stories can be interpreted on a time spectrum of past-present-future. Each narrative may have several plots. In this study, the healing event narrative is the key plot within the story of the participant's life.

The time and location of the event plays a critical role in the narrative and in relation to the study the researcher documented details pertaining to the time, place and duration of the supernatural healing experience. These descriptions were obtained directly from each participant in the study. Data collected from the audiological reports or audiograms were obtained to corroborate and support the narratives obtained from the participant. The categories of the participant's life were documented, with specific reference to the healing event; these categories include inward influencers such as emotions and personal belief systems as well as outward influencers such as the reactions of people and the cause of the hearing loss. A deeper thematic content analysis was used to understand these categories (Connelly & Clandinin, 1990).

5.6.2.2 Thematic Content Analysis

In this study the research is described as qualitative data first and then as narrative data and the researcher used the key elements described by Kim (2015) as indicated in Figure 5.1. The researcher initially deconstructed the qualitative raw data transcriptions into words or sentences that were coded thereafter the data was grouped into familiar categories, within each category there

were patterns that emerged as themes. The themes were derived from the data collected within the current study.

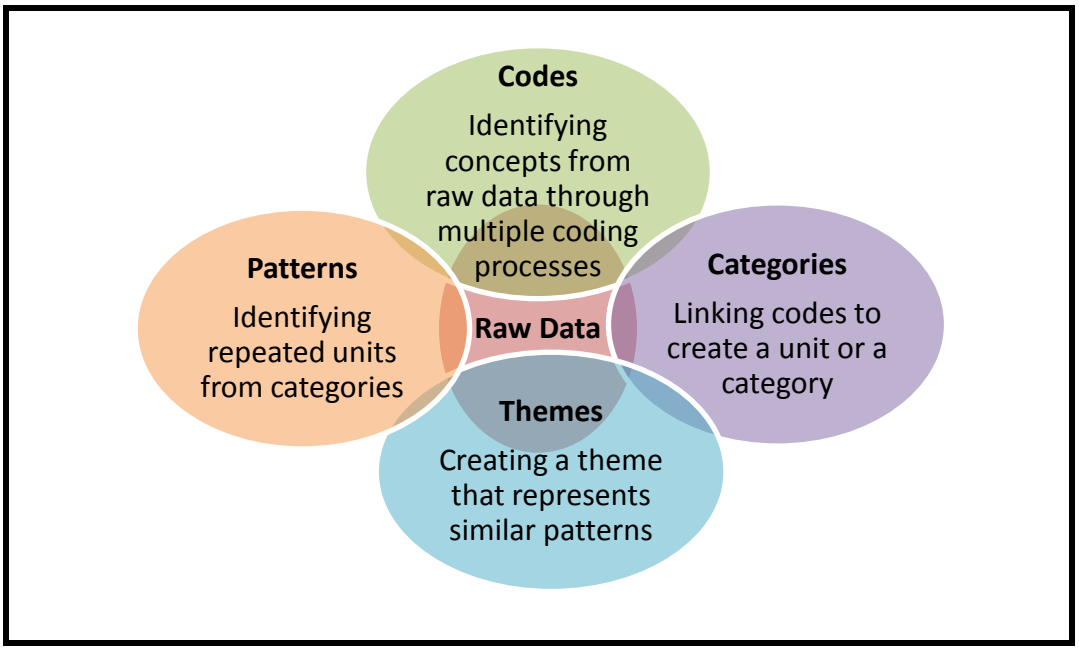


Figure 5.1: Basic Elements in the Process of Qualitative Data Analysis (Kim, 2015).

Thematic content analyses was the significant area of analysis within the narrative analysis as it was used to extract common themes of the individuals' experiences and perceptions, regarding the supernatural intervention and healing process (Symon & Cassell, 2012).

Thick Descriptions

There are various methods of data analysis available to present narrative data and some of these include the formulation of domains, classical content analysis and word count analysis (Leech & Onwuegbuzie, 2007). However for this study the researcher chose to present the data in the form of categories and themes within each category (Kim, 2015) as it provides a more integrated style of data analysis where the identified broad categories flow into specific themes.

5.7 Ethical Considerations

The ethical standing of a study cannot be disconnected from the reliability, validity and trustworthiness of the study hence these areas are reported on collectively.

5.7.1 Procedural Ethics

The research proposal was submitted to the University of the Witwatersrand Non-Medical Ethics Committee and unconditional ethical clearance was granted as protocol number H15/02/07 (Appendix I). Thereafter the researcher contacted religious leaders by sending a letter via email to request information about prospective participants.

5.7.1.1 Informed Consent and Assent

The individuals that agreed to participate in the study were required to sign an informed consent document (Appendix C) and participants could freely withdraw from the study at any time, with no negative consequences. If participants were younger than thirteen years old then parental consent was required (Appendix D). Once parents had consented, the assent of the participants was obtained (Appendix E). Participants were required to provide proof [copy of the audiogram] of the existence of a diagnosed hearing loss. If participants did not have the audiogram available then the participant or parent of participant, signed a consent form (Appendix F) whereby the researcher was granted permission to source the document from the relevant hospital, clinic or private practitioner. A specific consent form was used to ensure that all participants were aware of the audio and video recording of the session (Appendix H).

5.7.1.2 Role of the Researcher

The participants' emotional well-being was observed during the data collection phase and the researcher was aware that the recollection of events pertaining to the healing may become emotionally overwhelming for the participant. Should this distress be observed or reported, counselling services by a social worker or a psychologist would have been made available. There were no negative emotional reactions however to the data collection session hence there was no need to source a social worker and/or psychologist to assist the participants as originally planned. The non-maleficence and autonomy of participants were protected as the data collection process and the data itself is kept private and confidential thereby minimising risk to harm the participant (Fitzpatrick. & Kazer, 2011). Participants' personal information, dignity and well-being were protected by the researcher and were only disclosed to the research supervisor. The researcher ascertained that a language translator was not necessary during the verbal interviews however one participant did not understand something and needed a signed translation for clarity of that specific

word from verbal English to South African Sign language. All data was stored in a password protected computer.

5.7.1.3 Beneficence and Autonomy

Beneficence was adhered where the participants were given the opportunity to obtain the audio and video data if they requested it. No payment was made to any of the participants for their inclusion in the study, as the study is based on the voluntary participation of the individual, hence providing the individual with the autonomy of choice to participate or not to participate (Orb, Eisenhauer, & Wynaden, 2001), was important. All participants were given an information sheet (Appendix B) pertaining to the aims of the study, the data collection procedure and length of procedure, benefits and risks of participation (Marshall & Rossman, 2014).

5.8 Reliability

5.8.1 Trustworthiness

Trustworthy researchers have a moral reliability so that participants are ensured that the researcher will follow through with commitments made (Fitzpatrick. & Kazer, 2011) during the research process.

"When I disclose what I have seen, my results invite other researchers to look where I did and see what I saw. My ideas are candidates for others to entertain, not necessarily as truth, let alone Truth, but as positions about the nature and meaning of a phenomenon that may fit their sensibility and shape their thinking about their own inquiries" (Peshkin, 1985 cited in (Connelly & Clandinin, 1990).

This statement by Peshkin (1985) reflects the researcher's desire for conducting this study as the data needs to be a true representation of what the participants expressed through the narratives and the results must be clearly expressed so that other researches may engage in the work presented on a personal level based on their own ideas, thoughts, beliefs and understanding.

Narratives are descriptions of past events and the consequences of these events on the individuals' lives, therefore care will be taken to ensure that all data is recorded, transcribed and interpreted in a trustworthy manner. The audio recording of interviews ensured that data could be revised if there were discrepancies during transcription.

5.8.2 Inter-Rater Reliability

Each interview was transcribed twice, the researcher did the first transcription and a second transcription was conducted by the research supervisor; afterwards both transcriptions were matched to ensure consistency. The asymmetrical relationship between the participants and the researcher was evident in certain instances. Some participants were sometimes unsure of the researcher's religious background and understanding. The researcher is an academic and some participants were students or other professionals which led to different conversation patterns. There were instances where the researcher believed that the age and qualification difference may have affected the naturalness of the participants' responses, there was a school-aged participant that was very aware of the differences and her interview lasted the shortest of all participants. She provided the information in the quickest and easiest way possible and indicated that she was done. This did not prove to be a limitation of the study as the necessary data was still obtained. Parent interviews confirmed the narratives of the school-aged participants in the current study.

5.8.3 Credibility

The credibility of the hearing loss was confirmed by the diagnostic audiogram results. Participants provided proof of the audiological results that indicated that a hearing loss was diagnosed. One participant did not have audiological results as she is twenty-one years old at present however she was diagnosed and healed of a hearing loss before the age of one. The researcher tried to source the results from the hospital where the tests were conducted however the current staff reported that records were only kept for five years. The mother of that participant was requested to sign consent to proof that the diagnosis of a hearing loss was made.

5.8.4 Confirmability

Data collected from the narrative inquiry was supported by the diagnosis on the initial audiogram however the proof of a diagnosed healing and restoration of the hearing loss was not obtained with a retest. This was not an oversight as the researcher did not aim to confirm the hearing loss as the social implications of documented medical proof was a 'good to have' but not a validity necessity within the direction of this study. This study was not questioning or validating the narratives of the participants who reported that a supernatural healing occurred as the researcher was a reporter in her own right, of the stories that were told. The medical model and mind-set will require proof of

the healing and restored thresholds on the audiogram however the integrated models of patient care incorporate both humanistic and scientific aspects as discussed in literature.

5.8.5 Meaning-In Context

The data was collected in a manner that required the participant to recollect the events of the past and this created to-and-fro narratives in a time domain however the participant was directed back to the theme of the conversation. The researcher needed to probe for clarity of stories when the participant assumed that there was an understanding of when and where something occurred. The chronological age of the participants at the time of the healing event varied hence there were no similarities and specific meaning that was dependent on age.

5.9 Summary

The methodological framework within this chapter afforded the researcher the ability to have a solid structure for this study. All procedural and ethical implications were considered prior to embarking on the data collection phase. A clearly structured methodology assisted the researcher in effectively organising the data collection processes. The data collected was thick in descriptions with both verbal and non-verbal utterances. The following chapter presents the findings of the study.

Chapter 6: Results and Discussion

6.1 Introduction

This chapter includes presentation of qualitative results and an assimilated discussion of these results, due to the nature of the data collected. The presentation of a synchronized results and discussion chapter is apt for the present study as it forms a more interconnected representation of the data and its interpretation. This study chose to present the results and discussion in one chapter as it is recommended for research within health and social sciences, which differs from the more familiar notion of independent results and discussion chapters (Newing, 2010; G. Wisker et al., 2010).

Etic and emic factors (Ten Have, 2007) were considered during the presentation of the results and discussion. Utterances are presented and discussed with reference to each participant's belief system and culture. In this study, the researcher's viewpoints are also included as an outsider to each participant's context. Some blurring of lines occurred when discussing specific utterances from an etic perspective as the researcher could not directly relate to any of the feelings and emotions of being Deaf or having a child who is Deaf. Results were then presented verbatim and the subsequent discussion was based on literature that pertained to Deafness and Deaf culture. In this study, the researcher bias and influence on the discussion was evident in the researcher's personal experiences and beliefs however the researcher went into this research with a mind-set of truth. Hence the researcher in the current study trusted the participants who believed that they were healed; the researcher was merely a listener in the narrative of this event. In order for this research to have structure, the narratives were analysed, presented and discussed from both the participant's experiential context and a theoretical framework.

The ensuing results and discussion chapter is presented according to the sub-objectives of the study; however, the three main objectives are realised and integrated throughout the chapter. Categories and emerging themes that were derived from the data and the literature have been grouped under the objectives of the study.

6.2 Categories Leading to Themes

The main aim of this study was to document the narratives of healing experiences of individuals who reported a supernatural healing of a sensorineural hearing loss.

As discussed in the methodology chapter, this study has three main objectives and three sub-objectives, namely:

- Main Objectives

- To identify the recurring themes within the narratives of participants who reported a healing, with the purpose of deconstructing the aspect of healing amongst participants.
- To describe the cultural, religious, spiritual and social influences that impact the individual with a hearing loss.
- to design a proposed working Audiological Model: An Integrated Model of service delivery in Audiology

- Sub-Objectives

- To document the diagnosis of the sensorineural hearing loss.
- To identify the 'turning point' event or events that caused the reported healing.
- To explore the influences of the healing on the participant's life.

The narratives yielded dominant categories among the majority of participants. These categories had specific themes that emerged. This formed the framework of the results section as delineated in Table 6.1.

Table 6.1: Sub-Objectives, Categories and Themes.

Sub-Objective	Category	Theme	Presentation of Data
1: To document the diagnosis of the sensorineural hearing loss	1: Identification, Assessment and Management of a hearing loss	Identification phase of the hearing loss	Results and Discussion of Theme 1
		Assessment procedures, for the diagnosis of the hearing loss and the Emotional reactions of significant others, after diagnosis	Results and Discussion of Theme 2
		Educational decisions for management after the diagnosis of the hearing loss and the consequences of late diagnosis	Results and Discussion of Theme 3
	2: Cause of the hearing loss	Hearing loss and its relation to sin and curses.	Results and Discussion of Theme 4
		Providing a testimony for others	Results and Discussion of Theme 5
		The building of strength and the discovery of life's purpose	Results and Discussion of Theme 6
		Genetic cause of hearing loss	Results and Discussion of Theme 7
2. To identify the 'turning point' event or events that caused the reported healing.	3: The healing event	Traditional and alternate healing as a method of rehabilitation	Results and Discussion of Theme 8
		Physical restoration of hearing	Results and Discussion of Theme 9
		Non-physical healing	Results and Discussion of Theme 10
3. To explore the influences of the healing on the participant's life.	4: Areas of the participants life that changed based on the healing	Reactions to the healing	Results and Discussion of Theme 11
		The belief in God	Results and Discussion of Theme 12
		The life of prayer	Results and Discussion of Theme 13

The researcher chose to present a holistic discussion of all results obtained at the end of each theme as per Table 6.1. A final summary will be provided at the end to form a cohesive chapter. Pertinent direct quotes are italicised with P1, P2 etc. to represent the participant who uttered the response. The reader must be cognisant of grammatical differences in some of the narratives, these differences are indicative of Deaf speech. The utterances may appear to be incorrectly transcribed with grammatical errors however they are direct quotes from a participant who has Deaf speech (Herman et al., 2015).

6.3 Sub-Objective 1: To Document the Diagnosis of the Sensorineural Hearing Loss.

Results of sub-objective one is realised through category one and two. There are seven themes within these two categories. A discussion of each theme will be provided after the results of that theme.

6.3.1 Results and Discussion of Category 1: Identification, Assessment and Management of a Hearing Loss

Table 6.2: Details of Category One

Category	Theme	Presentation of Data
1: Identification, Assessment and Management of a Hearing Loss	Identification phase of the hearing loss	Results and Discussion of Theme 1
	Assessment procedures, for the diagnosis of the hearing loss and the emotional reactions of significant others, after diagnosis	Results and Discussion of Theme 2
	Educational decisions for management after the diagnosis of the hearing loss and the consequences of late diagnosis	Results and Discussion of Theme 3

Category one as per Table 6.2 depicts the initial detection phase, the assessment processes and the management methods for the HOH/D participant and their families. The detection of a hearing loss affects the decisions taken by parents when considering the growth, development and education of the child (Marschark et al., 2009). The researcher identified the themes as identification, assessment and management of the hearing loss as these play a critical role in the future of the HOH/D individual. The theory of practice in Audiology (Tharpe & Seewald, 2016) supports these themes as it highlights these 3 areas as being vital for an individual who is suspected of having a hearing loss.

6.3.1.1 Theme 1: Identification Phase of the Hearing Loss

The identification of a possible hearing loss is ideally the responsibility of the individual who performs the new-born hearing screening (NBHS) however this service is still gaining momentum in South Africa and it is not a mandatory practice (Swanepoel et al., 2009). The lack of the mandatory practice of NBHS in South Africa results in a hearing loss identification phase that may not involve audiologists. The researcher established that the family, extended families and educators were the main role-players in the identification phase, for participants in this study.

Parents were the main source of identifiers of a possible hearing loss with P2, 3, 4 and 5 and grandparents were the identifiers with P1 and 6. The identifiers of P7's hearing loss were the teacher in conjunction with the participant's dad and aunt. Grandparents were the first individuals to notice an abnormality with P1.

> *"When I was 18 months they found out. Through my grandmother, cos I was playing with my cousin and my grandmother was calling me and I didn't respond and my cousin responded. Then my gran went and got pans* (gestures showed the banging together of pans) *and banged them against each other and I didn't respond. So she went and told my mom that I am deaf and my mom didn't believe her"*. (P1)

Parents may not always have the time to identify a possible hearing loss as the time spent with a young child may be limited. Disbelief can occur as the acceptance of a hearing loss may be too weighty for the parent to bear as reported in the case of P2.

> "*I think my family knew from the time I was small that you know what, that there is slight hearing loss but they didn't know the extent of it, because they noticed that if I'm busy doing something* (gesturing as if she was writing and concentrating on a task) *and they speaking to me then I wouldn't hear, unless they would call me like P2,P2* (speaking louder the second time) *then I would say yes why* (are) *you shouting,* (they would say) *but we've been calling you...I didn't even find out till years later and will tell you how I found out, was because um I, people would always say like I'm calling you and I say but I didn't hear* (expression of frustration). *But over the years my friends and teachers knew that I would sit in front of the class like they took it for granted that, that's the family that they have a problem, the Deaf family"*. (P2)

The narratives of P2, as indicated below, revealed the delayed identification of a congenital hearing loss, where identification occurred in adulthood.

> *I didn't even find out till years later …what then happened was, when I started working, um that's when it, the problems actually started because remember now that the people I initially worked with were in the same small area, but when you start, but now I moved to Joburg now with people who didn't know me, didn't know my family I'm from, didn't know my background they didn't know, So people would make jokes like, hey we can gossip about her and stand next to her and she wouldn't even know we gossiping about her, you know like that there, they would say like that, because when she's concentrating on her work then she doesn't concentrate on anything else. They didn't know that I had a hearing problem, they just thought that once I'm fixated on my work nobody else matters, you know like that there. But then eventually as time went on, people obviously started to pick up that maybe you should go check your hearing* (as a recommendation) *and I was like there is nothing wrong with my hearing and I don't wana hear things that you know are not necessary. So um, what then happened was, a few years back I had this guy, he was a friend that I'd met like in Joburg and stuff like that and he was talking to me and he noticed that whenever he spoke to me, he'd tell me stuff and maybe I'd respond and maybe I wouldn't and he would say by I told you this and you know and I would you say oh, I didn't know. And then the one day he said to me um…have you ever considered you know having your ears checked and I said Why* (with head and facial expressions of disbelief at the question or request), *but I knew that there was a problem but to me it wasn't a problem, it was a problem for everybody else but to me it wasn't a problem, you know like that. If you want me to hear you then speak louder, you know like that, but I didn't realise that until this guy said to me, but I said there's no problem* (P2) *he said you know what actually there is because lots of times speak to you or say things to you and later on you will ask me the exact same thing I told you, you never you know acknowledge. He said maybe you should have them check and I said For What?* (In an irritated expression) *and he said because you probably hindering your performance. Maybe hindering your performance around people, it's hindering your performance around work. So then I just brushed him off you know like that because I just thought argh you know I don't need to go check them, they must just leave me alone. I'm fine, I'm doing fine* (waving her hands in front to indicate that she is fine) *and I don't need them to be checked but then what happened, oh no I'm lying like a cheap watch* (laughter from both P2 and the Interviewer)…… *So then what happened was when this guy said to me, said this to me, his friends are friends of mine, so I was*

on the phone with one of his friends and she says that umm, she said oh that she was speaking to her, her cousin, oh he's the cousin, she was speaking to the cousin and he said um, tell me something, does P2 have a problem with her hearing? And I started laughing when she said that cos I knew that he was referring to our conversation and she said, she said Oh My Gosh how can you say that, you don't mention that you know and then she started to tell, she said she didn't realise that I was sitting in my seat thinking 'you don't mention that' so these people are looking at us like we the Deaf family 'you don't mention this' you know, know they treat us so well and I'm open with them, why can't they be open with me. So but then I started to realise it was sort of like they knew so they decided, you know like if somebody has big ears, you won't say like ah look you got big ears, they know you just don't mention it, you tease them about their nose argh if they teasing you about your eyes, you say you got a big nose, you won't go near their ears, you leave it because you know they big (laughter). *So they knew that if we tease each other about anything, don't go there, that's a no go area but when I sat there you know and I heard her say that it was like 'oh my gosh so your'll just see us like the Deaf people' you like that there. But I left it because I got that, nothing really bothers me and um so what then happened was eventually the staff started to complain to my manager that she needs to speak to me because they can't be coming to speak to me all the time, they give instructions and I just ignore them, you know like that there. And sometimes I, sometimes I give them instructions and then they'll give me a response and then afterwards I will be like why aren't you doing this? Then they would say but I did tell you and I will be like oh and walk away.* (P2)

There is value in the integration of workshops and information sessions that can be added to prenatal care packages so that parents and caregivers are conscious of the sign and symptoms of a possible hearing loss that may exist. Participant 6's hearing loss was identified by her grandparents and they were 'deeply' concerned with what they were seeing as stated by P6 *"it was very real for her* (P6's Granny) *when she was cooking for us and I think she dropped pans or something, she dropped pans and spoons right next to me and it was loud and I just looked at her and I smiled"*.

P6's mother reiterated the grandparents' concern as they were reluctant to discuss a possible hearing loss however they knew that it was an urgent and serious concern.

"*Um I noticed that we would often take her to church services and when the loud praise and worship music she would sleep right through she wouldn't even move. When someone spoke loudly she wouldn't react at all and I, as time went I definitely noticed there was a problem with*

her hearing and one could take or drop anything right next to her and she wouldn't react. Especially her granny and her grandfather because they stayed with us, well they both would come up to us and they both were very concerned, they said we really concerned, we don't wana actually raise the issue but P6 definitely has a hearing problem and you know they, as time went they got more and more concerned about it you know". (P6's Mother)

Participant 7 was a minor and her mother was also interviewed to provide her perspective of the pregnancy and birth. The mother of P7 stated that her pregnancy was unplanned and there were various risks to the foetus during the pregnancy. The role of the extended family member and the foundation phase teacher was vital when identifying a possible communication difficulty with P7.

"*Aunty told me that, when I went there for holiday, she said that they were calling me, they were calling and calling me, I couldn't hear. So then they had to come near and call me. So then that I could say anything or whatever, so they had to come close and talk. Then after that I was in preschool* (and) *the teacher was calling me or something then I couldn't hear at all. I didn't have hearing aids, so the teacher told my father that I have to go, the teacher told my father that I can't hear when she was calling me, I cannot hear her at all. So then my father told my mother and then they had to organise hearing aids for me"*. (P7)

The early identification of a hearing loss is not an isolated event or medical procedure. Parents and caregivers in the current study went through a phase of rudimentary home based screening assessments, monitoring and questioning before the assumptions of a possible hearing loss was verified through a diagnostic audiological assessment. The signs and symptoms of a hearing loss can include the difficulty to localise to sounds, dizziness, tinnitus, nausea, delayed speech and language delays (Kahan, Miller, & Smith, 2008). Parents in this study performed their own basic hearing screening to identify if a hearing loss exists. These preliminary methods include the rattling of dishes or toys, calling the child's name from varying distances to determine if the child acknowledges the parent or caregiver. Grandparents as caregivers have played a significant role with the participants in the present study. The aim of any parent would be to identify a hearing loss as early as possible to ensure that intervention is timely.

Early identification (EI) and New-Born Hearing Screening (NBHS)

The need arises to identify new-borns who may have a hearing loss as early as possible. New-born hearing screening (NBHS) aims to identify a hearing loss when a baby is born to minimise the effects

of the hearing loss on the child's communication ability. The significance of NBHS is appreciated when the negative consequences of a late diagnosis are seen in a school aged child who has speech and language delays due to the lack of early identification. It is evident that there is a need for mandatory NBHS programs in the health sector but this study has shown that family members are still the first individuals who identify a possible hearing loss.

If NBHS is unavailable to parents then the sole responsibility of detection lays with the parents, family members and educators. There may be a delay in diagnosis and management if individuals are not au fait with the signs and symptoms of a hearing loss. This study found that all participants stated that the detection of a possible hearing loss occurred within the home environment by parents and family members, which illustrates the key position of the family in the identification phase. This initial phase of detection, as primitive as it might seem, is critical as it motivates the family to take the necessary steps towards a diagnosis. In South Africa, the reality of NBHS for all new-borns is not evident at present; hence parents and caregivers must be equipped to identify the signs and symptoms of a possible hearing loss in new-borns.

In South Africa, communities raise children and the reactions to the diagnosis affects the extended family and the community. Decisions are collectively made by all leading role-players in the family structure. Therefore community and religious leaders need to have access to information to provide the support to the parents who receive a new diagnosis of any illness or disorder. Workshops and information sharing sessions usually focus on caregivers, religious leaders and community leaders, as they are seen in the hospitals but community halls and elders meetings are sites that can be explored for empowerment of the community. Family members in a successfully developing unit will always consider the hearing and hard of hearing needs when making decisions (Hong & Turnbull, 2013).

Grandparents and Parents as the Primary Caregivers

The role of grandparents corresponds to the South Africa statistics which revealed that 60% of orphaned children live in grandparent headed households (Gray, Midgley, & Webb, 2012; Mall, 2005).

In South Africa, there is a growing elderly population (Lehohla, 2014) who are now playing the role of the primary caregiver. The community and extended family members also play a powerful role in the early detection of syndromes and disabilities in children (Fligor, 2015). These caregivers spend the majority of their time with the child and will facilitate the early identification of a hearing loss;

however, they need to be informed about the signs and symptoms of a hearing loss. The political history of South Africa has left a large number of older caregivers and grandparents uneducated (Kingdon & Knight, 2004). Therefore, intervention strategies should be moulded around presentation methods that meet the needs for grandparents who are not literate.

Mall (2005) states that any intervention that is targeted at grandparents in Africa, must include financial support. The role of the audiologist as 'information provider and educator' is thus highlighted and financial support from the department of social services is necessary to meet the needs of the elderly.

6.3.1.2 Theme 2: Assessment Procedures, for the Diagnosis of the Hearing Loss and the Emotional Reactions of Significant Others, after Diagnosis

The time of diagnosis of a hearing loss is critical for the development of communication milestones as timely management is required (Northern & Downs, 2002). Assessment procedures will depend on the age, physical and cognitive ability of the individual. Audiologist may decide to perform an array of procedures for the assessment and detection of a hearing loss which may include an auditory brainstem response (ABR), otoacoustic emissions (OAE), visual reinforcement assessments (VRA) and pure tone testing (Roeser, Valente, & Hosford-Dunn, 2007).

Caregivers and parents may accept a possible hearing loss and react immediately as with P6 whose mother stated a diagnosis was made as soon as the family suspected a hearing loss.

> "*On test* (when P6 was assessed by an audiologist) *it found, we found that she* (P6) *was born Deaf*". (P6's Mother)

There are a significant number of HOH individuals who may go undiagnosed due to their ability to develop spoken language (Bradham, Houston, & Diefendorf, 2014). This was evident with P2 who was not assessed as a child and only obtained a medically diagnosis when the hearing loss started to affect her work situation as an adult. Her narrative indicates:

> *When the people initially at work started to talk about it a lot, I on my own strength went and got my ears checked, I went to an audiologist and then from there they told me ok here and then they showed me all the different types of hearing aids and they showed me you know what the medical aid doesn't this and the type that I needed because I am in the office and I use the phone and all*

> *that. And they were ranging from like (R)20000 to 40000 and that was not in my budget and I was like* (her facial expressions showed that she is not impressed) *that can wait, one day when my ship sails in, I'll get me a pair of hearing aids. So then my boss then spoke to me and said lease P2 that's enough now, we've let it slide for years, we need you to go and get, do this, please if you not gona do it for yourself, do it for us, stop. And she made a joke of it cos she knows that I have a sense oh humour and then I said fine then I will do it but the this is what its gona cost. She said well then we will find a way to get around it and anyway I went and had that tested again and then um um only to find out that the medical aid they, for 2 hearing aids came to 25000* (Rands), *the medical aid was prepared to pay like 19000* (Rands) *some, like close to 20000 and then the audiologist that I was dealing with came from God cos she said I can get my hearing aids and the difference about 6000 I can pay it off, well its paid off now*. (P2)

Participant 3 provided information about her medical diagnosis and she provided her opinion about a parent's choice to seek a medical diagnosis.

> *"My parents tried to call my name, so wonder*(ed) *why I didn't look at them. So they took me to the Doctor* (Audiologist) *and Doctor found out that I am Deaf…..With babies, parents it's their babies so I think they may say no I accept it* (the medical assessment and management of the hearing loss) *or they have a right to pray for the child to hear. The child may say yes and will be healed from the heart"*. (P3)

In this category, it was found that the participants' lives are influenced by the actions and reactions of significant adults in the environment. The emotional reactions of the parents, grandparents, family members and teachers shaped this theme.

Parents Emotional Reactions to the Diagnosis of the Hearing Loss

Human beings react to situations with joy, anger, frustration, disappointment amongst an array of emotions (Lewis, Haviland-Jones, & Barrett, 2010). This study found that emotions were distinct and common amongst the parents of the participants in this study. These emotions included devastation, sadness, concern and fear.

Participant 1 described her mother's reaction as more pronounced than her father's reaction when she said *"They took me for tests and they found out that I was Deaf and my mom was* ***devastated****. Um my dad not so much"*.

Grief was evident with P3 who said *"So my parents were like **heartbroken**. Didn't understand why I am Deaf"*.

Maternal reactions were stated more often than paternal reactions and P4 reiterated the maternal response to a child with a hearing loss, when he said *"My parents are full of hearing. I'm the only Deaf* (person) *in my family. Mum was feeling it **difficult**. She is coping because God loves us"*.

Participant 5 had a family history of hearing loss as her mother is HOH. There was positivity about the diagnosis of a hearing loss with P5, as there was familiarity of a hearing loss and the stigma attached to HOH individuals was minimal.

The emotion of concern was verbalised with P6 when she said, *"They were very **concerned** about it"*.

This study found that the narrative of P7 and her mother contained multiple emotions as P7 was born prematurely and her mother was unaware of the pregnancy and had been consuming chronic medication during the pregnancy.

> *"I had a thyroid problem and I was on you know, Thyroid medication. So he* (The Dr) *said you know this is a **very risky pregnancy** and would I like to **terminate** and at that time I was in hospital and I didn't have my husband around and whatever it was and it was a **very tough decision to make.** Because a baby that far you know and to just go and abort it, for me it was the biggest thing you know, so anyway I spoke to my husband and whatever and he said 'no we'll take the chance' because he said 'if she was born, she wouldn't be a normal child'. So anyway I said doesn't matter I will take the risk and whatever it is, I'll leave it in God's hands you know"*. (P7's Mother)

Family Members and Others Emotional Reactions to the Diagnosis of the Hearing Loss

Extended family members and community involvement; in the raising of a child is a common practice in South Africa (Falola & Jean-Jacques, 2015; Singh & Devine, 2013). The influence of extended family members has a great impact on the future of the child. Communities can either be supportive and caring or communities can stigmatize the family who have children with disabilities. The diagnosis of a hearing loss can have a psychosocial impact on the family as stigma can influence the reaction of those who are associated with the individual with a hearing loss (Bainbridge &

Wallhagen, 2014; Hogan, Reynolds, Latz, & O'Brien, 2015; Kožuh, Hintermair, Holzinger, Volčič, & Debevc, 2015).

The researcher found that P1 and P6 had receptive and observant grandmothers who primitively tested what they were observing with their grandchildren as P6 said *"it was very real for her* (Grandmother)….. *you know what I mean like she knew that something was very wrong"*.

Respect was shown in the utterance of P2 as she mentioned that people in the community had full knowledge about her hearing loss and due to their respect for the family they did not speak out about it.

> *"And it's amazing how people when they know that you basically um have….they know that there's sort of like, how can you say it, like an issue in the family. People especially when you like in a small community, then tend to* ***not speak out about it****, they sort of feel like, they need to* ***respect*** **(us)".** (P2)

The current study found that the role of the community and extended family were highlighted with emotions that were positive, caring and loving with P3, P6 and P7.

> *"People in church did not have a problem. They showed* ***love and try and communicate*** (tried to communicate) *with me."* (P3)

> Participant 6's mother stated, *"family everybody was very* ***concerned****, they were all very concerned about her hearing"*.

Participant 7 has a caring and attentive family as her aunt and cousin noticed that there was something wrong when P7 was on holiday.

Participants' Emotional Reaction to the Hearing Loss

Emotional reactions may differ between individuals who are diagnosed with a hearing loss based on the age of onset and age of diagnosis (Kail & Cavanaugh, 2015). There are common emotions amongst all HOH/Deaf individuals and these include personal questioning, feeling of isolation and sadness (Cambra, 2005). The hearing and Deaf worlds use different modes to communicate (Caselli, 1983). There may be an occurrence where an individual from either the Deaf or hearing world, is left isolated from the dominant group in the social setting due to mode of communication utilised.

Children who are mainstreamed despite the diagnosis of a hearing loss may have a disadvantage (Mogford-Bevan & Sadler, 1993) and may feel isolated as the difference is noticeable to other children.

Participants 1 and 4 indicated that they both experience an ongoing internal personal conversation that is related to the reason for the hearing loss. Participant 1 mentioned *"Sometimes I ask **why me**? And I do have days when I feel, why or why I am Deaf, why you know"….I **feel left out**. Especially with family, they all forget that I'm Deaf, you know, and they carry on talking and I get left out"*.

Participant 4 stated that he is only alive because he stayed with God after the questioning *"Because I stayed with God and without God I don't know where I would be"*.

Participant 7's mother detailed the isolation and sadness that her child experienced at school.

> "*From day 1 at school she was **treated badly** by the kids and kids are like you know…they don't understand what's going on until I approached the teacher and I told her this is what's going on, this is the story. So she called her P7 to the front, she showed the kids her hearing aids and she explained to the kids, this is what your'll were lucky enough that God gave your'll, you know with your'lls ears your'll can hear everything. This is why she needs this equipment; this is why she needs this to hear. Your'll are fortunate enough you know that your'll can hear properly, your'll can speak properly so if she can't speak properly it's because of her hearing problem. She has a speech problem*". (P7's Mother)

Participant 2 stated that her parents did not pursue further hearing assessments when a hearing loss was suspected, despite a family history of hearing loss. Misinformation and lack of empowerment (Coulter, Entwistle, & Gilbert, 1999) leads to decisions that affect the HOH individual in adulthood, as was seen with the participants in this study. Stigma, isolation, depression and grief often occur concurrently with the diagnosis of a disease or disorder.

Stigma, Isolation and Depression

Positive and negative reactions of adults who belong to the circle of influence of the HOH/D child have an impact on the future of the child. The results obtained in the present study indicated that stigma, isolation, worry and depression were emotions that were apparent in all narrative data. The stigma associated with differently abled children still exists. The HOH/D individuals in this study

experienced isolation from conversations with family members, which is a common reaction (Cambra, 2005). Families tend to ignore or forget about the need to speak louder or to speak face to face with a HOH/ D individual, which poses a barrier to the interaction. Mothers who experience difficult pregnancies are at a higher risk for negative emotional reactions (Glover, 2014) as indicated by P7's mother's narrative.

Griffin (2013) states that as a parent of a HOH child she must voice her opinion on the decisions that are made with regards to her child to maintain wholeness of care. The process of assessment of a hearing loss starts at the initial suspicion from caregivers and teachers which then leads to the willingness of the parent to undertake formal assessments to diagnose a hearing loss. The preparedness of a parent who suspects an abnormality will differ, however the initial 6 months become critical in the overall developmental outcomes for the child (Walker, 1991). Parents who are proactive will ensure that the hearing loss is diagnosed and the management options are considered as soon as possible.

Assessment and Diagnosis

Early identification (EI) of a hearing loss should be the responsibility of the health sector as new-born hearing screening (NBHS) should be mandatory for every child. Health and education professionals support the NBHS initiative (Yoshinaga-Itano, Sedey, Coulter, & Mehl, 1998) as the time of detection may vary from family to family if NBHS is not conducted. The advantage of EI can be lost through ineffective support from the health sector (Young & Tattersall, 2007) in terms of availability of hearing aids and rehabilitation. Early intervention provides the family with more time to come to terms with the diagnosis (Young & Tattersall, 2007) and to support the child from the early stages of development.

The assessment procedures to diagnose a hearing loss have grown in reliability and efficiency over the last 20 years (Lenihan, 2010). Technology has developed radically; hence audiologists are now able to diagnostically assess a new-born within hours of being born. Electrophysiological assessments such as the AABR can provide a diagnosis of a possible hearing loss within the cochlear and retro-cochlear auditory regions (Mason & Herrmann, 1998). In the USA the identification age has decreased from 30 months to 6 months due to technological advances, early identification programs and timeous referrals (Harrison, Roush, & Wallace, 2003).

All states in the United States of America, currently have a NBHS program which has resulted in 95% of new-borns being screened (Lenihan, 2010). This vision is not fully established in South Africa and the main role-players in identification are the caregivers. A trend that focuses on the early identification of a hearing loss in new-borns is however emerging in South Africa (van der Spuy & Pottas, 2008). Parents will always seek for environments that support the child's academic, social, emotional and self-advocacy skills (Griffin, 2013). The South Africa public health sector is understaffed and underequipped to deal with the growing number of patients in all areas of healthcare (Cullinan, 2006). The collaboration between parents and professionals is necessary as parents and grandparents are generally the first to suspect a hearing loss (Thompson & Thompson, 1991).

There is an abundance of research that indicates that children with a hearing loss, who are identified and managed before 1 year of age have better outcomes (Yoshinaga-Itano et al., 1998). The concept of NBHS can be credited to Marion Downs who pioneered the screening of neonates since the 1960s (Hall, 2000). The development of the electrophysiological measures such as the Auditory Brainstem Response (ABR) and the Otoacoustic Emissions (OAE) tests (Alpiner & McCarthy, 2000) has transformed the accuracy of hearing screening in new-borns. Tharpe and Seewald (2016) discuss NBHS as 'A Silent Revolution' due to the significant impact of the early detection of a hearing loss in neonates which minimises the time between identification and diagnosis. In South Africa the new-born hearing screening initiative is guided by the (HPCSA., 2007a)

The South Africa position statement provides the South Africa audiologist with service delivery tools to assist in the implementation of a hearing screening program that will be efficient and effective. The statement clearly states 'The goal of early hearing detection and identification (EHDI) is to provide children with hearing loss optimal and timely opportunities to develop linguistic, literary and communicative competence in keeping with their full potential' (HPCSA., 2007b). New-born hearing screening for every new-born is a universal aim for all audiologists however South Africa faces various constrictions that hinder this process.

The limited resources, poverty, the lack of free education and a struggling health care system are amongst the hindrances of NBHS in a developing country (Morton & Nance, 2006) such as South Africa. However South Africa is continuously striving to provide its population with health care services that are on par with first world countries. Early hearing detection and intervention programs are increasing however parents state that 'knowing early' does not eliminate the feelings of shock, grief and loss that comes with the diagnosis of a hearing loss (Young & Tattersall, 2007). Emphasis

on the family unit in the rehabilitative process is growing, as audiologists' become cognisant of the emotional effects on the family, especially the mother (Prakash et al., 2013).

There is minimal emphasis on the structures available for social and emotional support for parents, such as the inclusion of a social worker, religious leader or psychologist (Athalye, Archbold, Mulla, Lutman, & Nikolopoulous, 2015). Support structures are necessary when assisting parents who are on a journey from the identification to the diagnosis of a hearing loss. The array of thoughts, feelings and emotions of parents should be managed in a holistic manner to assist the family with the diagnosis.

Grief, Devastation and Difficult Emotions

Emotions are self-organised changing processes that are connected to the individual's everyday life (Fogel et al., 1992). The birth of a child is usually accompanied by positive emotions such as joy and laughter (Young & Tattersall, 2007). The existence of an abnormality at birth may drastically change these joyous emotions into one of sadness, grief, fear (Braam et al., 2014). Family-centered services and family quality of life is vital (Hong & Turnbull, 2013) when there is a diagnosis of a hearing loss. Human communication is affected by a hearing loss and families may feel isolated when a hearing loss is diagnosed (Prakash et al., 2013). It is important that the audiologist is cognisant of the quality of life domains, that will impact on the outcomes of audiological care provided to the individual with a hearing loss and his/her family (Schalock, 2000).

The emotional reactions of parents to the possibility of a hearing loss (Alpiner & McCarthy, 2000) will dictate if EI will occur when a hearing loss is suspected. Worry is associated with the diagnosis of a hearing loss as families predict the future of the child (Hong & Turnbull, 2013). Thus, there is a need for an audiological service delivery model that educates and supports potential parents, caregivers and educators of children who are hearing impaired.

The theory of grief has transformed from the primary five stages of grief (Kubler, 1969) to more complex meaning-making theories (Douglas, 2014). Families with a newly diagnosed baby will go through the stages of denial, anger, bargaining, depression and acceptance (Kubler, 1969). The constructivist perspective allows the individual to construct and maintain an understanding of life due to their experiences (Neimeyer, Burke, Mackay, & Stringer, 2010). Parents who have a child with an abnormality will construct their understanding of the situation and go through stages of grief and questioning (Ramachandran & Stach, 2013) with the ultimate concern being the future of their child

(Hong & Turnbull, 2013). Making sense of the hearing loss can be either related to the parents' spiritual belief, or a change of spiritual beliefs to respond to the loss (Neimeyer et al., 2010). Emotions that are related to the diagnosis of a hearing loss can vary between families.

A study conducted in Canada found that social isolation and stigmatisation was evident with families with a HOH/D child (Hong & Turnbull, 2013). Parents in the Hong and Turnbull (2013) study stated that society lacks understand of a hearing loss and families with hearing impaired individuals often isolate themselves from social activities due to the difficulty of communication. Close family and friends helped families overcome stressors as they were support structures for families who are impacted by a hearing loss (Hong & Turnbull, 2013).

The Hong and Turnbull (2013) study also revealed that a hearing loss excluded their participants from the hearing world due to a communication difference. The HOH/D person is then left out of conversations and humours (Hong & Turnbull, 2013), and will detach from communication over a period of time. Feeling of regret and questioning emerged from the narratives in this study and in the Hong and Turnbull (2013) study, which indicate that participants in both studies present with an internal dialogue of constant reasoning pertaining to the hearing loss. The HOH/ D individual may become depressed due to the fear of God (Braam et al., 2014) as the hearing loss may be seen as a punishment. Self-reflections and blame are either beneficial or detrimental to the individual and support from a clinical psychologist or counsellor can assist in this process of internalisation.

Emotional and spiritual support for an expectant mother is as warranted as physical and medical support (Kavanaugh, Moro, & Savage, 2010). A study by Prakash et al. (2013) found that mothers who acquired coping strategies and assistance had children with better developed emotional sensitivity, reading competence and problem solving behaviour. The support of the community and religious leaders in difficult situations (Sixsmith, Boneham, & Goldring, 2003) is not always given the credit that it deserves. The inclusion of religious leaders in the decision making processes can provide additional emotional comfort to the parents on a personal level (Barnes, Plotnikoff, Fox, & Pendleton, 2000). Community and religious leaders can impact the parents on a more frequent basis than a doctor or therapist. The support that can be afforded to parents from religious leaders can ease the burden of raising the child alone (Barnes et al., 2000) as doctors and therapists cannot provide that level of support. Patients in a study in the USA stated that their medical experience was devoid of spiritual support (Balboni et al., 2007) however they deemed it important for the medical system to provide such support.

The cost of counselling and ongoing support from medical professionals is inaccessible and unaffordable for the majority of people in South Africa. However the social support from religious leaders who are included in the multidisciplinary team should assist in bridging the gap and lightening the load on medical professionals (Barnes et al., 2000).

6.3.1.3 Theme 3: Educational Decisions for Management after the Diagnosis of the Hearing Loss and the Consequences of Late Diagnosis

Schooling and educational decisions form an essential aspect of parental responsibility (Kimmons, 2005). The educational decisions are based on access to schools in the area, cost of school fees, and future aspirations of the parents for the child based on the child's strengths and talents as well as a school that is equipped for the specificity of needs of the child (Du Pont, Goodman, & Steiger, 2001). Parents of a child with a hearing loss are required to make an important decision about the method of communication for the child (Steinberg, Bain, Li, Delgado, & Ruperto, 2003). The educational decisions of the participants in the present study were varied.

Participant 1, P3, P4 and P5 were all diagnosed at birth and their parents selected a school for the Deaf and Sign language as their 1st language. Participant 3 was diagnosed and her parents made an initial decision to place her in a school for the disabled. Thereafter the school took a decision to transfer her to a school for the Deaf. The change of school environment was informed by the hearing loss and the need for a more conducive environment that caters for the needs of P3.

Participant 2, P6 and P7 were all mainstreamed however all three participants were diagnosed with a hearing loss at different ages. Participant 2 was diagnosed late despite her parents identifying the loss at an early stage and she described her experience as *"I think my family knew from the time I was small that you know what that there is slight hearing loss but they didn't know the extent of it"*. Participant 2 was also not able to afford initially the hearing aids once diagnosed as an adult.

> *So I knew where I was sitting, what hearing aids I needed but there was no money, no extra money. Cos obviously you can't pay them off, you have to pay them upfront so what happened was umm, what happened? Oh yes and then it got pushed to the side, every time I thought about it, I was like argh, all the time in my mind I was thinking, you got a fat lot to say but are you gona buy me those hearing aids you know. But I never ever said it to them but that's what I was thinking.*(P2)

The hearing loss started to affect the working environment and there were negative reactions from colleagues which obligated P2 to seek for management options.

> *So then obviously I got the hearing aids and I'll never forget the first 3 days after wearing them, I had a headache from hell. It was a headache from hell because now my, I could understand it, I couldn't drive home. It was like my vision was blurred, I eventually emailed her* (the audiologist) *the next day and said I don't know what's going on but this, this headache was, because in all my life I have never had a headache and now for the first time I'm having a headache and this is horrific. She* (the audiologist) *said to me you know P2 you've got these senses you know sensory, that now I'm not used to these levels of hearing. Then you hearing a lot of things that you didn't and it's a lot of things for the brain to process that it wasn't processing before. So I made a joke with her* (the audiologist) *and said so you mean that people suffer with headaches daily because they listening to nonsense?* (Laughter) *Or things that they shouldn't be listening to, they listening to that, that's why they have headaches, they must just cut all that nonsense. I've been fine, I've actually, I told my boss you know I've actually been fine (laughter) you see now you bringing out the headaches. So what happened is, but then she* (the audiologist) *did tell me that after a few days it will, if it still persists I must let know know but it should be fine. But by the 3rd day I didn't realise, it wasn't so bad you know. But then I found that ok when, when I was driving I couldn't hear because the tyres would make a noise you know you hear the tire. You know customers always complained about wind noise when they brought their cars in for service and I used to think 'just drive the car, what's wrong, just drive'* (in a louder irritated voice)*. You know the first time I was hearing wind noise and, and it's the most horrific thing so now I could empathise with those customers who were hearing wind noises. And then I could hear the tyres you know, it was just too much. It comes with a remote but then I can't be walking around with the remote, adjusting the volume up and adjusting. So when I'm driving I wouldn't put them on, as soon as I got to work I put them on. But the worse thing is flushing the bathroom cos I don't know how your'll manage flushing the bathroom, that's the loudest noise ever* (laughter). *So I'm like argh flush and run, you know* (laughter). *Flush and run and what happens is and then it's so funny cos I've always had a colleague that complained about the music and I used to wonder why she always complains and now that I had my hearing aids I realised that they play music at work but I enjoyed the music* (laughter) *but all the time that I didn't have my hearing aids I didn't hear the music, I never knew they played music and I thought ok fine there is music so I can't hear it. Fine I can do without it. And ur then what happened is ur um I got my hearing aids*

and ok the but then I found that I could wear them, I could put them on when I got to work then the whole day I could wear them but by 5 o' clock it was like they were weighing me down, by 5 o' clock my brain had too much, so 5 o' clock I would immediately as I'm leaving take them off. Even before I left I would take them off because now I feel if I don't take them off the headache is gona come, you know like that so that's what I used to do. And I'm actually gone naughty now cos lately I barely wear them because I find that you know little things will irritate me, I love kids but when I got my hearing aids on yuss-like it (South African expression of 'wow')*, I just hear noise. I'm like no man this is not, this is not the way I wana see kids. Take it off and then everything is beautiful again, um I hear the fan going you know like that there. I hear people talking conversations you know and I'm like you know I don't wana hear that you know. I'm like in all my life so accustomed to being you know, you know unless someone is speaking to me then I focus then people speaking there, that never bothered me but now all of a sudden you walking in mall and you can hear people arguing and you can hear people having a conversation and you like no* (laughter)*. That's non off my business that's why, that's why probably I have the attitude, it doesn't involve me it's got nothing to do with me because that's how I loved you know. That's of I lived, I don't know people will tell you the negatives and the positives but all I'm saying from my side is that.* (P2)

The delayed management of the hearing loss also created communication barriers between P2 and people in her environment.

I don't, you know you get people, like my one sister that can hear, she was always fighting you know like that. She heard this and she heard that and I will think so what you know if it's not true leave it, but I never heard these things even if like people said they were gossiping in front of me, I just left it you know it didn't bother me so what it's not true. In a way I don't know if I'm using it as an excuse or I'm using it to my advantage in a positive side you know like that. But um I don't know really how, how what the positives side of you guys hearing as well as you do because I feel if I'm, my one friend I used to get irritated because every time she speak to me, she couldn't speak to me from the room. She always had to come to me so eventually one day she said to me, it's you that has the hearing problem so you must come to me. I said no you want to have the conversation (laughter) *so you come to me, you know like that there. So it was always had to be that way whereas with family I would find that my mother will be in the kitchen or upstairs and she would shout down and you know, but it always forced us as a family to be*

> *like this* (interlocking her fingers to show connectedness) *we could never ever speak to each other from separate rooms we always had to be together*. (P2)

The decision for school placement for this participant consisted of mainstream educational settings with an undiagnosed and unmanaged hearing loss. The listening demand placed on a hearing impaired child in a mainstream school is not conducive of a good learning environment (Mogford-Bevan & Sadler, 1993). Inclusive education is a policy in South Africa however the support structures are minimal thus the learner with a hearing loss is not equipped based on his/her need within the educational settings.

The time between the diagnosis of the hearing loss and the healing of P6 was minimal and even though her parents were thinking about the educational and communication options, they were not required to make those choices. The mother of P6 stated *"And after* (the healing) *you know everybody was very happy because you know prior to that all the concerns, she might need treatment or she might need an operation you know and different treatment in the process you know"*.

It was significant that P6 had no recollection of a hearing loss as she reported that she was healed as a baby. She was oblivious of the processes and emotions surrounding her diagnosis except for the recollection of stories that were told to her.

> *"I don't think my family, they were concerned but they always believed cos like I never hear stories of them saying like negative things. But I don't think it was like a big thing like we gona have to do that and that our whole lives are gona change"*. (P6)

Therefore, with P6 the situational dynamics negated the option of a school for the Deaf and Sign Language as she reported that the healing occurred before the need arose to select a school. Participant 6 had a strong support structure at home and the family's concern about the possibility of a hearing loss was vital in the early diagnosis. The family of P6 ensured that an early diagnosis of a hearing loss was made, as they acknowledged that further educational decisions were required.

Participant 7 was diagnosed at birth with a bilateral severe SNHL and her parent chose mainstream education without inclusivity for the HOH/ D. The participant reported to have received healing on one ear while in high school. Participant 7 explains that there were educational setbacks as follows, *"And then when I went to primary school, if I was doing well in school I should pass and go to matric, this should be my last year. Because of my hearing I had to repeat twice so ya"*.

In this case a hearing loss was diagnosed early and hearing aids were worn however the selection of a mainstream educational option was not beneficial to the participant as she did not pass due to the lack of educational support. She states that the challenges experienced thus far are the result of having a hearing loss.

It was evident in this study, that general communication, work relationships and family relations were affected by the lack of an early diagnosis. The parents of participants in this study needed to decide to enrol their child into a mainstream oral school or a school for the Deaf. There was no evidence of parental support during the decision-making processes. The historical and political history of South Africa has impacted the fair distribution of healthcare services. Prior to the abolition of apartheid in 1994, there was little or no access of counselling and health support for families who were not in the white race group. There was an array of educational backgrounds for participants in this study; ranging from mainstream oral schools, schools for the Deaf and schools for the disabled. Parents need to make informed decisions, despite their own emotions and psychological coping mechanisms that surface due to the diagnosis.

This study found that:

- Parents of children who received a diagnosis of a bilateral severe to profound hearing loss opted for Sign Language as the primary mode of communication.
- Parents of children who were HOH opted for oral language for their children.

The participants in the current study who attended a school for the Deaf indicated that they could communicate with Deaf individuals and hearing individuals post healing. The dual communication modes were seen to benefit these individuals and this provided them with a connection to the hearing and Deaf worlds. This dual communication is beneficial for bridging the gap between the culture of the hearing world and Deaf culture as individuals who reported healing continued their education in the school for the Deaf. The one participant who was healed as a baby attended a mainstream school however her parents were discussing the educational options available, prior to the healing.

Models of Patient Care

One of the participants (P7) indicated that she would have preferred to be in a school that catered for her hearing loss as she is currently failing subjects and is bullied by fellow students. She wears hearing aids yet she has difficulty following the teaching within the classroom. An integrated model

of service delivery should incorporate information sharing and discussions around outcomes of the mode of communication that is selected. Audiologists need to be familiar with the psychosocial influences of the decisions that are being made by the parents, with a newly diagnosed baby. The South Africa education system should provide for the needs of all learners as per the mandate of inclusive education. The formulation of policy that favours inclusive education, does not however guarantee the implementation of the policy.

Hearing aids were selected in the management process for the participant who was mainstreamed however the expectations of her parents may not have been realistic. The parents of P7 decided on a mainstream school that did not cater for the child's hearing needs. Parents consider surgery and cochlear implants as options to provide the child with the best chance of developing verbal language. The HOH/D child may be an ideal candidate for a cochlear implant when considering the results on the audiogram; however, factors such as economic status, education, support structures and lifestyle form directives towards the final approval from the medical team involved.

Participant 3's statement pertaining to the parents' choice of management supports the right of the parent and the child. It is more important for a family to understand and love the child with the hearing loss more than it is to communicate effectively (Hong & Turnbull, 2013). The diverse South Africa population requires more parent support programs such as HI HOPES, to develop culturally congruent support systems for families.

Communities in South Africa grow and sustain themselves by the economic productivity of the working age group within the community. There is long term effects on society and the economy when a hearing loss is not detected (Storbeck & Calvert-Evans, 2008). The child who is diagnosed will have the opportunity to be educated appropriately and will add to the development of the community as a skilled, income earning individual.

Education and Management

A rapport may be established between the medical professional and the family so that there is a freedom to share experiences (Prakash et al., 2013) and beliefs about the hearing loss. The initial lack of detection may have minimal consequences for a toddler however the consequences emerge as the child matures (Alpiner & McCarthy, 2000). Knowledge about the developmental milestones of normal development will empower caregivers and educators to identify at risk children (Kover, Edmunds, & Weismer, 2016). Knowledge has power and when an atmosphere is created to allow the

different role-players to share and collaborate, the result is always beneficial for the child. Once the identification of the possible hearing loss is made, the cooperation and willingness of the parents are vital for the medical diagnosis of the hearing loss. Family identification depends on various factors such as parental acceptance of a possible hearing loss, stigma that is attached to differently-abled children and the hope that things will change with the growth of the child (Thompson & Thompson, 1991).

Trained teachers help HOH/D children with information and strategies that are beneficial for learning (Resciniti, 2013) and these strategies can be transfer to life in general. Teacher preparation programs are emerging in the USA where teachers are equipped to work with children with disabilities and they are provided with in-depth information pertaining to EI (Lenihan, 2010). There are many benefits and challenges of belonging to the Deaf culture and the attendance to a school for the Deaf (A. Young et al., 2006). Educational options are the dictators of the mode of communication that the child will develop (Resciniti, 2013). The decision of education mode is marred by the debates related to the best education method for a child who is HOH/D (Lenihan, 2010). Parents who decided on verbal communication and mainstreaming education may also opt for a cochlear implant for the management of the hearing loss.

The cost and implications of cochlear implants is vast (Tucker, 1998) and very few candidates are implanted in the South Africa context. Swanepoel (2006) stated that cochlear implantation commenced in 1986 in South Africa with an increase in implantations annually. Cochlear implant candidates require a strong family system (Pérez-Jorge, María, Alegre de la Rosa Olga, & Marrero-Morales M, 2016) to support the process from fitting to mapping and aftercare of the implants. Spencer and Marschark (2003) states that cochlear implants can be highly successful from a medical perspective however it can fail due to the lack of family support and care. The financial implications of a cochlear implant, on the family can amount to $22523 (Mulwafu, Gong, Francis, & Saunders, 2015). The costs are related to the follow-up programming and mapping of the cochlear implant, the transportation to the hospital, accommodation costs if the family resides far away from the hospital (Moroe & Kathrada, 2016). There are only seven sites in South Africa that conduct a cochlear implants surgery (SACIG, 2017).

Inclusive education is a topic of controversy as the resources and infrastructure required for the implementation thereof may not be available in the South Africa context. Mainstream schools that do not support the needs of HOH children will result in a higher number of children who do not progress

successfully (Griffin, 2013). Bullying and victimisation are common when HOH students are seen as different to their fellow hearing students in a mainstream oral language school (Whitney, Nabuzoka, & Smith, 1992). Negative emotional reactions are seen in the HOH child, who in turn starts to struggle at school. A consequence of the bullying and poor school performance is the isolation of the HOH child. The aims and objectives of inclusive education for individuals with a hearing loss must be supportive and beneficial. Hard of hearing/Deaf children need to be seen as normal in their own right, without being compared to hearing children (Young & Tattersall, 2007). Teachers should be taught skills such as the troubleshooting of amplification device issues, classroom acoustics and teaching styles for the HOH/ D (Lenihan, 2010).

There are 7 approved programs in the United States of America that focuses on listening and spoken language (Lenihan, 2010). The Individualised Education Program (IEP) at the New Mexico school for the Deaf is structured to support learners and families through the educational process (Gutiérrez, 2011). The IEP focuses on appropriate support, social integration and academic integration of Deaf children. The success of this program can be afforded to the holistically integrated system of teaching that factors in the different areas that are relevant to the learner and his/her family (Gertz & Boudreault, 2016). The points of discussion within the IEP and the addendum Communication Considerations (CC) form are presented in Table 6.3.

Table 6.3: IEP and CC Addendum Points (Gutiérrez, 2011)).

Major points to address within the IEP	The CC addendum requires that the IEP team:
Determining how fluid the student's communication is within a variety of settings	Identify the student's primary language and mode of communication
Determining if the student's proficiency in a particular language has been adequately addressed	Identify the language and mode the family uses to communicate with their child
Determining if the mode of communication being used with the student is fostering his or her ability to attain higher level academic and language skills	Take both of these factors into consideration when determining the supports needed to help the student gain grade-level skills
Identifying the types of supports the student requires to achieve grade-level skills	Determine the ability of staff who work with the students to communicate fluidly with him or her
Determining if the student has opportunities to interact with fluent language users and/or models	Determine whether the student has opportunities for direct communication and instruction using his or her primary language and mode of communication
Identifying what options are available on the continuum of placement options for the student	Determine whether the student has opportunities for direct peer interaction
Identifying what parts of the current school program can be adjusted to meet the needs of the student	Determine how accessible school programming is throughout the school day – not just within the classroom

The points and areas that are highlighted with the IEP and CC form above are vital when viewing the child and the family through holistic lenses. Parents and teachers work harmoniously to identify the support structures needed for the HOH/D child (Hong & Turnbull, 2013). The support programs available in developed countries can be used as sources of reference for developing countries so that the unique programs that are contextually relevant can be formulated to provide families with the tools that they require.

High expectations are required to ensure that all role-players are seeking for the best outcomes for the HOH/D child, when expectations are high then the maximum potential of the child can be realised. A study by Hong and Turnbull (2013) revealed that children are encouraged and receive benefit from parents with high expectations, as stated in a narrative of a HOH child, 'my parents taught me that my hearing loss is just a handicap….and that a handicap shouldn't stop me from anything. They were religious, of course. Most of their teachings were religion-related, and at the same time, taught me to rely more on God…because of my inability to hear….They repeatedly said to me, "Whose son are

you? You're my son! I believe in you!" It's a typical Korean saying, which is like saying you can do it'.

6.3.2 Results and Discussion of Category 2: Causes of the Hearing Loss

Deafness has never been seen as a normal state of hearing ability (Peterson & Siegal, 1999) and when a child is diagnosed with a hearing loss there are various allusions to the reason for the hearing loss (de Andrade & Ross, 2005). Category two provide documentation and discuss of the causes of the hearing loss that participants provided. The themes that shape category two include sin, purpose in life and medical causes as depicted in Table 6.4.

Table 6.4: Details of Category Two.

Category	Theme	Presentation of Data
2: Cause of the hearing loss	Hearing loss and its relation to sin and curses.	Results and Discussion of Theme 4
	Providing a testimony for others	Results and Discussion of Theme 5
	The building of strength and the discovery of life's purpose	Results and Discussion of Theme 6
	Genetic cause of hearing loss	Results and Discussion of Theme 7

6.3.2.1 Theme 4: Hearing Loss and its Relation to Sin and Curses

In South Africa there are many cultural and religious practices that consider sin and curses (Hanass-Hancock, 2009) as a significant role player when faced with differently-abled individuals. There is a desire to uplift a situation that seems ill-fated by asking for supernatural assistance to break a curse (Nicolas, DeSilva, Grey, & Gonzalez-Eastep, 2006).

Participant 1 believes that individuals in society think that deafness is a result of sin however she believes that a hearing loss is not a sin.

> "*I mean…it doesn't mean that it* (hearing loss) *is a sin, it's not a sin. And people think that deafness and blindness is sin and it's not that way. In the Bible, God said to not curse the deaf ur?* (nodding as if asking the researcher for an agreement with the statement). *And the Deaf person never went to God and asked Jesus to heal me, it was his friend. It was the friend's faith*

that he was healed, you know. Can I just say that because Black communities especially think it's a sin, they think it's a curse." (P1)

Hearing loss being a curse was reiterated by P2.

"Because you must remember a lot of people say it's a curse. A lot of people will say and I've prayed this prayer as well, Lord if it's some curse that's been, because it's hereditary. If it's some curse that's on the family then I've prayed for breaking of chains". (P2)

Participant 3's narrative revealed that *"There's only one God, Jesus Christ came and died on the cross for us to take our sins".* This participant believed in sin and she considered herself redeemed from that by her belief in Jesus Christ.

The medical perspective based on the medical model will negate the beliefs of the individual with a hearing loss; consequently the Speech Language Pathologist and Audiologist would historically follow the medical perspective of management. Regardless of religion, the areas of sin are common amongst all faiths and audiologists must be aware of the impact these beliefs have on the medical scope that they practice under.

Sinning that causes deafness, is a belief that must be taken into consideration when managing an individual with a hearing loss. The negative psychosocial impact of religious coping is possible when the hearing loss is seen as divine punishment (Balboni et al., 2007). Psychological counselling within an integrative model is necessary to ensure that the belief systems that are seen as detrimental to the welfare of the patient, is discussed prior to intervention. Audiologist should seek avenues of assistance from parents, to collaborate and share information regarding the holistic care program for the child with a hearing loss. Personal judgment and bias can occur when the audiologist's belief is not in alignment with the beliefs of the individual with a hearing loss. There needs to be headway made with relation to counselling and support for audiologists. Audiologists need to be equipped to incorporate the belief systems of the individual with a hearing loss, into therapy without compromising their own beliefs. Participants in the present study revealed a trend of belief, which accepted the hearing loss as a purpose driven situation, which was meant for the discovery of one's life's purpose.

Emotional aspects of religiousness, such as facets of the perceived relationship with God can be crucial in the understanding of why a hearing loss exists. The belief in sin and curses is evident in

different cultures and religions of the world (Ross, 2007). Religiousness often perceives that a poor relationship with God (Braam et al., 2014) leads to illness and disease. The existence of a supernatural being that curses people as a consequence of sin or 'wrong doing' is documented in all major books of religious belief. These include the Christian bible, the Jewish Torah, the Muslim Quran and the Hindu Gita. Illness and disease is believed to be a God given will for a family in Islam. The Hindu scriptures state the Laws of Manu indicates that disability is related to sin: thus in consequence of a remnant of (the guilt of former) crimes, are born idiots, dumb, deaf and deformed men, who are (all) despised by the virtuous (Doniger, 1991).

Illness and disease has been referred to as the consequence of wrong doing or ill fate (Ross, 2007). 'Breaking chains and curses' indicate that some of the participants in this study believed that a hearing loss is a result of the supernatural and the curse, that was caused by sin, needed to be broken. The redemptive procedures for wrong actions differ between religions, as seen in Table 6.5.

Table 6.5: Religious Redemptive Practices

Religion	Redemptive Practices to atone for sin or curse
Hinduism	Prayer, fasting, animal blood sacrifices, donations and charity work.
Islam	Fasting, prayer, rituals of reciting the Quran, animal blood sacrifices
Judaism	Fasting, prayer and animal blood sacrifices
Christianity	Prayer, fasting and belief in Jesus Christ who was the blood sacrifice at the crucifixion

The different ways to atone for illness and suffering is dependent on the beliefs of the individual (Barnes et al., 2000). Religious practices of atonement can include prayer (O'Connor, 1995), laying of hands (Christensen & Kockrow, 2013), visits to the ill, exorcism, wearing of religious objects, sacrifices, anointing oil and various other rituals and techniques. The belief system of a family may hinder the therapy methods if methods are not consistent with the goals for the patient (Jenkins, Le, McPhee, Stewart, & Ha, 1996). Barnes et al. (2000) state that therapists and families may exhibit differences in spiritual dimensions however the collaboration of all parties will benefit the child when goal of care is uniform.

Feelings of guilt, shame and blame (Mall, 2005) become evident when families perceive that they are responsible for the illness of the child. Some religious practices may be a barrier to medical management and families face the stigma attached to the 'lack of faith' if biomedical assistance is sought (Barnes et al., 2000). A transparent and non-judgmental case history discussion is the key to

providing a safe space for communication between the family and the healthcare provider (Grenness, Hickson, Laplante-Lévesque, Meyer, & Davidson, 2015). Hence the argument for a holistic paradigm when assessing and intervening with individuals that are HOH/D.

6.3.2.2 Theme 5: Providing a Testimony for Others

A testimony is a witness to the existence of a situation or event and the participants in this study provided their stories as testimony to the event of healing. Participants in the current study indicated that the evidence provided through the narratives, is proof that their belief in God produced the healing. The testimony of the healing was recognised by the participants in this study as a way to provide hope to other individuals with a hearing loss and their families. All participants stated that their lives are a declaration of hope for other individuals with a hearing loss.

> *"To tell Deaf people about God. And I believe that if you believe that you wanna be healed, you will be, you know. But I believe that God allowed it, me to be Deaf so that I can tell other people, other Deaf people about God"*. (P1)

Participant 4 echoed a similar sentiment in saying *"To communicate with Deaf people and hearing people, that's what I feel. So I share the Word of God about God with the people whose (*who are) *hearing and Deaf"*.

Hope is the expectation of good things to come in the future, a testimony of healing provides spiritual hope and a reason to live (Ross, 1994), for those who trust and believe for a healing. Stories of personal experience have greater impact when trying to convey a message, as human beings relate to lived experiences regardless of the proof of its existence. Lives are built around family traditions and testimonies of past generations, who encourage the perseverance of younger generations. The interconnectedness of humans depends on the formation of relationships with each other. A testimony that provides hope originates from the participants concern for others who are facing a similar situation.

Individuals who belonged to the Deaf community found an identity within the Deaf culture yet once the healing occurred they found an expansion of identity within the hearing culture. The reasons provided by these participants link strongly with their belief about their role in society. The individuals who were Deaf and experienced a healing understood the transformation as a testimony of the power of God. There is a global movement towards the supernatural to heal and restore

illnesses when the medical intervention is exhausted. Gardner (1983), presented cases of supernatural healings in field of medicine and the overarching themes that arose were that of community engagement and togetherness, regardless of the belief of healing. A study described by Gardner indicated that communities talked about the healings for years and the hope and belief for similar healings grew.

6.3.2.3 Theme 6: The Building of Strength and the Discovery of Life's Purpose

Life events, be they positive or negative, shape the way human beings grow and develop their outlook and purpose in life (Dyson et al., 1997). Children are born having no previous experience of the world and situations, interactions and events that occur from the time of conception will dictate the outcomes of life. Character is built throughout life and children grow and form an individual identity that is uniquely based on their day to day living. No two individuals can share an identity and the discovery of ones purpose in life is an individualistic journey (Frankl, 1959). Decisions are made on a daily basis, shape and build the mental, physical and spiritual strength of a person. Participants in the present study shared their thoughts about the building of strength and the discovery of purpose when they were diagnosed with a hearing loss.

Growth is inevitable and strength is gained through perseverance as mentioned by P1 *"And I think during that time **God allowed** me to be Deaf to prepare me to become a stronger person inside, you know"*.

Participant 4 stated that the purpose of his life was revealed through the hearing loss.

> *"And I feel God helped me to hear partially because there's so many Deaf people who don't know God and so **God was giving me purpose**. So far I'm happy that I still stayed hard-of-hearing because I can communicate with this side and this side* (meaning with the hearing and the hearing impaired). *If, imagine if God healed me 100% full I wouldn't have talked with Deaf people about God, cos they don't know. **I feel God's purpose is for me to be hard-of-hearing** and I'm happy with who I am. So I'm happy that I'm hard-of-hearing and I can hear a little bit and I know Deaf Culture. Deaf feelings, how the people feel if they don't hear and how the people who hear, how they feel. So I understand different situations, I'm happy with God, I always pray"*. (P4)

The mother of P7 stated "*But I believe that God sent her here for a reason and she needs to work on that because I could have terminated her pregnancy* (participant meant the termination of the child), *I took my chances and I did whatever I had to do for her and now it's up to her."*

The participants in this study related to the hearing loss because of their actions that resulted in the hearing loss. Some participants indicated a need to restore equilibrium by seeking atonement for the loss. Prayer was the vehicle used to remove curses in the lives of participants and to work towards the acceptance of the hearing loss.

The existence of God or a higher being has been, and will be debated for centuries (Gellman, 2001). The current study was undertaken with knowledge of the debate related to the existence of God however; the researcher resolved to document the role of the supernatural in the beliefs of participants so that a holistic understanding of patient care will start to emerge. The narratives of the participants in this study were not obtained to add to the debate but the narratives play a vital role in the dynamic and evolving healthcare service delivery. The situations and events in life help shape our understanding of the world and people analyse their experiences and they personalise things to make sense of life (Pargament, 1990). Identity and purpose in life are the areas that define who we are (Sumner, Burrow, & Hill, 2015) and why we are placed on earth. Being diagnosed with a hearing loss was seen by all participants as a purpose driven situation. The participants reacted to the diagnosis of a hearing loss from the belief that 'everything happens for a reason' which is a common cliché.

Humanities search of purpose is continuous and the events of life are described as lessons to the discovery of that purpose as mentioned by P1. The Christian participants described their healing as a form of evangelism tool for advocating the existence of God. Evangelism is the sharing of one's faith and the participants in this study believed that their experiences are proof that God could restore something that man could not restore. The growth and maturation process from diagnosis to healing was seen as a preparation for life by participants. Individuals require the maturity to accept the hearing loss and the strength, to deal with the inability to hear. Participant 7 and her family belong to the Hindu religion; however she reported that she was healed by the prayers of a Christian pastor. The mother of P7 stated that the family believed in a supreme God who provided the family with a child (P7). The existence of life and purpose was reiterated when P7'S mother indicating that her child must now determine why God sent the child to earth and what is the reason is for the child's

existence. All participants saw the hearing loss as something that was given to them by a higher power for the discovery of life.

6.3.2.4 Theme 7: Genetic Cause of the Hearing Loss

Medical diagnosis of a hearing loss always aims to determine the medical cause of the loss. The medical reason for the existence of a loss was only described by two participants despite the medical focus from professionals. Genetics and hereditary hearing loss is seen as one of the most common causes of sensorineural hearing loss (Smith, Bale, & White, 2005). The hearing loss is usually present from birth, with medically proven results of the genetic links.

This theme is represented in the utterances of P2 and P5. Participant 5 mentioned a family history of a hearing loss *"I was born Deaf and my father hears and mum has half hearing"*.

> *"Ok, basically it's something that's been in my family all my life. My great grandfather had a hearing problem, he used to wear those old hearing aids* (gesturing with hands to show how big they were) *you know those that you put in the pocket on the side, ya he had one of those. Um…somehow it was passed to my mom and her sister also had a hearing problem. My mom and her sister, from my mom it was passed on to my oldest sister, she was completely deaf in the one ear so the one ear she was excellent so it was like she didn't have a hearing problem and in the other ear she was completely deaf"*. (P2)

The participants who mentioned that there were genetic links to the hearing loss still believed that the hearing loss ultimately came from a higher power. Genetics and the understanding of the hereditary causes of a hearing loss should form part of the discussion with potential parents in the pre-counselling phases with high risk pregnancies. The incorporation of spirituality and religious beliefs and well as medically documented causes need to be openly discussed with the family to ensure the freedom to converse about underlying misconceptions.

The participants in the current study had varied reasons for the hearing loss and they had varying reasons for the supernatural healing of the hearing loss as well. These reasons are relevant regardless of the belief system of the audiologist who sees the person with a hearing loss.

6.4 Sub-Objective 2: To Identify the 'Turning Point' Event or Events that Caused the Reported Healing.

Results of sub-objective two is realised through category three. There are three themes within this category. A discussion will follow the presentation of each theme as per Table 6.6.

Table 6.6: Details of Category Three

Category	Theme	Presentation of Data
3: The healing event	Traditional and alternate healing as a method of rehabilitation	Results and Discussion of Theme 8
	Physical restoration of hearing	Results and Discussion of Theme 9
	Non-physical healing	Results and Discussion of Theme 10

6.4.1 Results and Discussion of Category 3: The Healing Event

Healing and the restoration of a sensorineural healing loss was the focal dictator of the commencement of this study. The initial premise of healing was purely linked to the physical restoration of a hearing loss. The orientation of the research was multidimensional after the data was analysed as a varied description of healing began to emerge. The differentiation between 'curing' and 'healing' began to arise from the data as a result of the psychosocial aspects affecting participants' lives. As previously discussed the term 'curing' is used when someone is relieved of a physical symptom or sign of a disease while the term 'healing' is a used to describe an experience of restoration and manifested healing that may be physical or spiritual and intangible, which involves the body, mind, spirit and soul (Young & Koopsen, 2010). It is this all-encompassing physical and non-physical concept of 'healing' this is discussed in this study.

Healing is the ultimate goal of anyone who is diagnosed with an illness. The thought processes around healing are varied as some may seek a physical healing, while others seek an emotional healing and some may also see medical and spiritual healing as the same thing (Alvord & Van Pelt, 1999). The methods of healing are grouped into traditional healing methods and religious healing methods in the ensuing paragraphs. These two methods encompass a physical healing or an emotional healing.

6.4.1.1 Theme 8: Traditional and Alternate Healing as a Method of Rehabilitation

Traditional healing encompasses a variety of sources depending on the culture, religion and sometimes ethnicity of the person (Hanass-Hancock, 2009). A traditional healer uses complementary and alternative healing and therapy, each culture and religion has its own form of traditional healers. A traditional healer such as a pastor may provide the patient with hope of a cure where medical intervention proves to have no cure (Abdullah et al., 2016). Participants in this study accessed Christian pastors as their main source of traditional support for the supernatural healing. Participant 1 presented one of the most common perceptions of a traditional healer in South Africa.

> *"Can I just say that because Black communities especially think it's a sin, they think it's a curse. The sangoma and everything, I have seen in this school a lot of spiritual warfare. Big spiritual warfare here. And kids come from different backgrounds and especially with traditional healers and all that, and they come to me crying for help"*. (P1)

Participant 5 indicated that the pastor prayed and there was a feeling of heat or 'fire' before the healing occurred.

> *"Just pray* (placing hands over her ears) *that's all, to God (pointing upwards). One time* (smiling). *And I felt fire* (pointing to ears) *and I can feel I can hear more. Before I can't* (could not) *hear, now I can hear"*. (P5)

Participant 6 and 7 stated that they were healed by a pastor at church, who was regarded as a traditional healer. This occurred after consulting a medical specialist and being diagnosed with a permanent hearing loss.

> *"And it was pastor X and he actually afterwards asked me to give a testimony but also being in Durban and we came back to Johannesburg but he was very touched by the testimony because the minute that I walked from a distance, he said yes you the lady that God said I must pray for…… And I really believe it was an angel, absolutely. Saying that I was there right in the presence of God you know."* (P6's mother)

> *"I was scared but, then the pastor prayed for me, he put his hands by my ears and prayed* (holding/covering her ears with her hands) *and then he was anointing and anointing and praying and saying 'you healed, hearing you healed."* (P7)

The literature review (Chapter 4) presented an in-depth discussion of religious methods of healing and traditional healing was presented in relation to the non-medical methods of care. In the presentation the results in this study, the researcher included all religious techniques of healing as 'traditional healings' and the individual who is performing the healing as the 'traditional healer'.

Pastors have an anointing to heal the sick by prayer (Asamoah-Gyadu, 2008) and healing ministries are active throughout South Africa. Traditional healing has been practiced for centuries and will continue to be a primary or secondary source of care regardless of the education levels in society or the developments in the medical field (Abdullah et al., 2016). A study in Ghana documented that traditional healers are consulted as they are more accessible, available, supportive and affordable in comparison to medical professionals (Ae-Ngibise, Cooper, Akpalu, Lund, & Doku, 2010). The use of traditional healing methods was documented by a study in an Islamic healing centre in Malaysia, the use of prayer and scripture provided the basis of the service provision to sick individuals of any religious affiliation.

The medical world cannot negate the use and existence of traditional healing and traditional healers, as this will be contradictory to the vision of holistic care. The South African audiologist has a complex task of amalgamating the beliefs and practises of a diverse population, into the audiological services. The diversity of the population and the fear of the unfamiliar should not be a reason for the abandonment of the idea to find a solution to integrate the aspects of culture, religion and spirituality into the model of service delivery in Audiology.

A hearing impaired individual should have a multidisciplinary team that are often there to support the grieving or disappointed parents (Griffin, 2013). There is an abundance of literature pertaining alternative therapies that produced a healing with cancer (Lee et al., 2000), back pains, arthritis however this study is one of the first to document the narratives of hearing related healings. The traditional healer's bill in South Africa is a step in the right direction to initiate the dialogue between traditional healer and the healthcare worker however there is still a long road ahead for the symbiotic relationship between medical and the spiritual worlds.

6.4.1.2 Theme 9: Physical Restoration of Hearing

Restoration of hearing in the current study refers to the physical reinstatement of a hearing mechanism to functioning state. A sensorineural hearing loss that is permanent cannot be restored as the hair cells within the cochlear are absent or damaged. There is no medical procedure that can

restore the hair cells to a functioning state therefore intervention requires a hearing device. Participants in the present study however claim the supernatural has occurred and what is currently impossible for human beings to do, is possible for the supernatural to accomplish.

Restoration of hearing was described by P1, she was a 3rd person in two events, as a witness to the physical healing of others.

> *"And I got a friend here from this school, very strong Christian and she had her pastor praying for her and she became healed.* The second situation was "*And then about 2 or 3 years ago a group of Deaf children from here* (the school) *went to Rosebank, a pastor from Rosebank, a youth pastor saw them signing. And God led that person to go up to that group and he went to this one girl and he said 'can I pray for you' and she said 'yes sure'. And he prayed for her and she said she could hear".* (P1)

Participant 2 reported a negative situation that she had experienced when a pastor had asked to pray for her.

> *"I believe that if you are blessed with healing people then try it. He blows in both my ears and I waited for months and months and I never get my hearing and I was like I'm never going back to that church again. I was so upset, how dare he, I didn't ask him, you know like that there. Somehow the people there told him that you know what she's got a hearing problem and then that's what they did. I mean God didn't lead him, it was gossip amongst themselves. It's not like something that God showed him without him knowing. The people that I lived with went and told him and that's why he did that".* (P2)

Participant 2 stated that she was healed during a different encounter when she stated, *"But when my ears got unblocked, everybody was loud and sat up at my desk and I was like 'oh my gosh I got my hearing' and I thought that God had healed me".*

Participant 4 recalls being healed as a child.

> "*Um a few years, I was 6years old or 7years old I started to hear on the right, no on the left ear* (pointing to the left ear). *I was so excited. I was so excited. So far I'm happy, I'm Christian, I know God always helps me to hear. Maybe later on he will heal me 100%, because now I'm growing up now I know sign language and English speaking. And I believe God helped me to*

speak and to hear. Even though I cannot hear in right ear, nothing in the right ear, only the left ear. I can speak, show the people how I talk, how I prove how I feel God's presence". (P4)

There was a documented response from P5 who stated that a pastor prayer for her with a group of friends without her seeking the prayer and they were all healed.

"The one time I was with my friends, we go to Rosebank Mall. We saw 4 men, they from church. So he asked me to come he wanted to pray for me. So me I thought how come he wants to pray with me? So he prayed for my ears to open (showing how he placed his hands on her ears). *So ya* (smiling). *Just pray* (placing hands over her ears) *that's all, to God* (pointing upwards). *And I felt fire* (pointing to ears) *and I can feel I can hear more. Before I can't hear very well, now I can hear. There were 3 people same like me, 3 people got healed".* (P5)

Physical hearing and a total restoration of hearing was described by the mother of P6.

"Um when she was about, I would say maybe about a year, year and a half years old, we went to a church service and we were sitting in the church service and one of the pastors actually said God is, he was ministering a message, he was actually into the message and he said um, he said to the congregation, he says there's a lady here and you very, very concerned about your daughter about your child's hearing and God says that she has been healed and quite a few people went up and he said you know I'll pray for you, I'll pray for you, in fact I was in the back, I was feeding I was breast feeding P6 and I just thought no no I..It's quiet a way to go and ur I thought I would give it a miss and he kept saying that person hasn't come up. So I thought well God are you talking to me so I went and I walked quiet (a distance) *and as he saw me from quiet a distance he said yes you the lady and God has told me that you the lady and you concerned about your baby and she has been healed. Then he prayed for he prayed for P6 and then after the service I was standing at the back, I was standing in the reception area and a gentleman came to me. Quiet tall and big and he said his name was Michael, he said sorry, he tapped me said sorry and could I have a word with you. And ur, I said yes sure, he said um when pastor was praying he said I was right there in the very presence of God he says I don't mean here down here* (pointing to the ground) *during praise and worship he said I was right in the very presence of God* (pointing to the sky/heaven) *and God went into the warehouse and took a new set of eardrums for baby and your child is completely healed. And no-one, ur he just said to me that his name was Michael and when I made enquires, no-one knew him and no-one saw*

him after that. And after that ur P6, her hearing was actually, she would react, I think it was exceptional (laughter and joy) *her hearing was 150% hearing"*. (P6)

Participant 7 stated that a physical restoration of her hearing occurred during a visit to a church.

"I think 3 years ago… the pastor prayed for me, he put his hands by my ears and prayed (holding/covering her ears with her hands) *and then he told he was anointing and anointing and praying and saying you healed, my hearing you healed and then I said that when P was talking on the mike* (microphone) *and she was telling the people and I was so scared now, I don't know all those people and she was telling and she said that now P7 can hear, P7 can you hear me without your hearing aids? Then I said yes I can hear. When we went for a prayer then he blessed me and I could hear everything they were saying. So now I was so scared now because he said I could hear, I had to slowly, slow I had to take my hearing aids out, I had to take my hearing aid out and I had to, I had to listen to what he said and when I, when I took my hearing aids off I could hear everything that he said. I could hear everything he said the whole day the, the church was ur 2 hours church we had, the church was 2 hours and I heard everything. Even when they were playing the gospel music, Siyabonga, I heard everything I, I was actually smiling* (fingers and hands on her face to show her excitement)*."* (P7)

"I felt like they (the audiologists) *didn't want to hear it* (the healing)*."* (Mother of P7)

Participants in this study described a feeling of fire when the healing occurred. This is congruent with literature that documents the healing of cancer patients (Lee et al., 2000). A heat is felt during the event of healing and it is described as the refining of the body and soul to ensure that the illness will leave the body. Physical acts of 'blowing in the ears' was mentioned in the current study, the literature has varied explanations of this method. The participants in this study had personal questions and questions for others, around the area of healing methods.

Deaf individuals in the current study who reported a supernatural healing were mocked, shunned and rejected because of the healing. The sense of Deaf culture and Deaf identity was now blurred as the previously Deaf individual is now either HOH or hearing. Questions arose about the favouritism from God with regards to the healing for specific people and not others. The sense of abandonment was expressed by some participants. Broken relationships were a result of one friend being healed and the other not being healed. The dynamic of human interaction and friendships are diverse, hence support and counselling are needed for the varied factors that were raised.

This study revealed that support is also needed for individuals who claim to be healed of a hearing loss as the backlash from society may outweigh the joy of restored hearing. Prayer that resulted in the healing of participants was conducted by Christian pastors. Participants in the present study stated that not all healing is physical and some healings were emotional. Emotional healing was evident through crying, as experienced by a Deaf participant in this study. She indicated that there was a release of hurt and disappointment when a pastor prayed for her.

The mother of P7 indicated that she did not discuss the healing with the audiologist due to her belief that medical professionals do not believe in supernatural healing. The viewpoint of the mother of P7 is not unique to this participant as literature indicates that patients fail to discuss the religious and spiritual beliefs with medical professionals due to the fear of being shunned (Best et al., 2016).

The medical model forces of physical restoration when healing is considered and since the early 1980's questions were posed to the medical professional and the patient (Gardner, 1983). Was the healing evident? Can the healing be proven? Is this healing useful to the medical field?

The answers to the questions above will ultimately depend on the need for such questions. In the current study the aim was not to prove that a physical healing was evident. The narratives obtained opened a dimension to audiological healthcare that has been untouched, a dimension that includes the emotional and mental healing that is linked to the individual's spiritual well-being.

6.4.1.3 Theme 10: Non-Physical Healing

Healing is multifaceted and physical healing is measureable in the medical paradigm where medical assessments and tools can produce a diagnostic outcome. Healing of the mind, soul and spirit can occur and have a greater impact on the well-being of the individual than a physical healing. In the context of this study, the participants described a non-physical healing as a psychological *acceptance* of their hearing status. Participants stated that there was a supernatural restoration and healing of the thoughts and cognitive processes of the participants so *acceptance* was achieved.

Participant 1 indicated that healing may occur on a psychological and emotional level and not necessarily at a physical level.

> *"So God doesn't only heal one child he heals us all indirectly, you know. And children were crying and we were letting go and that was healing, because their home lives, their parents*

neglect them, no communication, we come together as a family, you know. And everything was coming out, crying and crying, children that I didn't expect to cry and I didn't remember anything, I couldn't remember a thing. All I felt was that my hands are burning and I just put my arms out, all I felt was just burning burning and the kids were coming down like a sinkhole. They were all crying and saying Thank you Jesus, thank you Jesus. Afterwards one boy came to me and I prophesied something, I couldn't remember anything. But the next day we were like this (fingers from both hands interlinked in a circle to show unity*) one big family. We all try singing together, the hearing people tried learning sign language and the Deaf kids had the time of their lives. That was the best experience of my life. And God proved it to me, hey don't underestimate yourself because you Deaf, I can use you* (God showing the participant this)*. And with that I will hold on. Then I started speaking in tongues and the Deaf children just drew to me like I'm this magnet, hearing children came as well. I was speaking in tongues and other girl was speaking tongues on the other side of the room and we just started getting closer and closer and closer. And children were crying and we were letting go and that was healing…. And there are those that are spiritually deaf and spiritually blind you know. Physically we can are limited but spiritually God enables us to do anything you know."* (P1)

Participant 3 stated that her heart was emotionally healed by God.

"Yes God has, he give me people who love me, around me. I have a job, I have a wonderful parents. God has healed my heart. Yes I feel emotionally healed. I was still at school; I'm sure grade eight so must be fifteen years old. A Deaf child who can't hear, its fine because the child can do anything, like running, write, walk, cook, eat but except can't hear. Like the people in the wheelchair they are worse because they can't, they can do but not like the deaf who can't hear but can do things. It's just only hearing. The one time my parents asked me, do you want to hear? I said no, I'm happy, I'm proud to be who I am."

The narratives of the participants above provide a glimpse of the multifaceted definition of the word 'healing'. The participants in this study described the process of healing in a larger dimension than the physical realm. Non-physical healing, in the above-mentioned narratives in the current study was presented from an emotional and cognitive viewpoint. The field of Psychology falls under the medical profession and it is evident that there were psychological processes that occurred, to create the acceptance of the hearing loss in this study. However, the participants did not receive psychological care to obtain the outcome that is evidently psychological; the participants were

managed by religious and spiritual leaders. Literature states that spirituality may led to the individual finding the meaning to life as peace can be found in the non-physical healing and acceptance of the situation, no matter how severe the illness (Dickinson, 1975; Sims, 1987).

Deaf children and adults may seek spiritual clarity and comfort for the acceptance of the deafness (Desselle, 1994). This emotional restoration and acceptance can change the participant's outlook on life. According to Herth (1990), hope is common to everyone as it provides a harmony to the mental state. The connectedness with a God or higher being, which provides an individual with hope for a better quality of life, is linked to the emotional healing and a sense of wholeness of one's life (Dyson et al., 1997).

The medical paradigm aims for a restoration of health as a sign of healing however the restoration for participants in this study indicated that healing was articulated on a mental and emotional level. Holistic care involves the overall well-being of the patient, the turning-point in healing may occur at any time and on any level therefore service delivery in Audiology must include the non-medical factors that affect the patient's life if the holistic view to intervention is promoted.

6.5 Sub-Objective 3: To Explore the Influences of the Healing on the Participant's Life.

Results of sub-objective 3 is realised through category 4. There are three themes within this category. A discussion will follow the results of each theme as per Table 6.7.

Table 6.7: Details of Category Four

Category	Theme	Presentation of Data
4: Areas of the participants life that changed based on the healing	Reactions to the healing	Results and Discussion of Theme 11
	The belief in God	Results and Discussion of Theme 12
	The life of prayer	Results and Discussion of Theme 13

6.5.1 Results and Discussion of Category 4: Areas of the Participant's Life that Changed, Based on the Healing.

6.5.1.1 Theme 11: Reactions to the Healing

The participants in the current study, who were healed physically from a hearing loss, received mixed reactions from their family and friends. The expectation of happiness and joy, due to the restored

hearing was seen amongst family members however contrary reactions were observed from friends. The results in this theme fall under the sub-headings of: family reactions and Deaf reactions.

Family Reactions

The spouse of P1 needed to understand the healing event, P1 describes his reaction as *"So God has a plan for everything, then um I married Mr X but Mr X wasn't a Christian, he was confused.*

Participant 3 and P5 described their parents' reaction as positive.

> *"Yes, so now they told me they very happy, they told me they are proud and very happy to have me, they say God is good all the time."* (P3)

> *"Ya they were happy for me. They were shocked". (*P5)

Participant 6's mother stated that family reacted encouragingly towards the healing event.

> *"Everybody in the family were concerned and after this (*the healing) *they saw the big difference you know and, I must say it's a very big testimony and I can still see very clearly the person that spoke to me Michael you know* (laughter with joy). *And just to say that your daughter has been totally totally healed and got a new set of ears* (laughter with joy)….. *after that* (after the healing) *when we take her into the service she would, when there was music she would react and you know cry or she would react and you know family could see the difference you know. Absolute, absolutely a big big difference. In fact we also tested after that, when we dropped something she reacted, and before that she wouldn't. We would test in various ways and you know her hearing was exceptional".* (Mother of P6)

DEAF Individuals' Reactions

DEAF culture and identity are linked to the diagnosis of a profound sensorineural hearing loss and Sign language (Brevik, 2005). DEAF individuals reacted in various ways to the individual who reported a healing.

Participant 1 witnessed the healing of a friend and the reactions that were received from the Deaf individuals in the environment.

> "T*here was a big thing about it and um the Deaf went against her. They were like, how can you change like that, you know. And she said but no, it was God, was God, was God. It actually turned them away from God. Why God gives favouritism* (participant gestured to indicate that these were the words of the people) *why God chooses her to be healed and not us, you know. There was big talk about it* (meaning that is was the topic of conversation at the time, by everyone)". (P1)

Participant 1 also mentioned how she witnessed the reactions of Deaf individuals in a school setting.

> "*And when she (*a student that was healed) *came back there was a big upheaval because a lot people don't believe in God and it's very sad. And they were all like, no she is making it up, it's not true. This girl already has hearing, you know. So then, this youth pastor did not give up, he still comes to school, still interacts with us and um preachers, he has close contact with us. So God doesn't only heal one child he heals us all indirectly, you know"*. (P1)

At the initial conceptualisation stages of the current study, I did not consider the inclusion of participants who did not report a physical healing of a hearing loss. However, I had individuals insist on being participants in the study as they stated that they received a prayer that resulted in a psychosocial healing. Upon consideration, these participants were included in this study as the definition of healing is broader than the physical realm. A different and unexpected dimension evolved in the data that was now being obtained as the initial concept centred on a physical restoration of hearing only. Holistic care should consider all realms that are pertinent to the patient, physical and non-physical realms are equally important. The participants' above in this study provided insight into the physical and psychosocial aspects that need to be considered. The healing events in this study resulted in psychosocial reactions of joy, laughter, shock and anger.

Joy and Happiness

The stages of grief (Kubler, 1969) are discussed in psychology yet there are no descriptions for the stages of joy. It is understood that an ideal state of being, is to be joyful hence therapy occurs to restore one to that ideal. When the participants reported the healing to their loved ones or when their loved ones noticed that healing had occurred, there was a feeling of joy expressed. The families reacted in a positive way as the healing meant that the participants' lives had been altered supernaturally in a positive manner. Parents, spouses and family members reacted in a joyous and positive manner when the healing event occurred, as indicated by P6's statement. The belief in God

and the strength of faith grew within these families. The supernatural event was viewed by family members as a testimony of the goodness and love of God. There was an invested interest from significant others in the participants' lives, to see the life of the HOH individual being changed towards a 'normal' state of being.

The participants who reported a supernatural healing felt a personal change of their emotional and physical state. The audiologists who hear these testimonies need to be equipped to relate to the individual without judgement and disagreement. The aim of any medical intervention is to support and facilitate a healthy and positive state of being for all individuals. Therefore, audiologists should not aim to medically prove that the healing occurred but they need to consider accommodating the belief systems of the patient into the sessions. The reactions from other HOH/D individuals contrasted with the family members' responses in this study.

Shock, Confusion, Anger and Frustration

According to P1, shock and confusion were evident with her spouse as he witnessed a healing which was contrary to his belief. Participant 1 stated that her spouse's confusion was related to the supernatural change that was evident in her. Healing is not necessarily a physical audiological change that is seen when re-assessing a patient by medical means. Healing according to P1 can be an improvement in the psychosocial well-being of a person with a hearing loss: *"So God doesn't only heal one child he heals us all indirectly, you know…..And children were crying and we were letting go and that was healing…. And there are those that are spiritually deaf and spiritually blind you know. Physically we can are limited but spiritually God enables us to do anything you know."* (P1)

The psychosocial acceptance of a hearing loss can positively affect the well-being and quality of life of the individual with a hearing loss. Holistic care entails the inclusion of the significant other's thoughts and feelings into the rehabilitation process. The patient is the main individual however an audiologist should be aware of the family dynamics to ensure that psychosocial issues of confusion, frustration and anger are managed effectively.

Emotions of anger and frustration were experienced by individuals who shared the same diagnosis of a hearing loss, yet they did not receive the same healing. Participants in this study stated that onlookers who were hearing impaired but did not receive the healing seemed angry. These onlookers, according to participants in the current study, believed that God has favourites because he only healed certain people from a hearing loss. Participants in this study indicated that unbelief and

frustration in God occurred due to some individuals not being healed. The negative psychosocial state of HOH/D individuals who were not healed can affect any rehabilitation method used by audiologists. Holistic care would entail the inclusion of a psychologist to assist with the negative state of patients as these emotions will hinder the progress of the patient if they are unresolved. Case history taking and feedback sessions are appropriate means to discuss the belief systems, psychosocial factors and spiritual aspects that affect the patient and his/her family. Audiologists cannot be aware of every ritual and belief system that pertains to a hearing loss however they need to be willing to discuss the supernatural aspects that affect their patients.

According to Douglas (2014) medical professionals should ask their patients about spirituality and/or existential beliefs in the following manner: "Some people have told me that 'everything happens for a reason' or that 'God knows best'. How do you feel about that? Are you religious? Do you believe in a higher power? How might what have happened fit into your religious beliefs?" The researcher concurs with the view of Douglas (2014) as the questions above will provide the opportunity to discuss spiritual and religious issues that are not usually discussed in a medical model of practice.

The narratives from participants in this study indicated that God was the focus for all the participants. Some participants believed that God is allowing the deafness. The narratives obtained in the current study reinforce the need for a section in the case history or feedback session that will allow the audiologist to explore the beliefs of the individual with a hearing loss. A spiritual history taking should be a routine practice within the case history or feedback session (Koenig, 2004). The study by Hong and Turnbull (2013) reiterated that parents of HOH/ D children rely on God to assist them with their child: "It was a shock when I recognized that both my sons had hearing losses. I never saw any deaf people though my entire life, you know. I cried and prayed to God. He listened and gave me peace. Whenever life is tough and whenever I feel alone because of my sons' hearing losses, I pray and pray. God is always there to help me".

A common belief amongst the Deaf community, who believe in God, is the rationalisation of the disability as something given to them by a higher power (Worotynec, 2004). There are variations to the reason for the hearing loss and this depends on the religious background of people. Muslims believe that God gives someone a disability so that the family is strengthened. Hindus believe that God gives them the disability because of sin and wrong doing of parents. God is seen as the one who takes away the disability amongst the Christians as they believe that he did not give it to them whereas the Jewish people believe that God gives people a disability as a result of breaking the laws

and commandments. The reactions and opinions of significant people in one's life, will have an impact on choices and thought processes of the person. In the current study, the healing event created a range of emotions and reactions that had an effect on the individual with a hearing loss. A change occurred in the participants' lives, between the relationships of family members, friends and the community. Questions arose that could not be answered and the change in the hearing status of the participant impacted and changed, the dynamics between other individuals with a hearing loss who were not healed.

6.5.1.2 Theme 12: Their Belief in God

The human race consists of individuals from varying walks of life with an array of religious, spiritual, universal and new age beliefs (Hanegraaff, 1998). This theme provides the narratives that associate to a belief in God as a higher being who affected the lives of participants.

All individuals in this study regarded God as a relevant higher power in their lives. The healing events differed in terms of environment, procedure and belief however participants stated that God is the universal reason for the healing regardless of when and where the healing occurred. All participants in this study mentioned the belief in a God; however, the researcher chose to present the utterances of P1, P2 and P3 to illustrate their belief in a God:

> *"My relationship* (with God) *is important. God allowed me to be Deaf…as long as my relationship with God is right you know. So God has a plan for everything." (*P1)

> *"If God leads someone to pray for me then so be it. But when my ears got unblocked, everybody was loud and sat up at my desk and I was like 'oh my gosh I got my hearing' and I thought that God had healed me*." (P2)

> *"I grow up going to my parents' church but I don't understand but I thank God that here he helped me understand who I am, I love God, awesome God. There's only one God, Jesus Christ came and died on the cross for us to take our sins. I believe he came for us."* (P3)

Participants were interviewed individually however the belief of a God was evident in all the utterances. Participant 4 states that he didn't initially realise why he received the healing and he later believed and acknowledged that it was God who healed him.

> *"Then later on after about 7 years later (*7 years post healing), *I realised I'm a Christian. I didn't know before that. After when I was 14 years old then I realised that I'm Christian, Oh now I know who God is. Then I think back about what God did for me."* (P4)

The input of God was mentioned by the mother of P6:

> *"So I thought well God are you talking to me so I went and I walked quiet and as he saw me from quiet a distance he said yes you the lady and God has told me that you the lady and you concerned about your baby's hearing and she has been healed. Then he prayed for P6"*. (P6's mother)

Participant 7's mother indicated that she was aware of the great risks with the pregnancy yet she stated that God was in control.

> *"So anyway I said doesn't matter I will take the risk and whatever it is, I'll leave it in God's hands you know. And she was born, she was meant to be born in April and she was born on the 9th March and she was fine. A very active baby and whatever it was, but very tiny, at birth she only weighed 1.15kgs and she stayed in hospital for a few days."* (P7's mother)

The spiritual and religious beliefs of a patient become vital in management efficacy, as the patient and his/her family must accept the medical diagnosis and the recommended treatment in relation to the non-medical management. A positive relationship between religiosity and psychological well-being indicates that a patient will use religious coping and the belief in God, when a health issue occurs (Pargament, 1990). A study in the USA found that 72% of cancer patients stated that their spiritual and religious needs were not supported by the medical system (Balboni et al., 2007) which may consequently have a negative impact of the quality of life of the patient. In relation to Audiology, the holistic support of the patient should include a discussion of the religious and spiritual beliefs of the family. The study by Balboni et al. (2007) found that patients who had spiritual support presented with improved clinical outcomes than patients without support however the medical system is failing to provide sufficient spiritual and religious support to patients.

The failure to provide any form of spiritual support may stem from the notion of 'false hope' however patients have the freedom to choose what to believe. A pilot study was conducted in the United States of America that looked at the development and implementation of a spiritual coping support group for adults living with HIV/AIDS (Tarakeshwar, Pearce, & Sikkema, 2005). The pilot

study found that an 8-session group system that focused on the cognitive therapy of stress and spiritual coping yielded results of positive spiritual coping and lower depression amongst participants. The methodology of the pilot study in the USA can assist in the formation of a spiritual support based intervention for hearing impaired individuals and their families.

The poor support of spiritual-orientated intervention in the medical sphere is a result of poor attention to spiritual struggles of patients and their relationship with God (Pargament, Murray-Swank, Magyar, & Ano, 2005) . The study by (Tarakeshwar et al., 2005) presents a framework for a group intervention program that can be modified and adapted to fit into the field of Audiology. Figure6.1 illustrates the framework in the HIV/AIDS study and the researcher's modifications are in italics.

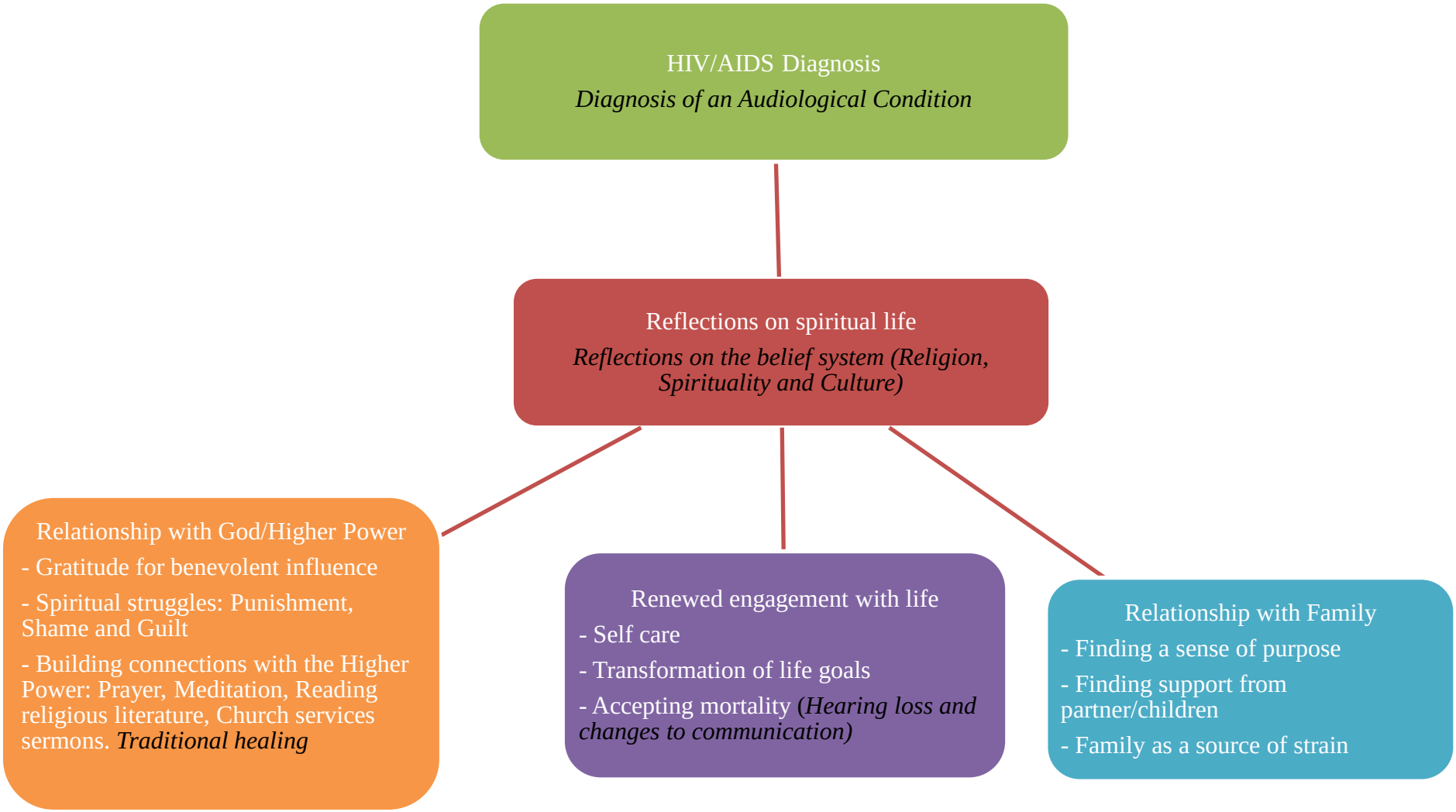


Figure 6.1: Relationship-Based Framework of Spirituality (Adapted from Tarakeshwar et al., 2005).

The belief in God or a supernatural being may provide the hearing impaired individuals with hope for a miraculous intervention (Balboni et al., 2007) therefore Audiology cannot negate the beliefs of the patient regardless of the audiologists own beliefs. A model of integration in Audiology should include the aspects highlighted in Figure 6.1. The education and training within the field of Audiology should start to include areas such as religion, beliefs, culture and spirituality if it intends to transform into a profession that is family-centred. The shift from the medical model towards an integrated holistic model of healthcare is necessary with the diverse South African context. Audiologists who are trained and equipped to incorporate the diversity into the service provision, will provide a more effective and efficient service to the hearing impaired individual (Moonsamy et al., 2017).

6.5.1.3 Theme 13: The Life of Prayer

Prayer is a form of communication with a higher being or universe. A range of reasons for prayer may exist, such as prayers for illness or for the birth of a new-born, thanksgiving may also be performed during prayer-time (Abdullah et al., 2016). The participants in this study provided narratives on their methods of prayer and descriptions that were used to facilitate the healing that occurred.

There are many facets to the concept of prayer, P3 described it as:

> *"Yes they did at my parents' church, they tried to pray for me…. So two, last month, this month, this month is July, there was one woman she told my sister, she said she want to pray for me to become hearing, my sister said no she doesn't want to hear, she is happy and she is proud of who she is. Then she was shocked and afterwards my sister told me, I'm* (meaning sister) *happy if you don't want to become hearing because I accepted who I am* (meaning P3)*."* (P3)

Participant 4 describes his prayer life and that of his family and he believes that his healing was due to their prayer requests to God.

> *"My family they Christian, my uncle is a pastor, my cousin is a pastor, my other uncle is a pastor. There's so many people who are also Christian in my family. And I realised that they were praying for me, God answered their prayers to improve my life and I received lots."* (P4)

Participant 7's healing occurred as a pastor prayed for her. This participant's mother supported her account of the healing event.

> "*He* (the pastor) *blessed me and I could hear everything they were saying."* (P7)

"Prayer yes, she went to church and the pastor prayer for her and she got some, part of the hearing back. Even without her hearing aids she can still hear." (P7's mother)

Personal prayer is regarded as the highest form of spiritual interaction with God or a supernatural being (Maltby, Lewis, & Day, 1999). The study conducted by Hong and Turnbull (2013) revealed that the parents of a HOH/D child, experienced isolation and prayer helped them 'keep the faith and stick to it'. A deep faith in God assisted the family in overcoming the stress and anxiety. Each major religion has specific ways of prayer that signifies that particular group as depicted in Table 6.8.

Table 6.8: Prayer Life within the Major Religions of the World

	Christianity	Islam	Judaism	Hindusim
How to address God	Father, Son (Jesus) and Holy Spirit. Almighty God	Allah	Almighty God	There are various names of deities within Hinduism however the supreme name of Vishnu is used
Prayer	Yes using Scripture from the Bible	Yes using Scripture from the Quran	Yes using Scripture from the Torah	Yes using Scripture from the Bhagavadh Gita
Sacrifices	Fasting	Fasting and Blood sacrifices	Fasting and donations for blood sacrifices	Fasting and Blood sacrifices
Places to pray	Churches	Mosques	Synagogues	Hindu Temples

Prayer and religious coping in one's spiritual or religious beliefs can have an effect, when there are stressful life events (Pargament, 1990; Sulmasy, 2002), such as the diagnosis of a hearing loss. Research indicates that religion and spirituality supports and improves the quality of life of individuals who face difficulties in health (McClain, Rosenfeld, & Breitbart, 2003; Nelson, Rosenfeld, & Breitbart, 2002; Tarakeshwar, Vanderwerker, & Paulk, 2006), such as a hearing loss. A study conducted in the USA stated that personal prayer was common in 61% of patients who were diagnosed with a terminal illness (Balboni et al., 2007). Prayer provided hope of good health and healing, thus providing patients with a channel of communication with the supernatural. The study by Balboni et al. (2007) found that 97% of patients were comforted by visits from religious and spiritual leaders. There are instruments that measure religious and spiritual coping and these include Religious methods of coping (RCOPE) (Pargament, Koenig, & Perez, 2000) and the Index or the core spiritual experiences (INSPIRIT) (VandeCreek, Ayres, & Bassham, 1995). The World Health Organisation declared that spirituality is vital in the quality of life (WHO, 1995) as it affects one's physical, psychological, and interpersonal states. A patient's spiritual history, present religious coping

methods, present biopsychosocial state, plus any spiritual intervention all would combine to affect the present state of spiritual well-being, which in turn would contribute to overall quality of life (Brady, Peterman, Fitchett, Mo, & Cella, 1999).

A Malaysian study by Abdullah et al. (2016) stated that prayer is performed as illness is more than a medical diagnoses, the Islamic description of illness has three categories: physical illness, spiritual/emotional illness and illness due to black magic or sihir. The gap between conventional medicine and belief systems of illness can only be minimised by a great understanding of the avenues that individuals pursue to find healing. Prayer performed by spiritual healers are less threatening as the healers are more open and approachable about the supernatural and the environment is more homely than a medical practitioners office (Abdullah et al., 2016). Individuals may initially pray and seek supernatural assistance for an illness as confirmed in the Malaysian study where 54% of individuals contacted a traditional healer before seeking a medical diagnosis (Abdullah et al., 2016).

Personal prayer and the belief, in a supernatural being to relieve one's pain or to cure an illness, has proven to have a positive effect on the well-being of the patient (Maltby et al., 1999).

6.6 Summary

This chapter presents the findings and discussion of this study titled, ***Supernatural Healing: Narratives of individuals who reported on the healing of a sensorineural hearing loss.*** The results and discussion of the three sub-objectives reflect the categories and themes that were identified to realise the main aim and three main objectives of this study:

The main aim of this study was to document the narratives of healing experiences of individuals who reported a supernatural healing of a sensorineural hearing loss.

The main objectives of this study were to identify the recurring themes within the narratives of participants who reported a healing, with the purpose of deconstructing the aspect of healing amongst participants; and to describe the cultural, religious, spiritual and social influences that impact the individual with a hearing loss. The final main objective was to design a proposed working Audiological Model: An Integrated Model of service delivery in Audiology.

The categories and themes identified from the narratives reflect the details surrounding the reported healing of a hearing loss. The details obtained in this study impact the current models of service provision in Audiology in South Africa. Pertinent findings can inform the formation of a holistic integrated service delivery model of care in Audiology. Highlighted findings in this study such as the

role of grandparents and caregivers in the early identification of a hearing loss, the emotional reactions to the diagnosis of a hearing loss, the decision making process of parents, beliefs related to the cause and reason for a hearing loss, the religious and cultural alternative methods used to heal an individual with a hearing loss, the lack of support for the belief in supernatural interventions and the role of prayer, can inform the future practices of Audiology in South Africa.

The difficult history of apartheid in the history of South Africa together with the current negative state of affairs of healthcare in the country, illustrates that a hearing impaired individual fits into a diverse ecosystem that is influenced by macro and micro influencers from the past and present. The future of the profession is being shaped by the evidence found in studies such as this, studies that provide documentation of the lived experiences on individuals who are seeking alternative methods of care in conjunction with the medical services that are provided. Participants in this study revealed that there are insufficiencies and gaps in the current medical model of practice in Audiology that need to be filled to ensure that a family-centred integrated and holistic model of care is obtained.

The results of this study confirm that there is a need to train and equip the future Audiologists in South Africa to embrace the diversity that affects the individual with a hearing loss. Diversity in South Africa was not accepted pre 1994 and people were required to assimilate to western methods, especially in healthcare. Globalisation at present, has resulted in the embracing of differences therefore it is necessary for audiologists to embrace the change from the current medical model of service provide to an integrated holistic care model that incorporates the different dynamics that affect the South African populous. Results from this study confirm that Audiology cannot be a compartmentalised aspect that fits into a specific section of the life of the individual with a hearing loss, without an interaction with other aspects of their life. This study revealed that beliefs, religion and spirituality are all-encompassing areas that are intertwined into the life of the individual with a hearing loss therefore these aspects must be discussed and included within the academic training and the clinical practice of Audiology. The service provision in Audiology can be informed by the findings of this study that illustrates that Audiology is so much more than just the diagnosis and management of a hearing loss. The hearing loss is only a factor that influences the person; therefore service delivery in Audiology must focus on the person as a whole.

The findings within all three sub-objectives of this study, add impetus for the modification of the current medical model of service delivery in Audiology. The results in this study reinforce the need to progress from a pathophysiological view of a hearing loss to an integrated holistic view of the human-being who is impacted by a hearing loss. The need for an integrated service delivery model is evident however there are factors that need to be considered before such a model is provided. The

following chapter provides a discussion of the integration and conceptualisation of a holistic approach that is required in Audiology. An integrated management of the mental, emotional and spiritual aspects of a human-being is required in Audiology.

Chapter 7: Integrated Service Provision in Audiology

7.1 Introduction

There is a global call for the reformation of healthcare service provision, as the current medical model excluded non-physical elements of healing and limits the development of a model that humanizes healthcare (Ross, 2009). Integration, collaboration, holistic care, family-centred therapy, multidisciplinary teamwork and biopsychosocial model are terms in healthcare that focuses holistically on the individual's life rather than the individual's illness. The array of terms illustrates the evolving methods of patient care globally, in this century.

The results in this study revealed a need for a chapter such as this, an *'Integration Chapter'* that focuses on key aspects related to integration within the field of Audiology. Three key aspects emerged from chapter 6, the *'Results and Discussion Chapter'*: there are gaps and insufficiencies in the current medical model healthcare practice in Audiology, which results in a need for a multidisciplinary team approach in the continuum of care in Audiology, that will lead to a final shift towards holism in Audiology that embraces and incorporates the diversities that exist in South Africa.

7.2 Gaps in the Current Medical Model of Practice in Audiology

The long standing medical model of care engages insufficiently with the holistic care of the patient (Balboni et al., 2007) hence the need for a healthcare model that incorporates all parameters that envelop a human-being: the body, mind and spirit. Knowledge is dynamic and it derives from the experiences of human-beings. Learning is the rounded process of modifying the current practice in a field, based on the experiences of those involved in the process (Englewood, 1984). The narratives obtained in this study have been used to inform changes that are recommended. The way forward with patient care in Audiology will entail the evolution of the academic and clinical training of students as well as the willingness of the current audiologists to embrace a change in service delivery.

7.2.1 Academic Training

The current study revealed an apparent barrier that contributes to the lack of spiritual and religious support. The lack of understanding of the diversity in the South African population is a historic barrier.

Participant 1 stated that:

"Can I just say that because Black communities especially think it's a sin, they think it's a curse. The sangoma and everything, I have seen in this school a lot of spiritual warfare. Big spiritual warfare here. And kids come from different backgrounds and especially with traditional healers and all that, and they come to me crying for help".

The participant above belonged to a different racial and religious group to the individuals that she was referring to, therefore her narrative indicates the perspective of someone who is not partaking in practices that include the sangomas and she viewed this as spiritual warfare. Even though the quote above was obtained from a participant and not an audiologist, the audiologist should be equipped to manage the differences in cultural, religious and linguistic differences that individuals present with. The history of South Africa, did not allow for interconnections among individuals from varying backgrounds. The segregation in South Africa led to the animosity between people, and the lack of acceptance and tolerance for diversity, which further entrenched the superiority and inferiority dichotomy. Diversity in the pre- 1994 South Africa was a barrier in itself as it highlighted and negatively portrayed any deviation from the 'white western norm'. Hence there was a lack of acceptance for the differences in culture, religion and beliefs between the different race groups in South Africa. The training of medical professionals, including audiologists, in the pre- 1994 South Africa consisted of the training of predominantly White English or Afrikaans speaking individuals who did not consider the beliefs, religion or culture of individuals who were different from them (Moonsamy et al., 2017). The lack of holistic healthcare training widened the division and inequality that already existed within an apartheid healthcare system in South Africa. The historically formed gap still exists in the current practice of Audiology in South Africa.

Audiological care starts from the identification phase and continues until vocation, therefore the inclusion of all aspects of the patient's life, within those phases, is vital. Academic training of audiologists currently revolves around the medical assessment, diagnosis and management of a hearing loss, which is similar to the training of medical doctors who do not have training into the spiritual aspects of therapy (Rickhi et al., 2011). Audiologists are currently not equipped to confidently converse with the patient about the patient's spirituality and belief systems, as related to their hearing. Bridging the gap between the scientific and spiritual worlds is necessary for an integrated service delivery system in healthcare.

The findings from this study reveal that there is a need for a curriculum modification in the training of audiologists, ensuring that audiologists become equipped with the understanding of service

provision within a diverse population, thus developing cultural competence. Discussions around the inclusion of spirituality and religious beliefs into training programs are ongoing however positive progress is being made in fields such as Nursing. Student audiologists therefore must explore, during a self-refection session, his/her own ideas, spirituality and beliefs before engaging with these areas as a professional.

These self-reflection questions were discussed by (Barnes et al., 2000):

- How is Ultimate health understood?
- How are affliction and suffering explained?
- What are the different parts of a person?
- How is a child's illness/sickness/disease understood and explained?
- What intervention and/or care are necessary?
- Who is qualified to address the different parts that need healing?
- What do the child and family mean by efficacy, or healing?

The abovementioned questions can be included in the student training session that focuses on the diversity within the South African context.

The training of audiologists is growing in complexity as the South African population becomes more diverse. New Age programs and workshops on healing and spirituality (Hanegraaff, 1998) have been included in society due to the demand for non-traditional options therefore audiologists should be equipped to manage the different influencers in the management process. The findings from this study support the notion that individuals are seeking alternative answers to managing their hearing loss. Participants in this study sought alternative healing through religious acts such as prayer and the laying of hands. The integration of spirituality and religion into a student training program may not be a fluid process however Barnes (2000, Pg903) provides ways to incorporate these areas into training and practice as seen in Table 7.1.

Table 7.1: Guidelines to Incorporate Spirituality and Religious Practices into Healthcare adapted from Barnes et. al., (2000).

Practical guidelines for the integration of Spirituality and Religion into the practice of Healthcare	Supportive role of the healthcare professional during the integration of religion and spirituality into healthcare practice
• Anticipate the presence of religious and spiritual concerns in care. • Develop self-awareness of your own spiritual history and perspectives. • Become broadly familiar with the religious worldviews of the cultural groups in your patient population. • Allow families and children to be your teachers about the specifics. • Build strategic interviewing skills and ask questions over time. • Refer to family-preferred spiritual care providers. • Listen for understanding rather than for agreement or disagreement	• Show sensitivity to and flexibility toward the religious beliefs and practices if families • Support legislation ensuring that all parents who deny their children medical care likely to prevent death or substantial harm or suffering be held legally accountable • Support the repeal of religious exemption laws • Work with other organisations and agencies to develop and implement laws for child care that is vital

Ultimate health is defined as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*(WHO, 1995) therefore this study aimed to highlight the social aspects of religious and spiritual belief systems that impact the ultimate health of a hearing impaired individual. Spirituality, medicine and family-centred care have been incorporated into the academic training at over 30 medical schools in the USA (Fortin & Barnett, 2004). The American Academy of paediatrics has provided supportive guidelines for multidisciplinary healthcare professionals who recognise that spirituality and religion play a role in healthcare. Furthermore, there should be no harm inflicted on the child in the process (Barnes et. al., 2000), as depicted in Table 7.1. Participants in the current study did not provide evidence of harm that was caused by the use of alternative practices. The evidence provided in the narratives of this study indicated that the outcome of seeking alternative methods was always positive.

Barnes et. al., (2000 pg 903) also highlights ethical issues that may arise when spirituality and religion are incorporated into healthcare as per Table 7.2. The training of Audiology students should also prepare them for the possibility of resistance from the individual with a hearing loss and his/her family. Individuals may not believe in a higher power or God, which could lead to conflict and the audiologist needs to approach the subject in an ethical and unthreatening manner. The individual with a hearing loss can be assured of the freedom to refrain from discussing areas that may create discomfort. As in the case of P7 who had a conflict in her religious beliefs as she was a Hindu, who

was prayed for by a Christian pastor, and the healing occurred. Resistance was documented in the narratives of P5 and P1 as the Deaf community did not accept the healing of a Deaf individual. The audiologist must be equipped to manage these psychosocial aspects that may arise in the management of an individual with a hearing loss.

Table 7.2: Ethical Issues that May Arise from the Discussion of Spirituality and Religion according to Barnes et. al. (2000).

Ethical issues that may arise
• Families and parents may feel like something is being imposed on them • Some families may experience it as a threat to their privacy • Vulnerability may be felt • If there is no ongoing relationship between the healthcare professional and the family then there is no context for the discussion in a safe manner • Tension may arise when there is differences in view • The parents' view of the role of the healthcare professional may dictate their openness to share about their beliefs in a transparent manner.

The training of future audiologists in South Africa is a dynamic process as there are constant modifications within the curriculums to ensure that the future audiologist is equipped to meet needs of the diverse population. The inclusion of an undergraduate course that allows the student audiologist the ability to engage with the current practice of Audiology within the South African context can assist in the development of a model of integrated holistic care in the continuum of practice in Audiology.

7.2.2 Current Practice

Findings from this study indicate that hearing impaired individuals and their parents are reluctant to discuss issues of healing and spirituality with the audiologist. The mother of P7 state that the audiologist was not interested in the healing as she mentioned *'I felt like they didn't want to hear it, you know they were concentrating on her'*. A change in the current practice of Audiology is vital so that individuals are not isolated; inclusion of aspects such as culture, spirituality and belief systems must be considered. A change that will focus on the patient from a birds-eye view, with the patient being the focus of the situation, is necessary. The various intrinsic and extrinsic factors that are unique to each individual will form the sub-areas of the ecosystem that can be targeted during the assessment and management of an individual with a hearing loss, as per Figure 7.1.



Figure 7.1: Ecosystem of an Individual with a Hearing Loss.

It cannot be one or the other, when deciding on which sub-areas to include in the care of the patient, it is idealistically best to co-treat using a medical and spiritual integrated method (Abdullah et al., 2016). The consideration of both the medical and spiritual aspects of the person's life will lead to a supportive healthcare environment. The results from this study indicate that all participants were interconnected with spiritual and religious individuals who were praying for a healing to occur in conjunction with the medical management of the audiologist. However, the audiologist was unaware of the spiritual aspects that were co-occurring with the medical management which seems to have resulted in a disjointed approach to healthcare.

Hearing impaired individuals present with the physical symptom of impaired hearing and the audiologist focuses solely on the diagnosis of a hearing loss, confirming the deficit approach, which needs to change, if holistic intervention is the target service delivery model. The medical role of the audiologist in the diagnosis of a hearing loss was evident in this study. The humanistic and supportive role of the audiologist in the wider holistic view of care was not evident in the narratives. Findings from the current study and literature indicate that individuals desire to be asked about religious and spiritual issues during a health assessment (King & Bushwick, 1994). Research has also indicated that 70% of individuals stated that medical workers should consider their spiritual needs, 37% wanted additional discussions pertaining to beliefs and 48% wanted the healthcare professional to pray for them. The studies conducted by Daaleman and Nease Jr (1994) found that 41% of individuals want their spirituality to be addressed, while another study by King and Bushwick (1994) found that 94% of individuals want their spiritual issues to be addressed. There were 45% of nonreligious individuals who stated that spiritual inquiry should occur out of respect for patients (Moadel et al., 1999). There is documented evidence that healthcare professionals should be aware of

the spiritual and religious beliefs of families, however there must be defined ethical boundaries in place to ensure that conflicts are resolved in a respectable manner (Barnes et. al., 2000). The narrative of P7's mother indicated that from her perception, the audiologist chose to ignore the conversation that pertained to supernatural healing.

The medical and spiritual worlds in healthcare is the barrier that concerns the current healthcare professional, there is an eminent fear of imposing on the beliefs of the patient and compromising autonomy (Best et al., 2016; Olive, 1995; Sloan & Bagiella, 2001). Healthcare professionals, such as audiologists, who fail to include the spiritual and religious aspects in patient care are neglecting to enforce a vital facet of healing and wholeness (Balboni et al., 2007). The inclusion of culture, religion and spirituality into the clinical care of the individual with a hearing loss will be beneficial for the family as a whole within the diverse South African context, especially given its historical injustices. The current continuing professional development (CPD) requirement in South Africa ensures that healthcare professionals are updating their current knowledge and practices in the respective fields. A CPD workshop can be developed to assist the current practice of audiologists to develop a model of integrated holistic care.

The step of transition is necessary to begin the process of change towards an integrating holistic model of practice in Audiology. Transition in healthcare service provision requires a team approach to ensure its success.

7.3 A Multidisciplinary Team Approach in the Continuum of Care in Audiology

The results from this study indicated that multiple influencers are present in the management of a hearing loss and the audiologist is no longer solely tasked with managing the hearing loss in isolation. This study showed that the continuum of care in Audiology from the initial suspicion of a hearing loss to the management of the hearing loss, are emotionally and socially loaded with reactions from family members and individuals with a hearing loss. There is evidence for inclusion of a psychologist, social worker, educator and parent councillor into the holistic model of care. It is beneficial to include individuals who are familiar with the processes associated with the acceptance of a hearing loss. This study revealed that parents of a child with a hearing impaired and individuals with a hearing loss will go through stages of disappointment and grief. The need for support is apparent; the negative and difficult emotions can be management in a holistic multidisciplinary team that considered the psychosocial factors present.

7.3.1 Integration of Traditional Healers

There is a perception that people seek alternative and traditional methods when medical intervention fails to provide results. However, there is evidence from the current study that indicates that people seek medical and supernatural intervention concurrently. Prospectively traditional healers are aware of the medical care that is being provided as the individual with the hearing loss is willing to share the medical diagnosis with the traditional healer. The audiologist however was not informed of the involvement of a traditional healer in the management process as there may have been issues of trust that affected the clear communication (Moodley, Epp, & Yusuf, 2012). The audiologist is then posed with self-reflective questions such as; 'Is there a rapport that is established between the individual with a hearing loss and the audiologist that is honest enough to openly discuss the area of alternative medicine? Why are hearing impaired individuals comfortable enough to express their medical information to the traditional healer yet there is reluctance to divulge traditional healing methods that were explored to the audiologist?'

The success of a strong integrated system involves the answer to the questions above. Personal boundaries may protect the belief of the professional however those boundaries may stop communication process. If audiologists are willing to collaborate with traditional healers then the individual with a hearing loss may see the need to connect the medical and spiritual practices. Audiologists will need to acknowledge the healing experience of the patient, to be open to collaboration with the spiritual leaders. Audiologist may then need to visit the alternative healers to witness the procedures that are being performed. The experiences of the healing processes were varied amongst participants in this study. Participants indicated that they felt the presence of God. This description has been reported in situations when individuals prayed for God to manifest his presence.

The exposure to such environments will assist in building a rapport between the audiologist and the traditional healers, in a non-judgemental manner. The integration of knowledge and true collaboration will take place when audiologists step out of their offices and into the spaces where the healings are reported. This will provide the audiologist with first-hand knowledge to accurately incorporate the supernatural experiences and the medical methods into a holistic integrated care model. The comfort of the individual with a hearing loss who arrives at the audiologist's room is not altered.

The compliancy of all role players, using teamwork in an integrated cohesive manner will ensure that the well-being of the individual with the hearing impairment is the focus. Strategic planning sessions

with traditional healers and audiologists can lead to open discussions related to identification, assessment and management methods. The collaboration between social support structures in religious circles and audiologists can fill the gap in specialised medical models of healthcare. Belief systems that cause regression of one's mental or physical state can be discussed collaboratively. The incorporation of the religious and spiritual role-players in the multidisciplinary management of the individual with a hearing loss is vital (Barnes, 2000).

7.3.2 Integration of Family Members

This study also revealed the significant influence of grandparents and family members in the early identification of a hearing loss. Medical anthropology incorporates the medical professionals own experiences into the service provision (Singer, 1995) however families may have opposing beliefs that affect biomedical instructions for care (Barnes et. al., 2000). Hence the need to include family members into the multidisciplinary team, when managing an individual with a hearing loss, the family plays a key role in the decision-making process. Opposing beliefs within the family structure can have drastic consequences for a child with a hearing loss. These beliefs can be revealed in the multidisciplinary integrated approach.

Communication and openness is necessary during the multidisciplinary discussions that are relating to the management methods for an individual with a hearing loss. This study revealed that the mother of P7 did not deem it necessary to discuss the healing of her child with the audiologist as she was afraid of being chastised. Research has shown that medical professionals maybe uncomfortable and ill-equipped to explore spiritual and religious facets with families (Barnes et. al., 2000). These negative and discontent emotions exist as medical professionals need methods to obtain the relevant information and maintain their beliefs at the same time. However, an integrated multidisciplinary team approach will ensure that a spiritual or religious advisor is included in the team to provide the necessary support. The inclusion of a spiritual advisor will lighten the burden on an unskilled or uncomfortable audiologist who does not want to attempt to council a person in terms of their spiritual beliefs.

7.3.3 Integration of Educators

Participant 7 and P6 indicated that bullying, teasing and isolation occurred in the school environment therefore an integrated multidisciplinary team for a school aged individual with a hearing loss must include an educator. Educators and caregivers can work together to take collegial responsibility to identify and manage delays in the child's development however support from medical professionals will form a holistic multidisciplinary family-centred collaboration. The inclusion of an educator in

the healthcare team can ensure that the child with the hearing loss is supported in the classroom. The educator, who is aware that a child has a hearing loss, can desensitise the other students in the classroom so as to minimise bullying and isolation of the child with the hearing loss. Educators who are also equipped to identify a child with a possible hearing difficult will be less likely to overlook a HOH child as the phases of 'normal' development still exist however the time of development milestones are delayed (Du Pont et. al., 2001).

The development of an integrated service delivery system will emerge, as the collaboration and integration of parents, caregivers and educators into the medical circle of professionals will improve the early identification of a hearing loss. As discussed in detail in the Literature Review Chapter of this study (Chapter 4) the biopsychosocial-spiritual model of care (Sulmasy, 2002) provides the most fitting framework for the adoption of medical, religious and spiritual aspects into the patient care model in Audiology. However the audiologist must advocate for the appropriate individual, such as a religious leader, to be included in the multidisciplinary team (Handzo & Koenig, 2004). The continuous transition of audiological service delivery methods, within a multidisciplinary team approach, that incorporate aspects such as spirituality; will ensure that progress is made towards holism in Audiology.

7.4 Holistic Integration in Audiology that Embraces and Incorporates the Diversity in South Africa

The definition of Holism (Merriam-Webster, 2017) states that it is: the theory that parts of a whole are in intimate interconnection, such that they cannot exist independently of the whole, or cannot be understood without reference to the whole, which is thus regarded as greater than the sum of its parts. Holism is often applied to mental states, language, and ecology. Holism refers to the treatment of the whole person while taking into account mental, physical and social factors.

The narratives in the current study indicated that holism is required in the continuum of care in Audiology as human-being are multidimensional, emotional, mental and spiritual beings. The influences of culture, religion, traditions and beliefs play a significant role in the holistic management of an individual with a hearing loss. Change is inevitable in the field of Audiology as there are major developments in technology and resources within healthcare. A change towards overall wellness creation in a holistic multidisciplinary model of care is required. Lenihan (2010) states that the development of New-Born Hearing Screening (NBHS), EI (Early Intervention) and CI (Cochlear Implants) has changed Deaf education and the practice of Audiology. These three key areas fit into the themes that arose in the present study namely, identifying a hearing loss, the assessment of the child and the management of the hearing loss.

The medical model is disability and disease focused (Engel, 1989) yet the individual with a hearing loss is more than the hearing loss. New inclusive methods of patient care have emerged however Audiological care is still being transformed by the renewing of assessment and management methods. A holistic integrated service delivery model is necessary in all stages of audiological care as supported by the narratives obtained in this study. Therefore, holistic care should be integrated into each stage, from the suspicion of a hearing loss to the management of the loss.

7.4.1 Holistic Integration in the Early Identification Phase

The notion of promotion of hearing practices and the awareness of hearing loss is idealistic however the mechanisms to provide this information are not always clear. Grandmothers and women in South African communities take on the leadership roles in many households and they are an available resource to the communities. In South Africa, women often gather at shopping centres or pension pay-outs on a regular basis, information pamphlets on ear care and educational workshops hearing and hearing loss, could be held at these sites that are convenient for the women. Caregivers can gain valuable tools for hearing protection to implement at home, thus the caregiver can be the change that is needed to destigmatise the community to the disabilities seen. Grandmothers specifically hold a strong dominance and authority (Mall, 2005) within South Africa communities and their informed positive influence could make a significant change in the early identification of a child with a hearing loss. The high percentage of uneducated adults in South Africa indicates that audiologists must be cognisant of the literacy limitations that exist when designing the materials for the awareness of a hearing loss and the promotion of good ear care. An inclusive model of care should ensure that prevention and promotion materials in Audiology must meet the needs and abilities of the individuals who will access this information. Holistic care in Audiology that integrates all facets of the family life will have a long term positive implication for the family and society as a whole.

The medical model has led to the person being seen as a specimen and despite the advances in cracking the genetic code, the understanding of the human as a whole has stagnated (Sulmasy, 2002). As far back as 1988 researchers such as McLeroy, Bibeau, Steckler, & Glanz began to discuss the notion of an ecological model of patient care. A model that focuses on the community, public policy, social and individual influencers. Bronfenbrenner (2009) biopsychosocial model looks at the patient as being affected by mutiple influencers and affecting multiple influencers. Individuals are beings-in-relationship and when disease and illness occur it interrupts the biological follow and consequently affects all relationships (Sulmasy, 2002) and this was revealed by participants in the current study.

The Deaf community is a unique group of individuals who are hearing impaired, who communicate using sign language and follow the Deaf culture. This sudy indicated that the flow was disrupted in a school for the Deaf when a student was supernaturally healed of a hearing loss. Figure 7.2 illustrates the interconnectedness of the HOH/D individual within society.

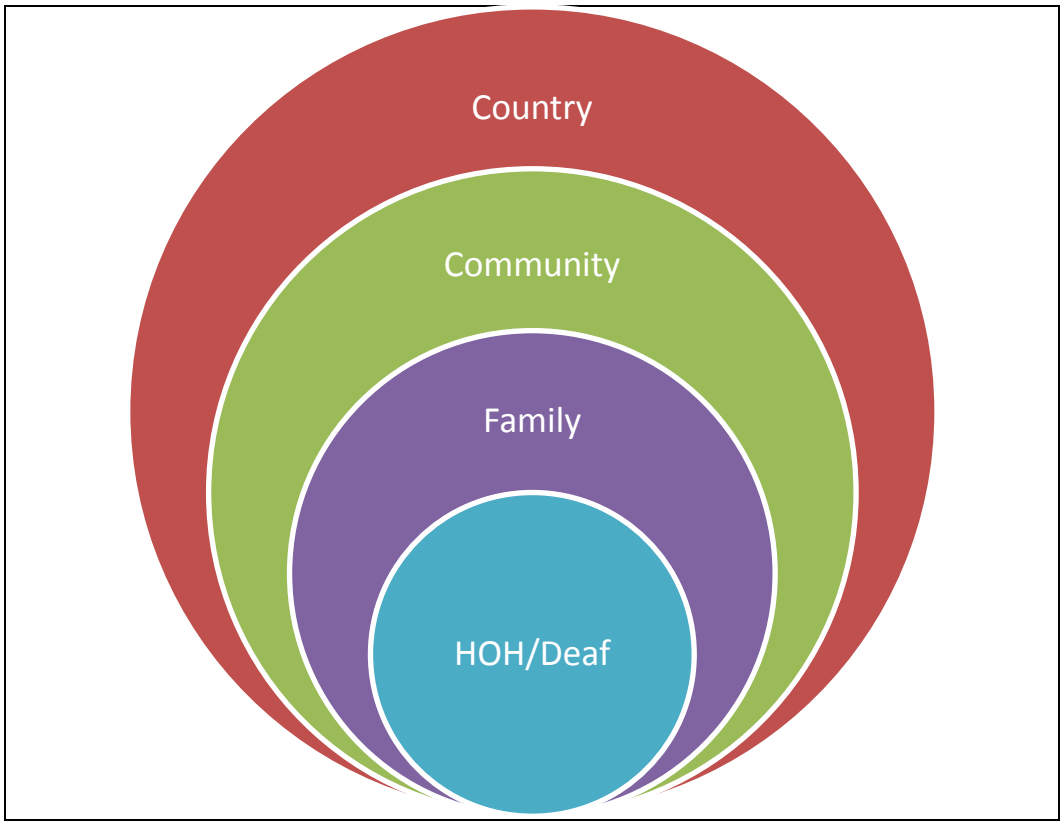


Figure 7.2: Interrelated relationship of the HOH/D Child.

The narratives of this study revealed that the impact of a hearing loss and the impact of a supernatural healing, stretches far beyond the borders of the home environment therefore the need for holism in Audiology in the diverse South African context. Holism should ensure that the management and care of the patient would span beyond the borders of the hospital. Audiologists need to be mindful of the early paradigms that parents develop, when a child is diagnosed with a hearing loss (Young & Tattersall, 2007) so that appropriate support is provided from the outset. The narratives of this study indicated that the inclusion of significant individuals within each layer of influence is crucial to effect change in the larger spheres of society as depicted in Table 7.3. Interpersonal relationships with family members, the community and society at large have an effect on the behaviours and decisions of the individual (McLeroy et al., 1988) as seen in the narratives in this study. Holistic integration should ensure that the social influencers are incorporated into the care of an individual with a hearing loss.

Table 7.3: Social Influencers in the Life of a HOH/D Child

	Family	Community	Country
HOH/D Individual	Spouse	Religious leaders	Policy makers
	Children	Teachers	Health professionals
	Grandparents	Health care workers	Health ministers
	Extended families	Political ward councillors	Employment officers

The importance of the early identification, assessment and management of the hearing loss is to facilitate the timely development of milestones of the child. Families have a vested interest in seeing the child develop to his/her full potential and there is a need to provide families with information and tools to identify a hearing loss. In this study, the beliefs related to the causes of the hearing loss varied from sin, curses and the purpose of life. The inclusion of spirituality and religion in the case history discussion with the audiologist will allow the individual to provide his/her thoughts and perceptions that are related to the cause of the hearing loss.

An integrated and cohesive system of identification is required to ensure that there is minimal time between parental concerns and diagnosis as a hearing loss. This study revealed that P2 and P7 had a hearing loss at birth however it was undetected until later in life and the effects on the speech and language development were evident. The role of the audiologist becomes one of an ‘information sharer’ with families to ensure the promotion and prevention information is shared within a safe space so that children with a possible hearing loss can be identified at an early stage.

7.4.2 Holistic Integration in the Diagnosis Phase

When a child is diagnosed with a hearing loss there are emotions that emerge and the audiologist needs to account for this stage of emotional transition that parents and caregivers experience. An audiologist is responsible for the feedback session to the parents, where the diagnosis of the hearing assessments is discussed. Audiologists may not have the depth of training to answer questions that parents may pose. Parents who receive a diagnosis of a child’s hearing loss may experience sadness and distress; however parents are forced to make life changing decisions at that point. Support structures may play a vital role in the overall well-being of parents and children therefore holistic models of care during the diagnosis of a hearing loss require the inclusion of counsellors.

Hence a comprehensive integrated model of pre and aftercare will provide support for the mother and the baby. Parents of a HOH/D child may question their role in causing the hearing loss, which in turn

unravels emotions of guilt and blame as in the case of the mother of P7 in the current study. Negative emotions cannot be addressed solely by the audiologist and appropriate referral to a psychologist is necessary. An integrated model should include prenatal care for mothers who are experiencing a difficult pregnancy that may put the baby at risk. The narratives of participants in this study also revealed emotions such as grief, devastation, sadness, isolation and stigma toward the diagnosis of a hearing loss. Holism in Audiology would thus require the incorporation of the emotional responses of the individual with the hearing loss as well as parents, family members and significant others into the healthcare model.

The HOH/D individuals tend to seek for a reason or cause of the hearing loss. In this study, there was a range of reasons identified, such as sin, the purpose of life and curses. How should audiologists respond to the beliefs on the cause of the hearing loss and the reasons for the hearing loss? Psychosocial factors of influence will dictate the compliance of parents to new born hearing screening (NBHS), hearing aid assessments and management. The audiologist must obtain the support of counsellors such as psychologists to assist with the demystifying of specific misconceptions. However, it is strongly advised that the religious leader or support member is consulted so that the information provided is in alignment and is respectful to the beliefs of the individual with a hearing loss.

The stages of response during the diagnosis of a hearing loss must be understood and supported by the multidisciplinary team that will be working with the family. Team members from different arenas, that are linked to the individual with a hearing loss, maybe more supportive during the three response stages than the traditional team of medical personal. Audiologist must initially establish and build a rapport with the family and the child in order to integrate them into a holistic team of advisors. An integrative model of care would allow for the family and the medical advisors to discuss the options available for the child with expectations and guidelines being clearly facilitated.

This study illustrates that the concept of healing is multifaceted with the inclusion of religious, spiritual, racial and cultural aspects. Participants in this study expressed different forms of healing that occurred through a supernatural means. A holistic integrated family-centred model of care ensures that the overall well-being of the individual with the hearing loss and the family are the focus. Once the child is diagnosed with a hearing loss the caregivers are expected to make important decisions that will impact the future of the child in a short period of time (Griffin, 2013) as revealed in the narratives of this study. Parents in this study were required to make important educational and life decisions for their newly diagnosed babies. If parents in this study had access to a

biopsychosocial-spiritual holistic multidisciplinary team approach, they could have had the support needed.

7.4.3 Holistic Integration in the Management Phase and Beyond

The findings from this study posed the following question to the researcher: *Are parents making informed decisions and did the parents know what the best management options were for their child's needs? So how are audiologists expected to provide effective and effective services to all individuals who require it?*

Management options for a HOH/D individual differs in relation to factors such as context, stigma, affordability and culture (Garstecki & Erler, 1998). Parents who are knowledgeable of the hearing loss at an early stage, are afforded time to tailor their decisions with regards to management (Young & Tattersall, 2007). Sulmasy (2002) reiterates that holistic care in the health sector must incorporate the physical, psychological, social and spiritual spheres of the patient's life.

In light of an integrated service delivery and support model it is vital to consider all individuals in the circle of the child with a hearing loss. A successful management model will depend on the long-term support of a strong parental and family structure. The incorporation of families will empower older individuals to play a significant role in the future of children as a hearing loss can be detected and managed in a timely manner. A network of medical professionals, educational professionals and family members form the core team who will decide on the management model in Audiology. A model of information sharing from a professional perspective is often the focus and the parents are required to commit to the risks during surgery in the case of a cochlea implant.

Parents may have seasons of happiness when the child is consistent and performing well at a particular stage in life. Major decisions need to be made when parents are expected to choose schools and career options for their children. The stages of change can be challenging and stressful for parents therefore support is required to ensure that informed decisions are made. Parents are the decision makers and major role players in the life of a new-born with a possible hearing loss, if parents are well supported during the stages of grief and devastation the outcomes are positive. Spiritual support will also be long term and advantageous for the parent and the child, as the religious leaders can have a direct and lasting influence on the family. In South Africa, there is an emerging shift to family-centred care with HI HOPES, where parent advisors are matched to the needs of the family thus positioning the family in a supportive environment. The care of the family is the ultimate goal for any health care professional and collaboration that enhances care must be explored. The

identity of an individual is shaped by the community and responsiveness to audiological management would be high if there is a strong support from the community.

Audiology in South Africa should consider a new integrated approach of healthcare that is suitable for the diverse South African population and context. The features of this approach are relevant and should benefit the audiologist and individual with the hearing loss equally. If the management of individuals with a hearing loss continues to operate as isolated pockets of care, the individual with a hearing loss will be negatively impacted by the medical methods that may be contrary to the family's belief system. The prayer life of everyone is unique however prayer is a vital practice of individuals who seek for a supernatural intervention when an illness is diagnosed. A holistic model of care in Audiology will ensure that the individual with a hearing loss and his/her spiritual and religious beliefs are included in the continuum of care.

7.5 Summary

The idea of an integrated model of service delivery in Audiology is a realist one. The field of Nursing has toyed with the concepts of medicine and its relationship with religion and spirituality. The documented evidence in the field of Nursing sets a foundation for the support of a model in Audiology that will include the biological, psychological, sociological and spiritual aspects on the patient's life.

A cohesive, integrated referral system and collaboration between professionals and caregivers are often the dictators of the assessment and early diagnosis of the hearing loss. A service delivery model that incorporates all aspects of life of individual with a hearing loss is therefore recommended within the profession of Audiology.

In the concluding chapter, there is a summary of the argument that the current medical model of practice in Audiology cannot effectively meet the needs of the diverse South African population. A change is necessary within the service delivery practices of Audiology in South Africa. A change that requires the integration and incorporation of all areas of life is necessary in Audiology. The narratives of the current study provide evidence to argue for an integrated and holistic model of care in Audiology. There is evidence in this study that supports the inclusion of the medical, psychological, social and spiritual aspects of life, into the practices of Audiology. The conclusion chapter is a culmination of the aim of this study, which was to document the narratives of individuals who report a supernatural healing of a sensorineural hearing loss. However, the conclusion chapter is in some way the end that leads to a beginning. The conclusion chapter provides the audiologist with clinical practice strategies to assist in the commencement towards a new model of practice in

Audiology. Case history taking allows the audiologist to obtain qualitative information that pertains to the individual and the hearing loss. This study argues that the audiologist should discuss aspects of alternate, religious and spiritual practices of healthcare in the case history session. The management of the individual with a hearing loss should also include traditional healers who can provide the spiritual support. The case history form that was developed from the evidence in this study, attempts to initiate the change that is required in Audiology, to meet the needs of the diverse South African population.

Chapter 8: Conclusion

8.1 Introduction

The reader of this study started as an explorer in a study based on the narratives of individuals who reported on their supernatural healing of a sensorineural hearing loss. The journey began with an introduction of my personal insights and experiences that was the driving force behind this research. My year of community service in rural Kwa-Zulu Natal solidified my love and passion of the field of Audiology and my love for the unique and diverse South African population. The varying healing practices are consequential of the diverse populace in South Africa. This study was shaped by the varied political and religious history of South Africa. Calvinism was a belief system that was practiced by the initial Dutch Settlers in the Cape which significantly changed the future of the indigenous inhabitants of South Africa. This study surmises that the influences of the British and Dutch dogma of healthcare, is responsible for the current medical model practices in healthcare in South Africa. A medical model of practice does not allow the audiologist, to engage with the religious, alternate and spiritual aspects that affect the individual with a hearing loss. The void in the medical model of practice in Audiology is evident however there is limited research evidence to indicate that a change in the model of service delivery is justified. This study was therefore conducted to document the narratives of individuals who are utilising alternative practices of healing, which do not fall under the medical model of practice. Literature pertaining to spirituality and religion is vastly available however the novel contribution of this study is significant as there is no documented study that considers the lived experiences and narratives of individuals who report on a supernatural healing of a sensorineural hearing loss.

This study commenced with the aim of answering the following research question: *What are the narratives of individuals who report that they have been healed of a permanent sensorineural hearing loss through supernatural intervention?*

The current study undertook an exploratory case-study design to obtain answers to the research question, within a qualitative paradigm. This concluding chapter illustrates how the data obtained in this study, was able to answer the research question by identify the recurring themes within the narratives of participants who reported a healing, with the purpose of deconstructing the aspect of healing amongst participants. The data provided a description of the cultural, religious, spiritual and social influences that impact the individual with a hearing loss. This study finally aimed to propose a practical working model of service delivery in Audiology, which is relevant for the diverse South African populous.

8.2 Concluding Comments on the Fulfilment of the Aims and Objectives of this Study

The findings of this study achieved the aims and objectives of the study. This study reiterates that the concept of healing is multidimensional. Individuals who are seen by the South African audiologist are also seeking for alternative methods to heal the hearing loss. The narratives obtained in this study argue that the individual with a hearing loss is influenced by culture, religion, society and spirituality. The impact of these influencers is significant in the practice of Audiology. The negation of the psychosocial-spiritual influencers in the practice of Audiology would be callous.

The results of this study indicate that religious and spiritual practices are a part of the everyday life of an individual with a hearing loss however there is a lack of freedom to discuss these practices with the audiologist. The narratives obtained argue that the current medical model of practice in Audiology fails to integrate the medical, psychosocial and spiritual aspects into the audiological practice. This study provides the evidence for bridging the gaps in service delivery in Audiology to ensure that holistic and integrated care is afforded to the individual with a hearing loss. The findings of this study reiterate the need for a multidisciplinary team approach of healthcare that supports the family through the assessment and management phases in Audiology. Healing and wholeness is the ultimate goal of any intervention process within the field of Audiology, therefore the collaboration of all relevant role-players in the life of the individual with a hearing loss, is necessary. The results of this study motivate for the proper inclusion of the medical, religious, spiritual and family support structures in a respectful and homogenous way will be beneficial for a successful intervention plan in Audiology.

This study contributes to the literature and clinical practice of Audiology in South Africa, by focusing on a holistic and integrated service delivery model that incorporates the biopsychosocial-spiritual aspects of life. The strength of the individual case study approach provided in-depth narrative data that revealed the evidence required for the construction of a new working model of service delivery in Audiology. The findings in this study influence the clinical practice of Audiology within the South African context as well as international contexts that resemble the diversity in South Africa. The narratives of a supernatural healing are thought provoking and should not be disregarded. The need for an integration of the alternative methods of practice into the service delivery model of care in Audiology is realistic and necessary for the overall well-being of the individual with a hearing loss. A divided and compartmentalised system of care is divisive and can lead to confusion in the management of an individual with an audiological related difficulty.

The theoretical framework in the current study was centred on an integrated model of healthcare in Audiology that will include the medical, psychological, spiritual, cultural and religious aspects of an individual's life. This study was theorized from a necessity to transform the current long standing medical model structures in Audiology. The long standing medical model approach has been adopted by audiologists in South Africa and is no longer beneficial to all areas of patient care.

The themes that were identified in this study, such as religion, God, prayer, belief systems and supernatural aspects, highlight that a hearing loss cannot be managed in isolation. The themes obtained through this study are relevant to the individual with a hearing loss however that the current medical approach of practice in Audiology does not include the information that is highlighted with the themes of this study. The relevance of the non-medical aspects is as equally relevant to the medical aspects therefore the integration of all aspects is important in holistic service provision.

A new line of thought is required for the integration of religion, culture and spirituality into the service delivery in Audiology. Literature indicates that it is right to be cautious about the incredulity surrounding the area of supernatural healing (Gardner, 1983). However, the scepticism about a supernatural healing does not deem the healing annulled and all healthcare practitioners, including audiologists need to be equipped to converse with their patients about the experiences. This study provides the audiologist with evidence that individuals in South Africa are seeking for alternative methods to heal a hearing loss, regardless of the scepticism of others.

The world and its concepts and paradigms are constantly evolving and this study proves that the scope of practice in the field of Audiology must follow suit and evolve, to meet the needs of the individual with a hearing loss. This study illustrates that audiologists don't need to prove that a supernatural healing has or has not occurred but they do need to discuss the beliefs of the patients within a holistic framework. Multicultural alternative practice methods for the healing of a hearing loss were clear in this study. This study therefore motivates for a holistic service delivery model in Audiology that is objective and impartial. Evidence was obtained in the current study, to motivate for a successful audiological service delivery model in South Africa, that inclusions religion, cultural and spiritual beliefs. The acceptance and implementation of an integrative intervention model is necessary however there was a lack of support for such a model due to the limited published research in relation to the supernatural aspects of culture, religion and spirituality in the field of Audiology.

This study was conducted to support the process of researching and documenting aspects that are unfamiliar to the medical management of hearing impaired clients. This study adds to the body of

knowledge that lends itself to the formation of a holistic and integrated service delivery model in Audiology.

8.2.1 Clinical and Theoretical Contributions

Biopsychosocial-Spiritual Model of Care

The Biopsychosocial-spiritual model of care by (Sulmasy, 2002) can inform the model that is proposed in this study for the field of Audiology. The results of this study reiterate that one cannot ignore the medical aspects of a hearing loss that include the assessment and diagnosis of the type, degree and laterality of the loss. However, the management of a hearing loss entails more than just the medical management with the use of amplification. This study argues that the political history of South Africa has shaped the intolerance for the differences in religion and culture within the populous. The intolerance has led to a single-minded medical approach to healthcare in South Africa that does not embrace the alternative healing practices of the diverse population. In an attempt to resolve the exclusion of alternate practices of healing in Audiology, the audiologist is required to explore and include the cultural, religious and spiritual aspects into the continuum of audiological care. A service delivery model that is well suited for the diverse population group in South Africa is vital. The results of this study indicate that audiologists are not equipped to converse about spirituality and religion in conjunction with medical care. Therefore prior to the discussion of non-medically related aspects, the audiologist must first self-reflect about one's own beliefs. Questions presented by Barnes et.al., (2000) were modified by the researcher in Table 8.2. These questions can assist the audiologist in the self-reflection process.

Table 8.1: Modified Questions of Barnes et. al., (2000).

Questions that allow the Audiologist to Self-Reflect
• How is Ultimate health understood? • How do you understand affliction and suffering? • What are the different parts of a person? • How is hearing loss understood and explained? • What intervention and/or care are seen as necessary? • Who is seen as qualified to address the different parts that need healing? • What do understand by the word healing? • What are your thoughts on religious, traditional and spiritual care in generally and then specifically with a hearing loss? • Do you believe in supernatural healing and if you don't believe then how would you handle a situation where a patient believes in a supernatural healing? • What are your thoughts with regard to the collaboration with non-medical individuals in the management of a hearing loss? • Would you be the one to initiate a multidisciplinary team that includes religious, spiritual and traditional healers in the care of an individual with a hearing loss?

This study argues that once the audiologist has established a foundation for his/her own beliefs on supernatural healing and alternative care then the next phase is the ability to find avenues to provide a holistic model of care. The initial assessment procedure in Audiology includes a case history taking session. A retrospection of case history tools such as the Columbus Speech and Hearing centre case history form, The University of Georgia Speech and Hearing Clinic form and The University of the Witwatersrand form revealed the following sub-sections:

- General
- Medical
- Hearing History
- Hearing Aid History

There is a lack of evidence of questions that pertain to religion, spirituality or cultural. This is possibly due to the lack of training provided to audiologists, to be able to follow through with such questions. The researcher proposes that a section be included into the case history forms being utilised by the audiologist.

The following questions can be included in the new section:

- Religious and Spiritual Aspects: Higher Power/God, Traditions, Culture

    - Do you belief that the hearing loss maybe a result of a non-medical cause?
    - Do you believe in God/Higher Power and if so how do you understand the hearing loss in relation to your belief?
    - Did you seek any other form of help for the hearing loss, for example prayer, traditional methods?
    - Is there someone who supports you spiritually?
    - Would you like to include non-medical support structures in the process of management of the hearing loss?

The questions above can be used as a guide to the audiologist when trying to obtain information that is related to religion and spirituality, Appendix J, provides the audiologist with a modified questionnaire that incorporates the additional aspects discussed. Individuals will be informed of their right to not answer the proposed questions if they are uncomfortable. The individual will be afforded the freedom to question the use of the answers that are provided on the questionnaire.

This study confirms that the field of Audiology cannot be taught or practiced without the medical components however the inclusion of religious practices, spiritual aspects and cultural beliefs is necessary. Holistic healthcare sees the patient from all angles and it includes all the relevant areas that affect the patient. The evolution of the service delivery system in the field of Audiology in South Africa can be the start of a global trend to consider the ‘forbidden’ areas such as religion and spirituality within healthcare. The mixture of science and religion have been a contentious issue in the medical world however one cannot ignore the growing desire within a human being to seek for alternative answers when a hearing loss is identified.

South Africa is called the ‘rainbow nation’ as its population is made up of an array of different race groups who speak various languages and who belong to diverse cultural and religious backgrounds. It could even be called ‘reckless practice’ not to consider the integration of areas that affect this unique rainbow nation, into the Audiological management model. However, the current practice of Audiology is South Africa is rooted in the medical model of practice and this study thus proposes a change to the long standing current model of care. A change of practice will require the audiologist to consider the proposed holistic integrated model of service delivery in Audiology that is necessary for the diverse South African populous. This study also provides support for the value of both the qualitative and quantitative approaches of research in the field of Audiology.

The medical model of practice provided rich quantitative data in research; however it can also be supported by valuable qualitative narrative data, to form an integrated paradigm of evidence based research practice in Audiology.

The audiologist has the expertise to play the key role in the planning, implementing and evolution of the profession in South Africa. The improvement of patient care is the focal point however the change towards an holistic model of care will also have effects on a wider scale when families, communities and the country is impacted by the change. A change in service delivery is a process and will not occur in a day or a week however a shift will require the formation of ways to best integrate all aspects of the hearing impaired individual's life into the management system (Model, 1994).

The training of future audiologists in South Africa can attempt to decrease the gap between the individual with a hearing loss and the current medical model of audiological care provided. This study argues for a clinical training modification within the University curriculum to ensure that the audiologist is equipped with the knowledge and tools to conduct holistic and integrated services. The narratives of this study have implication for the future practice of Audiology as there is documented evidence that individuals with a hearing loss are using, exploring and benefitting from supernatural practices. The negation of the evidence in this study, by an audiologist would be negligent as the incorporation of religion and spirituality in the audiological process is indicated to be beneficial. Wellness creation is established in a service delivery model that can accommodate different facets of the individual's life. This study was initiated to document and present the narratives of individuals who reported on a healing of a sensorineural hearing loss. The outcomes were achieved and the researcher hopes that novel ideas and propositions within this study will create an opportunity for dialogue between the relevant role-players in the medical, religious and spiritual worlds, thus establishing a stronger, well rounded, holistic and integrated model of care in Audiology. The strengths and limitations are outlined in the next section.

8.3 Limitations of this Study

The clinical and theoretical strengths and the limitations of this study provide direction for areas that can be explored further in future studies.

8.3.1 The Sample Size: A larger Sample Size

The researched evidence of supernatural healing is rare despite the common notion of the healing practices within various religious and spiritual groups. This study is one of the few documented

studies that tackle the association and relationship between science and spirituality. The rarity of documented proof of a supernatural healing in Audiology may be due to the lack of relationship between the audiologist and the individual with the hearing loss. The individual may not return for a reassessment as he/she assumes that the audiologist will not believe the report of healing. The sample that was obtained in this study includes individuals who were referred by religious leaders.

A larger sample size would have been obtained if there was more time afforded to the study. The occurrence of a supernatural healing is usually consequential of the individual seeking or practicing a religious or spiritual act. These healing practices usually occur in places of worship. Therefore, more time would have provided the researcher with the ability to attend those places of worship where healing is sought as this could have been a sample source. It would have been beneficial to obtain a larger sample however the current sample provided in-depth and complex narratives with overlapping themes that allowed for the richness in the data collected. A large sample would have quantitatively provided a large number however the details to answer of the overarching aims of this study would not have changed in content.

8.3.2 Proof of a Physical Healing

The researcher was often asked if this study can provide proof of a physical healing. It was not an aim of the current study to medically prove that a healing occurred however the questions raised by individuals who were interested in the findings, indicates that people want to see the medical proof of a healing to believe. It is not vital to find the medical proof to consider the effectiveness of supernatural practices on an individual with a hearing loss as the effects may be non-medical. However, the questions raised and the answers provided by the researcher were justified based on the methodology of the current study yet to those asking the questions, it seemed like the answer was a limitation to their expectations.

8.3.3 Considering the Thoughts and Perspectives of the Religious and Spiritual Leaders and Audiologists

This study focused on the reports of individuals who stated that they were healed however the audiologist did not report on the experience with the participant. Religious and spirituals healers were also not consulted to obtain their perspectives on the healing process.

8.3.4 The Challenge of Implementing a New Working Service Delivery Model in Audiology

This study proposes a new working model of integrated service delivery in Audiology however a limitation of the study is the evidence that the audiologist will buy into the proposed model. There is no evidence that the audiologist will step out of his/her comfort zone and change the current methods of practice.

8.4 Future Research Ideas that Arose from this Study

A prospective study could be conducted on a larger scale with relation to hearing and hearing related symptoms. The larger sample group could include individuals who report on the supernatural healing of tinnitus, vertigo, dizziness, stiff middle ear bones, Eustachian tube abnormalities and hearing loss. If a larger study is undertaken then more time must be afforded to this long-term study as there is a need to search for potential participants.

A study that aims at proving that a supernatural healing has resulted in a physical restoration of hearing is further option. There must be a clearly designed methodology that aims to assess the current hearing thresholds of the individual who report on the healing. The assessment requires time, resources and availability of the individuals who need to be assessed. A future study can aim to verify the reports of supernatural healings.

A future study could explore the perspectives, thoughts and practices of audiologists in relation to supernatural healing. Another study could look at the views and practices of religious and spiritual healers in relation to Audiology.

There is a niche to explore the audiologists' perspectives of the benefits and challenges that are related to the currently used medical model of service delivery. The results obtained may provide a collective voice that indicates that audiologists are aware of the need for change and a need for a new holistic model of service delivery that considers.

The research agenda is the implementation and testing of a holistic integrated model of care in Audiology to determine its effectiveness. The diverse South African context has various areas to be researched in the future and these include:

- A study to determine if audiologists seek supernatural help when they are faced with a medical diagnosis.
- To research and explore the effects of religion on the current state of affairs in South Africa

- To study the effects of the inclusion of a spiritual advisor within the multidisciplinary team of care for an individual with a hearing loss.

Future studies and research niches can be explored within the field of Audiology with the diverse South African context. However, the need to integrate all aspects of the individual's life into the service delivery model must be at the forefront of the future research plans.

This PhD process has been a life changing experience for me as an Audiologist, a woman, a South African and as a researcher.

8.5 Reflections on my Research Journey

Personal Reflections



Storytelling was the premise behind the use of narratives within this study. Our lives are built on the foundations of scientific evidence and socially constructed evidence through stories that are relayed by those who choose to share those stories. Generations of individuals before us decided to document information so that information could be transferred across the years. The initial rock art, hieroglyphics and pictograms evolved to texts within books and dissertations such as this. The documentation of this research was conducted by a researcher, Dhanashree Pillay, however this section pertains to personal reflections of the individual who is more than a researcher. Therefore, there will be a reference to 'I' instead of 'the researcher'.

When I began this study, I expected to document and transfer the lived experiences of the participants. However, a personal transformation occurred as I commenced with this study. A change occurred within me at each stage of this PhD process, a change that allowed me to grow in the 'quietness and strength'. As a lecturer, I am often the one who is teaching and sharing knowledge with students, who I thought of as less knowledgeable, however this PhD process has given me the grace to be the student. I was able to be the listener in this process; a listener who became more intrigued and fascinated by the wisdom that I gained. I was afforded the ability to read, listen and learn in areas that are so diverse, I navigated through South African history, religion, beliefs, and community, life and novel ideas of healing. My own beliefs and interests became more 'Real' to me and I began to immerse myself into a process of understanding my own identity during this PhD process. Questions arose in my own growth while endeavouring to complete my PhD, questions that

were relevant to me at different stages of Who am I? What do I stand for? What has shaped the South African in me? What has moulded me into the Woman that I am today? How have I become a better researcher? What can I do to become a more effective Audiologist within the South African Context?

I acknowledge that the details of my personal reflections and inner thoughts cannot be equated to words however I will share the significant changes with you…. the reader…. the Explorer. Creativity is a fuel to my fire and I would colour, paint or create pieces of Art to depict how I was feeling at each stage in my PhD process. I always had a sense of accomplishment and confidence throughout this PhD process despite the unforeseen challenges that arose. The treble clef artwork was inspired by the narratives that I obtained in this study. Each narrative had a uniqueness and rhythm to it however the interlinking of lived experiences impacted the stories of individuals that were connected to the participant. The stories were likened to individual music notes however these music notes were blended together in this study to compose an integrated song that impacts the field of Audiology within the diverse country of South Africa.

I included my creative pieces for you the explorer, so that you may consider your creativity within the field of research that is vital to you at this stage. May you have the grace to complete what you need to as I received the grace to conquer this journey. Each stage of the PhD journey played a role in my growth therefore I presented my reflections per stages of this study.

8.5.1 Concept Paper and Ethical Clearance Stage (June 2014 – July 2015)





My personal insights will provide the explorer with information about my thoughts and vision for embarking on such a study. I decided to begin this PhD in the area of supernatural healing as I have always been intrigued by the divergent methods, of doing things in life. There are always different

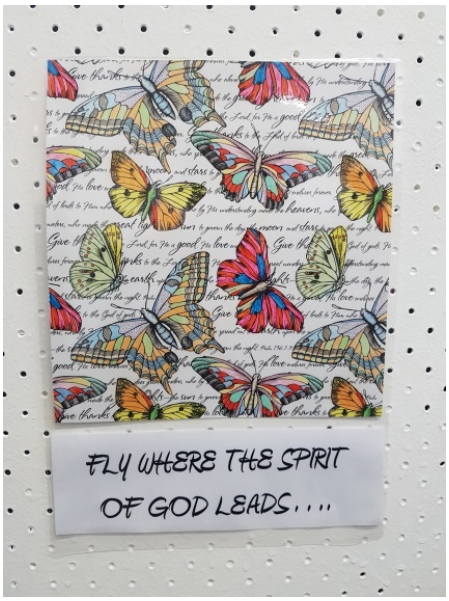
thoughts and methods to a situation and I have a personality that enjoys the explorations of these differences. This study was unique in the field of Audiology, a controversial area in the field of medicine, however this did not deter me from embarking on the topic, and the controversy fuelled my determination to conduct this study. I was secure in the fact that it is not a popular area to research and there would be opposition and questions. I did share my thoughts with other audiologists as I was not afraid of anyone 'stealing' my topic as the exploration of such a topic was received with scepticism from audiologists.

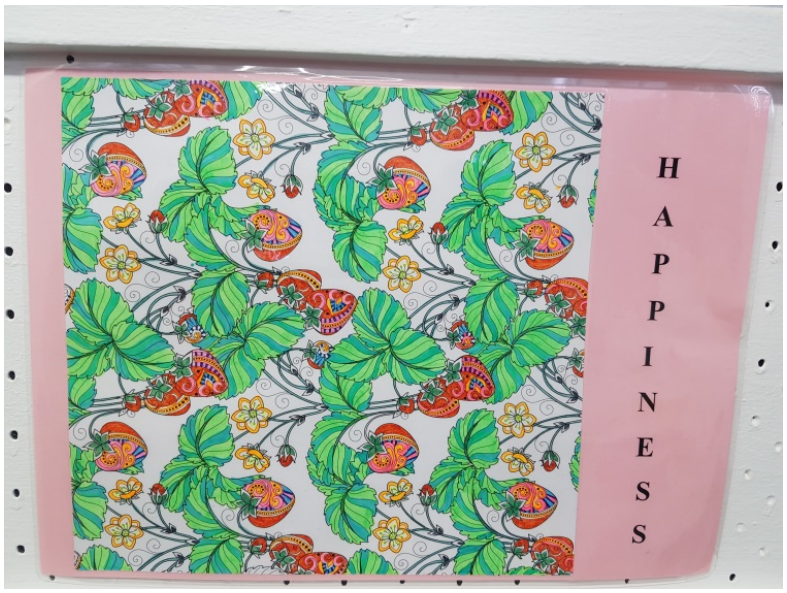
I was initially afraid of the rejection of such a study by the Ethics Committee at the University of the Witwatersrand as I am fully aware of the divide that exists between the medical world and the supernatural spiritual world. Despite my lack of intention to prove that one world was superior to the other, I assumed that a topic entitled '*Supernatural Healing: Narratives of individuals who report on the healing of a sensorineural hearing loss'* would create opposition from the committee. The concept paper was initially accepted with interest from my supervisor who was a huge support throughout this PhD process.

My fears were still eminent however I pursued through the ethical committee submission, the positive feedback from the Ethical committee and internal reader committee was surprising. The favour was evident for the commencement of this study as the ethical clearance was unconditionally awarded with the initial submission. The area of study was a personal one that was shaped by my experiences as a community service audiologist in rural Kwa-Zulu Natal. Although I had personal evidence from my community service experiences to validate my intentions, there was no evidence to guarantee that I would obtain the participants for this study. The pool of participants who can provide the narratives of a supernatural healing of a hearing loss is uncommon.

Despite the positive feedback from the Ethical Committee, the strength of a supportive supervisor and the go ahead to collect the data required, I was still nervous and anxious for the next stage of this study….the data collection.

8.5.2 Data Collection Stage (July 2015 – December 2015)





The University of the Witwatersrand afforded me a time of sabbatical which coincided with the data collection phase of my study. There was a clear, linear alignment for the advancement of this study, as the process from concept to approval was quick and efficient. My internal thought process was not as linear as the natural process that occurred, the study that was once just an idea in my brain, is now an ethically cleared PhD study that requires participants to fulfil the ensuing stage. I did not have a source or pool from which I could obtain these participants. I began to send out letters of request to religious leaders in the hope of obtaining participants.

After a month of waiting, my 1st participant 'broke the silence' in this data collection stage. I was relieved that I could start the process, I was researcher driven and my initial focus was the collection process. The data collection phase had a significant impact on me as an individual who was simultaneously exploring my own spiritual beliefs. As I conducted each interview I became more and more fascinated at the intricacies of healing, spirituality and religion. The audiologist in me began to comprehend the gap in service delivery that was evident in the narratives that were being recorded. I enjoyed embarking on the trips down memory lane with my participants as they recollected the events that occurred in their lives and the lives of their significant others.

I often found myself teary or with goose bumps on my arms as I listened to the narratives and I experienced the delight that was expressed by the participants. The growth within me was based on my witness of the interviews of the lived experiences of the participants. As a researcher, I needed to maintain focus to ensure that I was not swayed by my own judgements, I wanted to let the narratives speak for themselves. I would take two or three days with each interview transcription, ensuring that

I solely focused on documenting the fully essence and depth of the narratives. Some days were challenging as I would converse with other researchers about the data being collected and I would be asked 'what proof' was there to ensure that the healing occurred. I was never despondent, I was always happy that I had participants who were courageous enough to talk to me about atypical situations. The aim was never to obtain medical proof of the physical restoration of hearing….I always aimed to provide the documented evidence of the narratives of individuals who reported on supernatural healings. These reports deserved attention as they were relevant encounters of the individuals who keep the Audiology profession alive. An unexpected occurrence during the data collection phase was the conversations with potential participants who challenged me about the physical nature of healing verses the non-physical nature of healing. When I began this study, my sole focus was to document the healing that occurred through supernatural means. However, I began to have a deeper understanding of the influence that religion, culture and spirituality have on the life of an individual with a hearing loss. The multidimensional view of healing became more apparent to me as I collected the data for this study. The data collected added to the evidence that is necessary to motivate for a change in service delivery. I completed the data collection within six months and the study started to take shape.

8.5.3 Analysis and Construction of the Write Up Stage (January 2016 – July 2016)





This stage of the study was the most difficult stage for me. I had an array of information within the transcriptions and I needed to find the relevance, themes, commonalities and differences. I felt like a tiny fish trying to swim through a sea of data and it was a little overwhelming. My organisational skills started to emerge as I frequently engaged with the data. I saw the patterns that were beginning to form and I was able to gain knowledge about facets of analysis that was new to me.

This stage of the study necessitated that I had to read up on the ability to sort through and analyse the relevant information that was obtained while ensuring that I answer the aims of the study. Qualitative data was threatening and overwhelming as it was new to me as researcher. I was familiar with quantitative analysis and was now required to engage in a meaningful way with the narratives of participants. The researcher in me was push out of my comfort zone and I was allowed to explore areas that were new and I was able to gain insight into methods that were unfamiliar.

8.5.4 Writing Up Stage (August 2016 – March 2017)





The results and discussion chapter were written a few times as I attempted to present the abundance of data in the best way possible. I had a concern that I would miss the relevance of some of the findings however I always received the reassurance from my supervisor and I would regroup my thought processes. The chapters of this study began to flow and the common threads became apparent. The purpose and need for such a study became clearer as I started to see the final thesis being formed. Chapter Seven 'Results and Discussion' played an important role in shaping the audiologist in me. I began to solidify my thoughts of an integrated service delivery model in Audiology that attempts to incorporate all areas of life into the services provided.

Chapter two was written towards the latter stages of the study and this chapter played a significant role in moulding the South African woman in me. I have always understood the history of South Africa from a personal experience perspective as I enjoy the engagement that comes from a personal experience. The mechanism of learning that comes from a true desire to gain knowledge in an area

allows me to process and comprehend the information that I desired to learn. Chapter two 'The role of this research within the South African Context' spurred my engagement with a deeper understanding of the liberation that is afforded to me as a *South African Indian Female Researcher.* I loved writing the information that related to the role of my study within the diverse and dynamic South African context. The information learnt in the writing of chapter two will have lasting effects on me as I navigate my role in my country of birth.

While writing this chapter I recalled the experiences of my community service year, I was determined to leave South Africa to go and work in the United Kingdom (UK). My friends and I began to save for the relocation, which was scheduled to occur in 2006 after my community service year. As the year of community service continued, my desire to leave diminished as I felt more and more in love with my role as a South African audiologist. The need for Audiology became tangible and relevant to me and I decided to stay in South Africa while all my friends had embarked on a different journey to the UK. That was the best decision that I have ever made in my life, I began to grow as a researcher and as an audiologist. My career as a lecturer started in 2008 and I have been able to impact future audiologists for the last 10 years and I have appreciated every minute of my role in shaping a sector of the country that is dear to my heart. The learning that occurred while I wrote the information in chapter two evoked a desire to further explore the history of freedom that has paved the way for me as a *'Women of Colour'* in the South African context.

The title of Doctor of Philosophy has never been something that held a status value for me however the pursuit of that title has become one of achievement of a different level for me. I am one of fifteen grandchildren and I am the only individual in my family to complete a degree, and this is my third degree. My father was unable to complete his high schooling as he needed to earn money to care for his siblings; my mother was unable to pursuit further studies due to finances and the lack of opportunity to enter into tertiary studies during apartheid. My maternal great grandfather was brought to South Africa at the age of 5 when the Indians were brought to work on the sugarcane fields by the British. My paternal grandfather was of 'mixed' race as his mother was a Cape Coloured and his father was Indian therefore he was not affording the privilege to study within the apartheid governance.

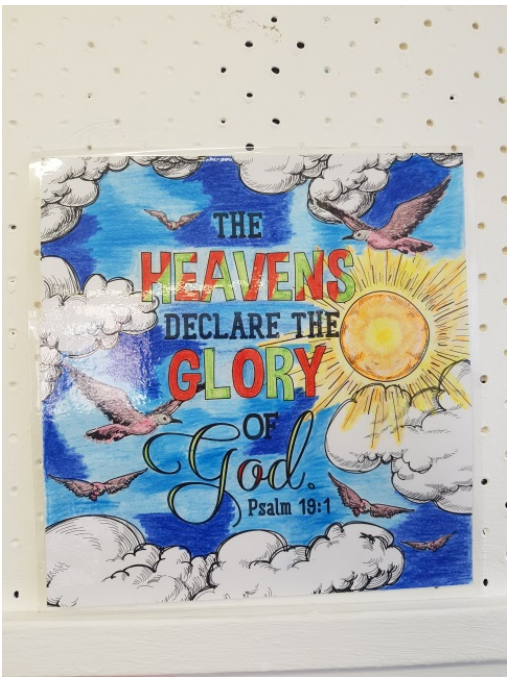
I have memories of living as a young child within the end days of the apartheid governance in South Africa and longing to swim at a specific beach that was only a few kilometres from my home. I remember driving past the beach and asking my parents why we could not go into the area, they said that we were not allowed there but we had our 'own' beach further away, which was less beautiful. I questioned the fact that it's the same water that flows in the ocean so why were we not allowed.

Democracy after the 1994 elections in South Africa afforded me a freedom that was not available to my previous generations; I have been able to achieve something that was not possible for those who went before me. The picture above is the same beach, Ansteys Beach, which I could not enter as a child, now I frequent it every time that I go home to my parents in Durban, South Africa. Let alone the ability to swim wherever I wanted, I was now able to study wherever I wanted. I was one of 10 individuals to enter a 'Model C or previously White' high school and it was a difficult and interesting journey. The sacrifice of my parents paved a way for me to pursue my journey in life.

This thesis has already allowed me to travel to different countries and to explore things that were only a dream for my previous generations. I have already had the privilege to present aspects of this study at four different conferences within South Africa and India. The valuable discussions and interactions that occurred at the conference in India provided me with insight and direction for the final write-up phases of this study. Facets of the study have been accepted for publication in two journals thus far, as there is a growing interest in the relationship between Spirituality and Healthcare. My lived experience is evidence of the need to fight for things that matter for the benefit of those to come, the need for change is required so that we are always striving for a better life for all, especially those who cannot fight for themselves.

8.5.5 Finalisation Stage (April 2017 – July 2017)





The 'finishing touches' stage of this PhD process was a time of completion and reflection. When I began this research, I was uncertain about how I would cope though the process. The flow of events always allowed me to reflect and appreciate the significant positive changes that have occurred in the

core of my identity as a South African Indian Female Audiologist and Lecturer. I can honestly state that I did not experience any negative aspects in the process of completing this thesis; I account it all as ‘beautiful’.

The experiences that I had will be testimony to motivate others to pursue further studies to contribute to the profession and to build one’s character. This PhD has grown me in ways that I had not pre-empted and it will always stand out as one of the memorable processes that have moulded my LIFE.

This PhD is dedicated to my parents and grandparents (The Pillay and Reddy Family’s) who were unable to pursue further studies yet they played a practical role in schooling me in LIFE.

Appendices

Appendix A: Letter to Religious Leaders, to Source Participants

Appendix B: Information Sheet for Participants

Appendix C: Informed Consent Document for the Participant

Appendix D: Parental Consent Form

Appendix E: Child's Assent Form

Appendix F: Consent Form to Access the Audiogram

Appendix G: Interview Schedule (Participant)

Appendix H: Consent Form for Audio and Video Recording

Appendix I: Ethical Clearance Form

Appendix J: Proposed Case History Form

Appendix A: Letter to Religious Leaders, to Source Participants

SPEECH PATHOLOGYAND AUDIOLOGY

SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

FACULTY OF HUMANITIES

UNIVERSITY OF THE WITWATERSRAND

Private Bag 3, WITS, 2050

Tel: (011) 717 4577Fax: (011) 717 4572

Date:

Dear Pastor/Rabbi/Guru/Priest/Traditional healer

Divine Healing: A narrative inquiry of individuals who reported having been healed of a permanent sensorineural hearing loss

My name is Dhanashree Pillay and I am currently registered for my Doctor of Philosophy in Audiology (PhD) degree, at the University of the Witwatersrand. As a requirement for this degree I am conducting a study titled:

Supernatural Healing: Narratives of individuals who report on the healing of a sensorineural hearing loss.

The aim of the study is to document and explore the stories and the lived experiences of individuals who claimed to have experienced divine healing of a permanent hearing loss. The study's objectives will be to document the 'turning point' event or events that caused the reported healing to occur. I hope to describe the individuals' perceptions of the mechanisms involved with the healing and to identify commonalities between participants.

By conducting this research study I would like to assist audiologists, who are working within the diverse country of South Africa, with documented experiences of the patients seen on a daily basis. These experiences may enable the audiologist to be sensitive to the individual and his/her lifestyle, cultural and religious beliefs. Treatment and management methods could then be more inclusive, incorporating medical and spiritual aspects for the ultimate benefit of the patient. I hope to record the social influences of spirituality and beliefs on the healing process in Audiology.

I would like to request your assistance in identifying people who have stated that they were divinely healing of a permanent hearing loss. The study would require me, the researcher to interview the participant. Please consider providing me with the contact details of such individuals and I will contact them to request participation in the study, at a time and place convenient for them. Participation is voluntary and if the participant wishes to withdraw from the study, there will be no negative consequence.

Should you require any further information, please do not hesitate to contact me at work on (011) 717 4546 or via email on dhanashree.pillay@wits.ac.za

Kind regards, Dhanashree Pillay

_____

Appendix B: Information Sheet for Participants

SPEECH PATHOLOGYAND AUDIOLOGY

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FACULTY OF HUMANITIES

UNIVERSITY OF THE WITWATERSRAND

Private Bag 3, WITS, 2050

Tel: (011) 717 4577Fax: (011) 717 4572

Date:

Dear Sir/Madam

My name is Dhanashree Pillay and I am currently registered for my Doctor of Philosophy in Audiology (PhD) degree, at the University of the Witwatersrand. As a requirement for this degree I am conducting a study titled:

Supernatural Healing: Narratives of individuals who report on the healing of a sensorineural hearing loss.

The aim of the study is to document and explore the stories and the lived experiences of the divine healing of your hearing loss. The study's objectives will be to document the 'turning point' event or events that caused the reported healing to occur. I hope to describe your perceptions of the mechanism of the healing and to identify commonalities between participants.

By conducting this research study I would like to assist audiologists, who are working within the diverse country of South Africa, with documented experiences of the patients seen on a daily basis. These experiences may enable the audiologist to be sensitive to the individual and his/her lifestyle, cultural and religious beliefs. Treatment and management methods could then be more inclusive, to incorporate medical and spiritual aspects for the ultimate benefit of the patient seen. I hope to record the social influences of spirituality and beliefs on the healing process in Audiology.

I would like to request your participation in my study. The study will involve an interview with me, regarding your experiences that led to the healing of your permanent hearing loss. The pre-arranged interview will be conducted at a time and place at your convenience. There will not be a specific time frame for your interview therefore you are free to express your story in the best way possible. All the interviews will be audio and video recorded so that I can listen to it in the future for the research

documentation. Your personal information will be confidential and all recordings will be discarded once transcribed.

The interview may bring up personal emotional thoughts and memories therefore you are free to stop and have breaks in-between or reschedule for another time. If you would like to speak to a counsellor regarding the emotions experienced, then you can be referred to the Social Work or Psychology Department at the nearest public hospital or to the university psychology clinics and I will provide you with a letter for that consultation. You are free to not answer some questions within the interview if you prefer not to share the information; you are also permitted to leave the study at any time with no negative consequences to you.

The information you provide will be beneficial to health professionals, especially audiologists as it will provide added information into the management options available to patients. The treatment methods may be revised to ensure that the spiritual aspect of the patients' life is included and considered in intervention practices.

Should you require any further information, please do not hesitate to contact me at work on (011) 717 4546 or via email on dhanashree.pillay@wits.ac.za

Kind Regards

Dhanashree Pillay

_____

Appendix C: Informed Consent Document for the Participant

SPEECH PATHOLOGYAND AUDIOLOGY

SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

FACULTY OF HUMANITIES

UNIVERSITY OF THE WITWATERSRAND

Private Bag 3, WITS, 2050

Tel: (011) 717 4577Fax: (011) 717 4572

Date:

I, _____ agree to participate in the study titled:

Supernatural Healing: Narratives of individuals who report on the healing of a sensorineural hearing loss.

An information letter was provided to me and it explained what the study entails and what will be required of me. I have read and understood all the information provided and I understand that I can request for clarification if required.

I understand that my participation is voluntary and that I am free to withdraw from the study at any time with no negative consequences. I understand that the information provided during the interview will remain anonymous and confidential and no personal details will be divulged when the research is written up.

By signing below, I hereby give consent to participant in the current study.

Signature_____ Witness _____

Date _____

Appendix D: Parental Consent Form

SPEECH PATHOLOGYAND AUDIOLOGY

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FACULTY OF HUMANITIES

UNIVERSITY OF THE WITWATERSRAND

Private Bag 3, WITS, 2050

Tel: (011) 717 4577Fax: (011) 717 4572

Date:

I, _____, mother/father of _____(Child's name) agree that my son/daughter participates in the study titled:

Supernatural Healing: Narratives of individuals who report on the healing of a sensorineural hearing loss.

An information letter was provided to me and it explained what the study entails and what will be required of my child. I have read and understood all the information provided and I understand that I can request for clarification when required.

I understand that my child's participation is voluntary and that he/she is free to withdraw from the study at any time with no negative consequences. I understand that the information provided during the interview will remain anonymous and confidential and no personal details will be divulged when the research is written up.

By signing below, I hereby give consent for my child to participate in the current study.

Signature_____ Witness _____

Date _____

Appendix E: Child's Assent Form

SPEECH PATHOLOGYAND AUDIOLOGY

SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

FACULTY OF HUMANITIES

UNIVERSITY OF THE WITWATERSRAND

Private Bag 3, WITS, 2050

Tel: (011) 717 4577Fax: (011) 717 4572

Hello, my name is Dhanashree Pillay and I am a student at Wits University. I would like to invite you to take part in a project that I am doing.

You are allowed to ask any questions you have before making a decision. You can refuse to take part in the study, or leave the study at any time if you would like to take part. You will not get into trouble for this.

I have read (or someone has read to me) this form. I have asked questions if I needed to before making a decision. I want to help in this research project.

Yes ☐ No ☐

I have explained the research to the participant before requesting the signature or tick above.

_____ _____

Printed name of child written by research Signature of researcher

_____

Date

Appendix F: Consent Form to Access the Audiogram

SPEECH PATHOLOGYAND AUDIOLOGY

SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

FACULTY OF HUMANITIES

UNIVERSITY OF THE WITWATERSRAND

Private Bag 3, WITS, 2050

Tel: (011) 717 4577Fax: (011) 717 4572

Please complete the relevant information below which will allow me to access your or your child's hearing results for the study titled:

Supernatural Healing: Narratives of individuals who report on the healing of a sensorineural hearing loss.

FOR PARTICIPANT

I, _____ with _____ hospital number agree that my audiogram be made available to Dhanashree Pillay.

FOR PARENT

I, _____agree that my son's/daughter's_____(Child's name) with_____ hospital number agree that my audiogram be made available to Dhanashree Pillay.

Hearing assessments were conducted at _____ (hospital name) on the _____ (dates).

I hereby give consent for the results of the hearing assessment to be accessed by the researcher from the relevant hospital/audiologist.

Signature_____ Date _____

Appendix G: Interview Schedule (Participant)

Biographical Information

Name:

Age:

Gender:

Province of residence:

The proposed study will employ a narrative inquiry approach therefore the interview will consist of a maximum of three open-ended questions. The initial question will be asked thereafter two additional questions will be asked, if probing is required.

The first question will be:

Please tell me the full story about your healing?

Tell me how your significant other reacted/felt about your healing?

Probing questions if required:

Tell me about your hearing loss in the past?

What do you believe caused your healing?

Tell me about the fitting of any device to assist you with your hearing and are you still using it?

Appendix H: Consent Form for Audio and Video Recording

SPEECH PATHOLOGYAND AUDIOLOGY

SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

FACULTY OF HUMANITIES

UNIVERSITY OF THE WITWATERSRAND

Private Bag 3, WITS, 2050

Tel: (011) 717 4577Fax: (011) 717 4572

Date:

I, _____ give consent for the audio and video recording of my/my child's interview with Dhanashree Pillay for the study titled:

Supernatural Healing: Narratives of individuals who report on the healing of a sensorineural hearing loss.

I accept that after the necessary information is obtained the tapes will be destroyed. I also trust that the information on the audio and video-recording will be kept confidential and there will be no mention of my name or my child/family when writing up the research.

I understand that I/my child can request for the audio and video-recording to be switched off if there is something that I/he/she would not like to record during the interview.

Signature _____ Witness _____

Date _____

Appendix I: Ethical Clearance Form

Appendix J: Proposed Case History Form

Section A:

Biographical Data

Name and Surname:

Date of Birth:

Age:

Address:

Contact Details:

Section B:

Birth and Pregnancy History

- Full-Term/Pre-Term/Delayed-Term Delivery:
- Any Complications:
- Medication or Incubation:

Section C:

Developmental History

- Physical Milestones in Years: (Sitting……..Crawling…….Standing……Walking……..)
- Auditory and Head-turning Milestones in Years: (Awareness of Loud Sounds……..Name Recognition……..Awareness of Mother's Voice…….Awareness of Soft Sounds…….)
- Speech Milestones: (Babbling……Vocalisations……1st Words……..Sentence Construction……Intelligible Conversation……)

Section D:

Medical History

- Surgery
- Hospitalisations
- Medication
- Diagnosis

Section E:

Religious and Spiritual Aspects: Higher Power/God, Traditions, Culture

- Do you belief that the hearing loss maybe a result of a non-medical cause?
- Do you believe in God/Higher Power and if so how do you understand the hearing loss in relation to your belief?
- Did you seek any other form of help for the hearing loss, for example prayer, traditional methods?
- Is there someone who supports you spiritually?
- Would you like to include non-medical support structures in the process of management of the hearing loss?

Reference List

Abdullah, K. H. A., Saini, S. M., Sharip, S., & Shaharom, M. H. (2016). Seeking help at an Islamic spiritual healing centre: Malaysia's perspective. *Mental Health, Religion & Culture, 19*(7), 742-751.

Ae-Ngibise, K., Cooper, S., Akpalu, E., Lund, C., & Doku, V. (2010). "Whether you like it or not people with mental problems are going to go to them": A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *International Review of Psychiatry, 22*(6), 558-567.

Afọlayan, F. S. (2004). *Culture and Customs of South Africa*: Greenwood Press.

Africa, S. S. (2003). *Census 2001: Census in brief*: Statistics South Africa.

Africa, S. S. (2010). Mid-Year Population estimates. Retrieved June 2017, from https://www.statssa.gov.za/publications/P0302/P03022010.pdf

Africa, S. S. (2015). Mid-year Population Estimates. June 2017, from https://www.statssa.gov.za/publications/P0302/P03022016.pd

Al-Azri, M. H., Al-Awisi, H., Al-Rasbi, S., & Al-Moundhri, M. (2014). Coping with a diagnosis of breast cancer among Omani women. *Journal of health psychology, 19*(7), 836-846.

Alpiner, J. G., & McCarthy, P. A. (2000). *Rehabilitative Audiology: Children and Adults*: Lippincott Williams & Wilkins.

Alvord, L. A., & Van Pelt, E. C. (1999). *The Scalpel and the Silver Bear. The First Navajo Woman Surgeon Combines Western Medicine and Traditional Healing*: ERIC.

Andrade, V. d., & Ross, E. (2005). Beliefs and practices of Black South Afrcan traditional healers regarding hearing impairment. *International Journal of Audiology, 44*, 489-499.

Asamoah-Gyadu, K. (2008). African-led Christianity in Europe: Migration and diaspora evangelism. *Lausanne World Pulse*.

Ashkanasy, N. M., Trevor-Roberts, E., & Earnshaw, L. (2002). The Anglo Cluster: legacy of the British empire. *Journal of World Business, 37*(1), 28-39.

Athalye, S., Archbold, S., Mulla, I., Lutman, M., & Nikolopoulous, T. (2015). Exploring views on current and future cochlear implant service delivery: the perspectives of users, parents and professionals at cochlear implant centres and in the community. *Cochlear implants international, 16*(5), 241-253.

Ayer, W. A. (2005). *Psychology and Dentistry: Mental Health Aspects of Patient Care*: Routledge.

Ayles, H., Schaap, A., Nota, A., Sismanidis, C., Tembwe, R., De Haas, P., . . . Beyers, N. (2009). Prevalence of tuberculosis, HIV and respiratory symptoms in two Zambian communities: implications for tuberculosis control in the era of HIV. *PloS one, 4*(5), e5602.

Babbie, R. (2013). *The Basics of Social Research*: Cengage Learning.

Babeu, L. A., Kricos, P. B., & Lesner, S. A. (2004). Application of the Stages-of-Change Model in Audiology. *Journal of Academic Rehabilation Audiology*, 41-56.

Bainbridge, K. E., & Wallhagen, M. I. (2014). Hearing loss in an aging American population: extent, impact, and management. *Annual review of public health, 35*, 139-152.

Balboni, T. A., Vanderwerker, L. C., Block, S. D., Paulk, E. M., Lathan, C. S., Peteet, J. R., & Prigerson, H. G. (2007). Religiousness and Spiritual Support Among Advanced Cancer Patients and Associations With End-Of-Life Treatment Preferences and Quality of Life. *Journal of Clinical Oncology, 25*(6), 555-560.

Baltussen, R., & Smith, A. (2012). Cost effectiveness of strategies to combat vision and hearing loss in sub-Saharan Africa and South East Asia: mathematical modelling study. *Bmj, 344*, e615.

Bandura, A. (1991). Social cognitive theory of self-regulation. *Organizational behavior and human decision processes, 50*(2), 248-287.

Bandura, A. (1998). Health promotion from the perspective of social cognitive theory. *Psychology and health, 13*(4), 623-649.

Bandura, A. (2001). SOCIAL COGNITIVE THEORY: An Agentic Perspective

Annual Reviews Psychology, 52, 1-26.

Bandura, A. (2002). Social cognitive theory in cultural context. *Applied psychology, 51*(2), 269-290.

Bandura, A. (2003). COMMENTARY:" On the Psychosocial Impact and Mechanisms of Spiritual Modeling". *The International Journal for the Psychology of Religion, 13*(3), 167-173.

Bank, W. (2015). New County Classification. Retrieved June, 2017, from https://blogs.worldbank.org/opendata/new-country-classifications

Bank, W. (2016). Macro poverty outlook for South Africa. Macro poverty outlook. . Retrieved June, 2017, from http://documents.worldbank.org/curated/en/125721475867577104/Macro-poverty-outlook-for-South-Africa

Barnes, L. L., Plotnikoff, G. A., Fox, K., & Pendleton, S. (2000). Spirituality, religion, and pediatrics: Intersecting worlds of healing. *Pediatrics, 106*(Supplement 3), 899-908.

Batthyany, A. (2016). *Logotherapy and Existential Analysis: Proceedings of Viktor Frankl Institute Vienna*. Vienna: Springer.

Baumgarten, A. I., Assmann, J., Stroumsa, G. A., & Stroumsa, G. G. (1998). *Self, soul, and body in religious experience* (Vol. 78): Brill.

Beck, R. B. (2013). *The History of South Africa*: ABC-CLIO.

Beinart, W., & Dubow, S. (1995). *Segregation and apartheid in twentieth-century South Africa*: Psychology Press.

Best, M., Butow, P., & Olver, I. (2014). Spiritual support of cancer patients and the role of the doctor. *Support Care Cancer, 22*(5), 1333-1339.

Best, M., Butrow, P., & Olver, I. (2016). Doctors discussing religion and spirituality: A systematic literature review. *Palliative medicine, 30*(4), 327-337.

Bhardwaj, A. (2015). Holistic Health through Yogic Life Style.

Blanchette, O., Imamichi, T., & McLean, G. F. (2001). *Philosophical Challenges and Opportunities of Globalization*: CRVP.

Blausten, R. (1976). Foreign investment in the black Homelands of South Africa. *African Affairs, 75*(299), 208-223.

Blustein, D., Franklin, A., Makiwane, M., & Gutowski, E. (2017). Unemployment in South Africa.

Bond, P. (2003). *Against global apartheid: South Africa meets the World Bank, IMF and international finance*: Palgrave Macmillan.

Bonser, W. (1963). *The medical background of angle-Saxon England*. London: Wellcome Historical Medical Library.

Boorse, C. (1975). On The Distinction Between Disease and Illness. *Philosophy and Public Affairs*(5), 49–68.

Booth, D. (2003). Hitting apartheid for six? The politics of the South African sports boycott. *Journal of Contemporary History, 38*(3), 477-493.

Bowden, V. R. (2010). *Children and their families: The continuum of care*: Lippincott Williams & Wilkins. .

Bown, J., & Williams, C. (1993). Spirituality in Nursing: a review of literature. *Journal of Advances in Health and Nursing Care, 2*(4), 41-66.

Braam, A., Schaap-Jonker, H., van der Horst, M. H., Steunenberg, B., Beekman, A. T., van Tilburg, W., & Deeg, D. J. (2014). Twelve-year history of late-life depression and subsequent feelings to God. *The American Journal of Geriatric Psychiatry, 22*(11), 1272-1281.

Bradford, H. (1996). Women, gender and colonialism: Rethinking the history of the British cape colony and its frontier zones, c. 1806–70. *The Journal of African History, 37*(03), 351-370.

Bradham, T. S., Houston, K. T., & Diefendorf, A. O. (2014). Assessing a Child With Hearing Loss: Past, Present, and future. *Assessing Listening and Spoken Language in Children with Hearing Loss*, 1.

Brady, M. J., Peterman, A. H., Fitchett, G., Mo, M., & Cella, D. (1999). A case for including spirituality in quality of life measurement in oncology. *Psycho oncology, 8*(5), 417-428.

Bramadat, P., Coward, H., & Stajduhar, K. I. (2013). *Spirituality in Hospice Palliative Care*: SUNY Press.

Braswell, G. W. (2000). *What you need to know about Islam & Muslims*: B&H Publishing Group.

Brevik, J.-K. (2005). *Deaf identities in the making: Local lives, transnational connections*: Gallaudet University Press.

Bronfenbrenner, U. (2009). *The ecology of human development*: Harvard university press.

Brown, Bonello, R., & Pollard, H. (2005). The biopsychosocial model and hypothyroidism. *Chiropractic & osteopathy, 13*(1), 5.

Brown, B. B. (1987). Facing the 'Black Peril': The politics of population control in South Africa. *Journal of Southern African Studies, 13*(2), 256-273.

Brown, C. G., Mory, S. C., Williams, R., & McClymond, M. J. (2010). Study of the therapeutic effects of proximal intercessory prayer (STEPP) on auditory and visual impairments in rural Mozambique. *Southern medical journal, 103*(9), 864-869.

Burkey, J. M. (2006). *Baby boomers and hearing loss: A guide to prevention and care*: Rutgers University Press.

Burnard, P. (1992). *Writing for health professionals: A manual for writers*: Chapman & Hall.

Byl, F. M. (1984). Sudden hearing loss: eight years' experience and suggested prognostic table. *The Laryngoscope, 94*(5), 647-661.

Cambra, C. (2005). Feelings and emotions in deaf adolescents. *Deafness & Education International, 7*(4), 195-205.

Cannon, K. (2017). Prayer is part of holistic care. *Nursing Standard, 31*(40), 32-32.

Carby, H. V. (1992). The multicultural wars. *Radical History Review, 1992*(54), 7-18.

Carter, G. M. (1963). African Nationalist Movements in South Africa. *The Massachusetts Review, 5*(1), 147-164.

Caselli, M. C. (1983). Communication to language: Deaf children's and hearing children's development compared. *Sign Language Studies, 39*(1), 113-144.

Cassell, E. J. (1978). *The Healer's Art: A New Approach to the Doctor-Patient Relationship*. Harmondsworth: Penguin Books.

Ceylan, A., Celenk, F., Kemaloğlu, Y., Bayazıt, Y., Göksu, N., & Özbi, S. (2007). Impact of prognostic factors on recovery from sudden hearing loss. *The Journal of Laryngology & Otology, 121*(11), 1035-1040.

Charon, R., & DasGupta, S. (2011). Editors' Preface: Narrative Medicine, or a Sense of Story. *Literature and medicine, 29*(2), vii-xiii.

Chirinda, W., & Zungu, N. (2016). Health status and years of sexually active life among older men and women in South Africa. *Reproductive Health Matters, 24*(48), 14-24.

Christensen, B. L., & Kockrow, E. O. (2013). *Foundations of Nursing*: Elsevier Health Sciences.

Chryssides, G. D. (2001). *Unrecognized Charisma? A Study of Four Charismatic Leaders.* Paper presented at the Center for Studies on New Religions (CESNUR) conference in London.

Cinamon, U., Bendet, E., & Kronenberg, J. (2001). Steroids, carbogen or placebo for sudden hearing loss: a prospective double-blind study. *European Archives of Oto-Rhino-Laryngology, 258*(9), 477-480.

Claassen, G. (1999). The neo-fascist and pro-apartheid (right-alternative) Afrikaans press: a historical perspective. *Ecquid Novi, 20*(2), 41-62.

Clark, N. L., & Worger, W. H. (2016). *South Africa: The rise and fall of apartheid*: Routledge.

Clarke. (1973). The Impact of the African on the New World—A Reappraisal. *The Black Scholar, 4*(5), 32-39.

Clarke, A. (2010). *The Sociology of Healthcare*: Longman.

Cohen, S. M., Labadie, R. F., & Haynes, D. S. (2005). Primary care approach to hearing loss: the hidden disability. *Ear, nose & throat journal, 84*(1), 26.

Colony, E. B. C. (2017). History of Cape Colony Pre-1806. Retrieved June, 2017, from https://www.revolvy.com/main/index.php?s=History%20of%20Cape%20Colony%20Pre-1806&item_type=topic

Conle, C. (2000). Narrative inquiry: Research tool and medium for professional development. *European journal of teacher education, 23*(1), 49-63.

Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry. *Educational researcher, 19*(5), 2-14.

Constitution, S. A., & Devenish, G. (2005). South African Constitution. *Pretoria. Government Printers*.

Coombes, A. E. (2003). *History After Apartheid: Visual Culture and Public Memory in a Democratic South Africa*: Duke University Press.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. *The lancet, 374*(9692), 817-834.

Coulter, A., Entwistle, V., & Gilbert, D. (1999). Sharing decisions with patients: is the information good enough? *BMJ: British Medical Journal, 318*(7179), 318.

Crawford, T. A., & Lipsedge, M. (2004). Seeking help for psychological distress: The interface of Zulu traditional healing and Western biomedicine. *Mental Health, Religion & Culture, 7*(2), 131-148.

Crosley, R. O. (2004). *Alternative Medicine and Miracles: A Grand Unified Theory*: University Press of America.

Cuffy, C., & Farnsworth, C. A. (2013). *The Laying on of Hands*: eBookit.com.

Cullinan, K. (2006). Health services in South Africa: A basic introduction. *Health-e News Service*.

Curley, R. (2012). *Explorers of the Renaissance*: Britannica Educational Publishing.

Daaleman, T. P., & Nease Jr, D. E. (1994). Patient attitudes regarding physician inquiry into spiritual and religious issues. *Journal of Family Practice, 39*(6), 564-569.

Dalebout, S. (2009). *The praeger guide to hearing and hearing loss: assessment, treatment, and prevention*: ABC-CLIO.

Davenport, T., & Saunders, C. (2000). *South Africa: A modern history*: Springer.

Davids, A. (1990). Words the Cape slaves made: A socio–historical–linguistic study. *South African Journal of Linguistics, 8*(1), 1-24.

de Andrade, V., & Ross, E. (2005). Beliefs and practices of Black South African traditional healers regarding hearing impairment: Creencias y prácticas de los curanderos negros sudafricanos en torno a la hipoacusia. *International Journal of Audiology, 44*(9), 489-499.

De Gruchy, J. W. (1986). The revitalization of Calvinism in South Africa: some reflections on Christian belief, theology, and social transformation. *The Journal of Religious Ethics*, 22-47.

De Kiewiet, C. W. (1966). *A history of South Africa*: JSTOR.

De Vaus, D. A. (2001). *Research design in social research*: Sage.

De Villiers, E., Weisse, W., & Anthonissen, C. (2004). The Influence of the Dutch Reformed Church on Public Policy during the late 80s and 90s. *Maintaining Apartheid or Promoting Change? The Role of the Dutch Reformed Church in a Phase of Increasing Conflict in South Africa*, 223-234.

Desselle, D. D. (1994). Self-esteem, family climate, and communication patterns in relation to deafness. *American Annals of the Deaf, 139*(3), 322-328.

DeVilliers, J. (2006). The Dutch East India Company, scurvy and the victualling station at the Cape: history of medicine: SAMJ forum. *South African Medical Journal, 96*(2), 105-110.

Dick, A. L. (2007). *The development of South African libraries in the 19th and 20th centuries: Cultural and political influences*: na.

Dickinson, C. (1975). The search for spiritual meaning. *American Journal of Nursing, 75*(10), 1789-1793.

Digby, A. (2007). The last cohort of early black doctors who studied abroad, 1931-1940. *South African Medical Journal, 97*(7), 508-510.

Dixon, J. A., & Reicher, S. (1997). Intergroup contact and desegregation in the new South Africa. *British Journal of Social Psychology, 36*(3), 361-381.

Doel, M., & Shardlow, S. (2009). *Educating Professionals: Practice Learning in Health and Social Care*: Ashgate Publishing.

Domene, J. F., & Bedi, R. P. (2013). Counseling and Psychotherapy in Canada. *Handbook of counseling and psychotherapy in an international context*.

Doniger, W. (1991). *The laws of Manu*: Penguin UK.

Douglas, H. A. (2014). Promoting meaning-making to help our patients grieve: An exemplar for genetic counselors and other health care professionals. *Journal of genetic counseling, 23*(5), 695-700.

Du Pont, P. S., Goodman, J. C., & Steiger, F. S. (2001). *An education agenda: let parents choose their children's school: a joint project by the National Center for Policy Analysis and Children First America*: National Center for Policy Analysis.

Du Toit, A. (1985). Puritans in Africa? Afrikaner" Calvinism" and Kuyperian Neo-Calvinism in Late Nineteenth-Century South Africa. *Comparative studies in society and history, 27*(2), 209-240.

Dubos, R. (1987). *Mirage of health*. New Brunswick: Rutgers University Press.

Dunn, C. C., Tyler, R. S., Oakley, S., Gantz, B. J., & Noble, W. (2008). Comparison of speech recognition and localization performance in bilateral and unilateral cochlear implant users matched on duration of deafness and age at implantation. *Ear and Hearing, 29*(3), 352.

Durrheim, K., & Dixon, J. (2001). The role of place and metaphor in racial exclusion: South Africa's beaches as sites of shifting racialization. *Ethnic and Racial Studies, 24*(3), 433-450.

Dyrness, W. A., & Karkkainen, V. (2009). *Global dictionary of theology: A resource for the worldwide church.*

Dyson, J., Cobb, M., & Forman, D. (1997). The meaning of Spirituality: A Literature Review. *Journal of Advanced Nursing, 26*, 1183-1188.

Eddy, L. L. (2013). *Caring for Children with Special Healthcare Needs and Their Families: A Handbook for Healthcare Professionals*: Wiley.

Eisenberg, L. (1977). Disease and illness Distinctions between professional and popular ideas of sickness. *Culture, medicine and psychiatry, 1*(1), 9-23.

Ellison, C. G., & Levin, J. S. (1998). The religion-health connection: Evidence, theory, and future directions. *Health Education & Behavior, 25*(6), 700-720.

Engel, G. L. (1989). The need for a new medical model: a challenge for biomedicine. *Holistic Medicine, 4*(1), 37-53.

Englewood, C. (1984). *Experimental healing: Experience as the source of learning and development*. New Jersey: Prentice Hall.

Enquist, R. (1979). A Tillichian Analysis of Afrikanerdom. *Dialog, 18*, 125-131.

Espinosa, G., García, M. T., Stevens-Arroyo, A. M., Busto, R. V., & Lloyd-Moffett, S. R. (2009). *Mexican American Religions: Spirituality, Activism, and Culture*: Duke University Press.

Etherington, N. (2014). *The Great Treks: the transformation of southern Africa 1815-1854*: Routledge.

Falola, T., & Jean-Jacques, D. (2015). *Africa: An Encyclopedia of Culture and Society [3 volumes]: An Encyclopedia of Culture and Society*: ABC-CLIO.

Falvo, D. (2013). *Medical and Psychosocial Aspects of Chronic Illness and Disability*: Jones & Bartlett Learning.

Fedderke, J. (2006). From chimera to prospect: South African sources of and constraints on long-term growth, 1970-2000. *Poverty and policy in Post-Apartheid South Africa. Cape Town: Human Sciences Research Council*, 18-58.

Ferrans. (1990). *Development of a quality of life index for patients with cancer.* Paper presented at the Oncology nursing forum.

Ferrans. (1996). Development of a conceptual model of quality of life. *Scholarly inquiry for nursing practice, 10*(3), 293-304.

Ferrans, C. E., Zerwic, J. J., Wilbur, J. E., & Larson, J. L. (2005). Conceptual model of health-related quality of life. *Journal of Nursing Scholarship, 37*(4), 336-342.

Fields, G. S., Cichello, P. L., Freije, S., Menéndez, M., & Newhouse, D. (2003). For richer or for poorer? Evidence from Indonesia, South Africa, Spain, and Venezuela. *Journal of Economic Inequality, 1*(1), 67-99.

Fitzpatrick., J. J., & Kazer, M. (2011). *Encyclopedia of Nursing Research, Third Edition*: Springer Publishing Company.

Fligor, B. J. (2015). *Understanding Childhood Hearing Loss: Whole Family Approaches to Living and Thriving*: Rowman & Littlefield.

Flint, K. (2006). Indian–African Encounters: Polyculturalism and African Therapeutics in Natal, South Africa, 1886–1950s∗. *Journal of Southern African Studies, 32*(2), 367-385.

Fogel, A., Nwokah, E., Dedo, J. Y., Messinger, D., Dickson, K. L., Matusov, E., & Holt, S. A. (1992). Social process theory of emotion: A dynamic systems approach. *Social Development, 1*(2), 122-142.

Fortin, A. H., & Barnett, K. G. (2004). Medical school curricula in spirituality and medicine. *Student Journal of American Medical Association, 291*, 2883.

Frankl, V. E. (1959). *Man's search for Meaning*. Washington: Washington Press.

G, W. (2001). *The postgraduate research handbook: Success with your MA, MPhil, EdD and PhD*. Palgrave: Basingstoke.

Gardner, R. (1983). Miracles of healing in Anglo-Celtic Northumbria as recorded by the Vernerable Bede and his contemporaries: a reappraisal in the light of twentieth century experience. *British Medical Journal, 287*, 1927-1933.

Garstecki, D. C., & Erler, S. F. (1998). Hearing loss, control, and demographic factors influencing hearing aid use among older adults. *Journal of Speech, Language, and Hearing Research, 41*(3), 527-537.

Gellman, J. I. (2001). *Mystical experience of God: A philosophical inquiry*: Ashgate Publishing.

Gertz, G., & Boudreault, P. (2016). *The SAGE Deaf Studies Encyclopedia*: SAGE Publications.

Ghazali, R., & Abbas, M. Y. (2017). Paediatric wards: Healing environment assessment. *Asian Journal of Environment-Behaviour Studies, 2*(3), 83-93.

Ghose, L. (2007). Karma and the possibility of purification: An ethical and psychological analysis of the doctrine of karma in Buddhism. *Journal of Religious Ethics, 35*(2), 259-290.

Glik, D. C. (1986). Psychosocial wellness among spiritual healing participants. *Social Science & Medicine, 22*(5), 579-586.

Glover, V. (2014). Maternal depression, anxiety and stress during pregnancy and child outcome; what needs to be done. *Best practice & research Clinical obstetrics & gynaecology, 28*(1), 25-35.

Goldberg, D. T. (1993). *Racist culture*: Blackwell Publishers Cambridge, MA.

Graham, R., Litt, F., & Irwin, W. (1998). *Healing from the Heart: A Guide to Christian Healing for Individuals and Groups*: Wood Lake Publishing Inc.

Gray, M., Midgley, J., & Webb, S. A. (2012). *The SAGE handbook of social work*: Sage.

Greaves, D. (2002). Reflections on a new medical cosmology. *Journal of medical ethics, 28*(2), 81-85.

Green, J., & Thorogood, N. (2013). *Qualitative methods for health research*: Sage.

Grenness, C., Hickson, L., Laplante-Lévesque, A., Meyer, C., & Davidson, B. (2015). The nature of communication throughout diagnosis and management planning in initial audiologic rehabilitation consultations. *Journal of the American Academy of Audiology, 26*(1), 36-50.

Griffin, C. (2013). Standing Up for Our Children. *Odyssey: New Directions in Deaf Education, 14*, 26-28.

Gruchy, J. W. d. (1986). The church and the struggle for South Africa. *Theology today, 43*(2), 229-243.

Gutiérrez, P. S. (2011). A Team Approach to Quality Programming for Deaf and Hard of Hearing Students. *Odyssey: New Directions in Deaf Education, 12*, 28-32.

Hackland, B. (1980). The economic and political context of the growth of the progressive federal party in South Africa, 1959–1978. *Journal of Southern African Studies, 7*(1), 1-16.

Hall, J. W. (2000). *Handbook of Otoacoustic Emissions*: Singular Thomson Learning.

Hall, M. (2006). Identity, Memory and Countermemory The Archaeology of an Urban Landscape. *Journal of Material Culture, 11*(1-2), 189-209.

Hamm, D. (1990). Paul's Blindness and Its Healing: Clues to Symbolic Intent (Acts 9; 22 and 26). *Biblica, 71*(1), 63-72.

Hanass-Hancock, J. (2009). Disability and HIV/AIDS-a systematic review of literature on Africa. *Journal of the International AIDS Society, 12*(1), 34.

Handzo, G., & Koenig, H. G. (2004). Spiritual Care: Whose job is it anyway? *Southern Medical Journal, 97*, 1242-1244.

Hanegraaff, W. J. (1998). *New age religion and western culture: Esotericism in the mirror of secular thought*: Suny Press.

Harris, B., Goudge, J., Ataguba, J. E., McIntyre, D., Nxumalo, N., Jikwana, S., & Chersich, M. (2011). Inequities in access to health care in South Africa. *Journal of public health policy, 32*(1), S102-S123.

Harrison, M., Roush, J., & Wallace, J. (2003). Trends in age of identification and intervention in infants with hearing loss. *Ear and hearing, 24*(1), 89-95.

Hayden, M., Hopkins, H., Macrea, M., & Beighton, P. (1980). The origin of Huntington's chorea in the Afrikaner population of South Africa. *South African medical journal= Suid-Afrikaanse tydskrif vir geneeskunde, 58*(5), 197-200.

Haynes, B. F., Pikus, A., Kaiser-Kupfer, M., & Fauci, A. S. (1981). Successful treatment of sudden hearing loss in Cogan's syndrome with corticosteroids. *Arthritis & Rheumatology, 24*(3), 501-503.

Helman. (1981). Disease versus illness in general practice. *JR Coll Gen Pract, 31*(230), 548-552.

Helman. (2014). *Culture, Health and Illness: An Introduction for Health Professionals*: Elsevier Science.

Hendriks, J., & Erasmus, J. (2005). Religion in South Africa: The 2001 population census data. *Journal of Theology for Southern Africa, 121*(1), 88-111.

Henning, E., Van Rensburg, W., & Smit, B. (2004). *Finding your way in qualitative research*: Van Schaik.

Henningsen, P. (2015). Still modern? Developing the biopsychosocial model for the 21st century. *Journal of psychosomatic research, 79*(5), 362-363.

Herman, R., Ford, K., Thomas, J., Oyebade, N., Bennett, D., & Dodd, B. (2015). Evaluation of core vocabulary therapy for deaf children: Four treatment case studies. *Child Language Teaching and Therapy, 31*(2), 221-235.

Herth, K. (1990). Fostering hope in terminally ill people. *Journal of Advanced Nursing, 15*, 1250-1259.

Hesse-Biber, S. N., & Leavy, P. (2010). *The practice of qualitative research*: Sage.

Hirschmann, D. (1990). The black consciousness movement in South Africa. *The Journal of Modern African Studies, 28*(01), 1-22.

Hogan, A., Reynolds, K. J., Latz, I., & O'Brien, L. (2015). Stigma and its Consequences for Social Identity1. *Hearing Impairment and Hearing Disability: Towards a Paradigm Change in Hearing Services*, 33.

Holloway, I. (2005). *Qualitative Research In Health Care*: Open University Press.

Hong, J. Y., & Turnbull, A. (2013). Family Quality of Life from the Perspectives of Individual Family Members: A Korean-American Family and Deafness. *International journal of special education, 28*(2), 91-103.

Houston, G. (2004). The post-Rivonia ANC/SACP underground. *The Road to Democracy in South Africa, 1*, 1960-1970.

HPCSA., H. P. C. o. S. A. (2007a). *Early hearing detection and intervention programmes in South Africa: Position statement.*

HPCSA., H. P. C. o. S. A. (2007b). *South Africa EHDI Position Statement*.

Hudson, P. (1986). The Freedom Charter and the theory of national democratic revolution. *Transformation, 1*(1).

Hughes, R. A. (1990). Psychological perspectives on infanticide in a faith healing sect. *Psychotherapy: Theory, Research, Practice, Training, 27*(1), 107.

Humber, J. M., & Almeder, R. F. (2013). *What Is Disease?* : Humana Press.

Hunter, K. M. (1986). " There was this one guy...": the uses of anecdotes in medicine. *Perspectives in Biology and Medicine, 29*(4), 619-630.

Hussey, P. A., & Kennedy, M. A. (2016). Instantiating informatics in nursing practice for integrated patient centred holistic models of care: a discussion paper. *Journal of Advanced Nursing, 72*(5), 1030-1041.

Incayawar, M., Wintrob, R., Bouchard, L., & Bartocci, G. (2009). *Psychiatrists and Traditional Healers: Unwitting Partners in Global Mental Health*: John Wiley & Sons.

Jacobson, C. K., Amoateng, A. Y., & Heaton, T. B. (2004). Inter-racial marriages in South Africa. *Journal of comparative family studies*, 443-458.

Jenkins, C. N., Le, T., McPhee, S. J., Stewart, S., & Ha, N. T. (1996). Health care access and preventive care among Vietnamese immigrants: do traditional beliefs and practices pose barriers? *Social Science & Medicine, 43*(7), 1049-1056.

Jenkins, H. A., Niparko, J. K., Slattery, W. H., Gail Neely, J., & Fredrickson, J. M. (2004). Otologics middle ear transducer™ ossicular stimulator: Performance results with varying degrees of sensorineural hearing loss. *Acta oto-laryngologica, 124*(4), 391-394.

Jenson, R. W. (1999). *Systematic Theology: Volume 1: The Triune God*: Oxford University Press.

Johns, S. (1973). Obstacles to Guerrilla Warfare–a South African Case Study. *The Journal of Modern African Studies, 11*(02), 267-303.

Johnson, D. (2007). Representing the Cape" Hottentots," from the French Enlightenment to Post-apartheid South Africa. *Eighteenth-century studies*, 525-552.

Jolley, R. J., Lorenzetti, D. L., Manalili, K., Lu, M., Quan, H., & Santana, M. J. (2017). Protocol for a scoping review study to identify and classify patient-centred quality indicators. *BMJ open, 7*(1), e013632.

Jones, I., Brown, L., & Holloway, I. (2012). *Qualitative Research in Sport and Physical Activity*: SAGE.

Jørgensen, J. A. (2008). *Jesus Imandars and Christ Bhaktas: Two Case Studies of Interreligious Hermeneutics and Identity in Global Christianity*: Lang.

Kahan, S., Miller, R. G., & Smith, E. G. (2008). *Signs and Symptoms*: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Kahn, E. (1943). The right to strike in South Africa: an historical analysis. *South African Journal of Economics, 11*(1), 24-47.

Kail, R. V., & Cavanaugh, J. C. (2015). *Human Development: A Life-Span View*: Cengage Learning.

Karlen, A. (1996). *Man and microbes: disease and plagues in history and modern times*: Simon and Schuster.

Kavanaugh, K., Moro, T. T., & Savage, T. A. (2010). How nurses assist parents regarding life support decisions for extremely premature infants. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 39*(2), 147-158.

Kelley, K., Clark, B., Brown, V., & Sitzia, J. (2003). Good practice in the conduct and reporting of survey research. *International Journal for Quality in health care, 15*(3), 261-266.

Khoza-Shangase, K., & Michal, G. (2014). Early Intervention in Audiology: Exploring the Current Status from a Developing Country Context.

Kim, J.-H. (2015). *Understanding Narrative Inquiry: The Crafting and Analysis of Stories as Research*: SAGE

Kimmons, W. J. G. (2005). *A Parenting Guidebook: The Roles of School, Family, Teachers, Religion , Community, Local, State and Federal Government in Assisting Parents with Rearing Their Children*: AuthorHouse.

King, D. E., & Bushwick, B. (1994). Beliefs and attitudes of hospital inpatients about faith healing and prayer. *Journal of Family Practice, 39*(4), 349-353.

Kingdon, G. G., & Knight, J. (2004). Unemployment in South Africa: The nature of the beast. *World development, 32*(3), 391-408.

KingJamesVersion. (copyright 1998). *Holy Bible*. Tennessee: Broadman and Holman.

Kirkland, J. (1992). *Herbal and Magical Medicine: Traditional Healing Today*: Duke University Press.

Kiyaga, N. B., & Moores, D. F. (2003). Deafness in Sub-Saharan Africa. *American Annals of the Deaf, 148*(1), 18-24.

Koenig, H. G. (2004). Taking a spiritual history. *Student Journal of American Medical Association, 291*, 2881.

Kothari, M., & Mehta, L. (1984). White/might has rights: apartheid and health. *Journal of postgraduate medicine, 30*(2), 65.

Kover, S. T., Edmunds, S. R., & Weismer, S. E. (2016). Brief report: Ages of language milestones as predictors of developmental trajectories in young children with autism spectrum disorder. *Journal of autism and developmental disorders, 46*(7), 2501-2507.

Kožuh, I., Hintermair, M., Holzinger, A., Volčič, Z., & Debevc, M. (2015). Enhancing universal access: deaf and hard of hearing people on social networking sites. *Universal access in the information society, 14*(4), 537-545.

Kubler, R. E. (1969). On death and dying. *New York: Macmillan, 22*(4), 45-49.

Kunin, S. D. (2003). *Religion: The Modern Theories*: Edinburgh University Press.

Leatt, P., Pink, G. H., & Guerriere, M. (2000). Towards a Canadian model of integrated healthcare. *HealthcarePapers, 1*(2).

Lee, M. M., Lin, S. S., Wrensch, M. R., Adler, S. R., & Eisenberg, D. (2000). Alternative therapies used by women with breast cancer in four ethnic populations. *Journal of the National Cancer Institute, 92*(1), 42-47.

Leech, N. L., & Onwuegbuzie, A. J. (2007). An array of qualitative data analysis tools: A call for data analysis triangulation. *School psychology quarterly, 22*(4), 557.

Lehohla, P. (2014). Statistics South Africa,(2014). *Quarterly Labour Force Survey-Quarter, 1*, 2013.

Lenihan, S. (2010). Trends and challenges in teacher preparation in deaf education. *The Volta Review, 110*(2), 117.

Leo, C. G., Mincarone, P., Sabina, S., Latini, G., & Wong, J. B. (2016). A conceptual framework for rationalized and standardized Universal Newborn Hearing Screening (UNHS) programs. *Italian journal of pediatrics, 42*(1), 15.

Lewis, M., Haviland-Jones, J. M., & Barrett, L. F. (2010). *Handbook of emotions*: Guilford Press.

Lipton. (2002). *Religious Freedom in Africa*: Nova Publishers.

Lipton, M. (1986). *Capitalism and Apartheid: South Africa, 1910-1986*: New Africa Books.

Lodge, T., & Nasson, B. (1991). *All, here, and now: Black politics in South Africa in the 1980s*: New Africa Books.

Lombard, A. (2014). The impact of social welfare policies on social development in South Africa: an NGO perspective. *Social Work/Maatskaplike Werk, 43*(4).

Louw, B., & Avenant, C. (2002). Culture as context for intervention: Developing a culturally congruent early intervention program. *International Pediatrics, 17*(3), 145-150.

MacNutt, F. (1974). *Healing*. Notre Dame: Ave Maria Press.

Madell, J. R. (2008). *Paediatric Audiology: Diagnosis, Technology, and Management*: Thieme.

Mall, S. (2005). Attitudes of health care professionals in South Africa to the use of traditional medicine by their patients on antiretroviral treatment: A research note. *Social dynamics, 31*(2), 118-125.

Maltby, J., Lewis, C. A., & Day, L. (1999). Religious orientation and psychological well-being: The role of the frequency of personal prayer. *British Journal of Health Psychology, 4*, 363-378.

Mangaliso, M. P. (2001). Building competitive advantage from Ubuntu: Management lessons from South Africa. *The Academy of Management Executive, 15*(3), 23-33.

Marais, H. (2001). *South Africa: Limits to change: The political economy of transition*: Palgrave Macmillan.

Marais, H. (2013). *South Africa pushed to the limit: The political economy of change*: Zed Books Ltd.

Maree, J. (1985). The emergence, struggles and achievements of black trade unions in South Africa from 1973 to 1984. *Labour, Capital and Society/Travail, capital et société*, 278-303.

Marks, S., & Rathbone, R. (1982). *Industrialisation and social change in South Africa: African class formation, culture, and consciousness, 1870-1930*: Longman London.

Marschark, M., Sapere, P., Convertino, C. M., Mayer, C., Wauters, L., & Sarchet, T. (2009). Are deaf students' reading challenges really about reading? *American Annals of the Deaf, 154*(4), 357-370.

Marshall, C., & Rossman, G. B. (2014). *Designing qualitative research*: Sage publications.

Mason, & Herrmann, K. R. (1998). Universal infant hearing screening by automated auditory brainstem response measurement. *Pediatrics, 101*(2), 221-228.

Mason, J. E. (1991). The slaves and their protectors: reforming resistance in a slave society, the Cape Colony, 1826–1834. *Journal of Southern African Studies, 17*(1), 103-128.

Mathers, C. (2008). *The global burden of disease: 2004 update*: World Health Organization.

Matthews, J. (1989). *The Park*: Longman.

Mattingly, C. (1998). *Healing dramas and clinical plots: The narrative structure of experience* (Vol. 7): Cambridge University Press.

Maylam, P. (2017). *South Africa's racial past: The history and historiography of racism, segregation, and apartheid*: Routledge.

Mayosi, B. M., & Benatar, S. R. (2014). Health and health care in South Africa—20 years after Mandela. *New England Journal of Medicine, 371*(14), 1344-1353.

McClain, C. S., Rosenfeld, B., & Breitbart, W. (2003). Effect of spiritual well-being on end-of-life despair in the terminally ill cancer patients. *Lancet, 361*, 1603-1607.

McClintock, A. (1991). " No longer in a future heaven": Women and nationalism in South Africa. *Transition*(51), 104-123.

McClintock, A., & Nixon, R. (1986). No Names Apart: The Separation of Word and History in Derrida's" Le Dernier Mot du Racisme". *Critical Inquiry, 13*(1), 140-154.

McLeroy, Bibeau, Steckler, & Glanz. (1988). An ecological perspective on health promotion programs. *Health education quarterly, 15*(4), 351-377.

Melton, J. G. (2014). *Faiths Across Time: 5,000 Years of Religious History [4 Volumes]: 5,000 Years of Religious History*: ABC-CLIO.

Meraviglia, M. G. (1999). Analysis of Spirituality. *Journal of Holistic Nursing, 17*(1), 18-33.

Merriam-Webster. (2017). Holism. Retrieved June, 2017, from https://www.merriam-webster.com/dictionary/holism

Mesthrie, R. (2002). South Africa: a sociolinguistic overview. *Language in South Africa*, 11-26.

Meyer, C., Barr, C., Khan, A., & Hickson, L. (2017). Audiologist-patient communication profiles in hearing rehabilitation appointments. *Patient Education and Counseling*.

Midgley, J. (1997). *Social welfare in global context*: Sage.

Miles, J., & Gilbert, P. (2005). *A handbook of research methods for clinical and health psychology*: Oxford University Press on Demand.

Miller, L. J. (2012). *The Oxford Handbook of Psychology and Spirituality*: Oxford University Press.

Mitchell, M., & Egudo, M. (2003). *A Review of Narrative Methodology*. Australia: Defence Science and Technology Organisation Systems Sciences Laboratory.

Model, A. A. R. P. (1994). A decision-analytic approach to audiological rehabilitation.

Mogford-Bevan, K., & Sadler, J. (1993). *Child Language Disability: Hearing Impairment* (Vol. 3): Multilingual Matters.

Møller, A. R. (2006). *Cochlear and brainstem implants* (Vol. 64): Karger Publishers.

Moodie, T. D. (2002). Mobilization on the South African gold mines. *Social Movements: Identity, Culture, and the State, 47*.

Moodley, R. (2016). Traditional Healing. *The Wiley Blackwell Encyclopedia of Gender and Sexuality Studies*.

Moodley, R., Epp, L., & Yusuf, H. (2012). *Counseling Across the Cultural Divide: The Clement E. Vontress Reader*: PCCS Books.

Moolla, N., & Pillay, D. (2016). *Hakeems and their role in the community in relation to Speech Pathology and Audiology*. University of the Witwatersrand.

Moonsamy, S., Mupawose, A., Seedat, J., Mophosho, M., & Pillay, D. (2017). Speech-Language Pathology and Audiology in South Africa: Reflections on Transformation in Professional Training and Practice Since the End of Apartheid. *Perspectives of the ASHA Special Interest Groups, 2*(17), 30-41.

Moosa, E. (2000). Tensions in legal and religious values in the 1996 constitution.

Moroe, N., & Kathrada, N. (2016). The long-term concerns post cochlear implantation as experienced by parents/caregivers of prelingually deaf children between the ages of 3 and 5 years in Gauteng Province, South Africa. *South African Journal of Child Health, 10*(2), 126-129.

Morton, C., & Nance, W. E. (2006). Newborn hearing screening—a silent revolution. *New England Journal of Medicine, 354*(20), 2151-2164.

Morvillo, N. (2009). *Science and Religion: Understanding the Issues*: John Wiley and Sons.

Moses, A. D. (2011). Official apologies, reconciliation, and settler colonialism: Australian indigenous alterity and political agency. *Citizenship Studies, 15*(02), 145-159.

Mulwafu, W., Gong, W., Francis, H. W., & Saunders, J. E. (2015). GDP Matters: Cost-Effectiveness of Cochlear Implantation and Deaf Education in Sub-Saharan Africa.

Munthali, A. C., Mannan, H., MacLachlan, M., & Swartz, L. (2016). Seeking Biomedical and Traditional Treatment is a Spiritual Lapse Among Zionists: A Case Study of the Zion Church in Malawi. *Ufahamu: A Journal of African Studies, 39*(2).

Nasson, B. (2002). Waging total war in South Africa: some centenary writings on the Anglo-Boer War, 1899-1902. *The journal of military history, 66*(3), 813.

Neimeyer, R. A., Burke, L., Mackay, M., & Stringer. (2010). Grief therapy and the reconstruction of meaning: from principles to practice. *Journal of Contemporary Psychotherapy, 40*, 73-83.

Neimeyer, R. A., & Sands, D. (2011). Meaning reconstruction in bereavement: From principles to practice. *Grief and bereavement in contemporary society: Bridging research and practice*, 9-22.

Nelson, C. J., Rosenfeld, B., & Breitbart, W. (2002). Spirituality, religion, and depression in the terminally ill. *Psychosomatics, 43*, 2002.

Newing, H. (2010). *Conducting research in conservation: Social science methods and practice*: Routledge.

Ngokwey, N. (1989). On the specificity of healing functions: A study of diagnosis in three faith healing institutions in Feira (Bahia, Brazil). *Social Science & Medicine, 29*(4), 515-526.

Nicolas, G., DeSilva, A. M., Grey, K. S., & Gonzalez-Eastep, D. (2006). Using a multicultural lens to understand illnesses among Haitians living in America. *Professional Psychology: Research and Practice, 37*(6), 702.

Northern, J. L., & Downs, M. P. (2002). *Hearing in Children*: Lippincott Williams & Wilkins.

Ntsebeza, L. (1999). *Land tenure reform in South Africa: an example from the Eastern Cape Province*: MPKV; Maharastra.

Nussbaum, M. C. (2004). Beyond the social contract: capabilities and global justice. An Olaf Palme lecture, delivered in Oxford on 19 June 2003. *Oxford Development Studies, 32*(1), 3-18.

O'Connor, B. B. (1995). *Healing traditions: Alternative medicine and the health professions*: University of Pennsylvania Press.

O'Malley, M. R., & Haynes, D. S. (2008). Sudden hearing loss. *Otolaryngologic Clinics of North America, 41*(3), 633-649.

O'Reilly, J. (2000). The hospital prayer book: A partner for healing. *Literature and medicine, 19*(1), 61-83.

Olive, K. (1995). Physicians religious beliefs and the physician-patient relationship: a study if devout physicians. *Southern Medical Journal, 88*(12), 1249-1255.

Oliver, M. (2017). Defining impairment and disability. *Disability and Equality Law*, 3.

Orb, A., Eisenhauer, L., & Wynaden, D. (2001). Ethics in qualitative research. *Journal of nursing scholarship, 33*(1), 93-96.

Oulanova, O., & Moodley, R. (2016). Lessons 7 From Clinical Practice. *Indigenous Cultures and Mental Health Counselling: Four Directions for Integration with Counselling Psychology*, 90.

Pargament, K. I. (1990). God help me: Toward a theoretical framework of coping for the psychology of religion. *Research in the Social Scientific Study of Religion, 2*, 195-224.

Pargament, K. I. (1997). *The Psychology of religion and coping* New York: Guildford.

Pargament, K. I., Koenig, H. G., & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of clinical psychology, 56*(4), 519-543.

Pargament, K. I., Murray-Swank, N., Magyar, G. R., & Ano, G. (2005). Spiritual Struggle: A phenomenon of interest to psychology and religion. In M. W. R & D. H (Eds.), *Psychology and human nature*. Washington DC: APA Press.

Patel, L. (2016). Social welfare and social development. *Social Work/Maatskaplike Werk, 52*(2).

Pérez-Jorge, D., María, R.-J., Alegre de la Rosa Olga, M., & Marrero-Morales M, S. (2016). Evaluation of the Effectiveness of Cochlear Implant According to Age of Implantation.

Peterson, C. C., & Siegal, M. (1999). Representing inner worlds: Theory of mind in autistic, deaf, and normal hearing children. *Psychological Science, 10*(2), 126-129.

Phillips, D. Z. (2016). *Religion and morality*: Springer.

Pitney, W. A., & Parker, J. (2009). *Qualitative research in physical activity and the health professions*: Human Kinetics Champaign, IL.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*: Suny Press.

Posel, D. (2001). Race as common sense: Racial classification in twentieth-century South Africa. *African Studies Review, 44*(02), 87-114.

Prakash, S. S., Prakash, S., Ravichandran, A., Susan, K., & Alex, W. (2013). Measuring Levels of Stress and Depression in Mothers of Children Using Hearing Aids and Cochlear Implants: A Comparative Study. *International journal of special education, 28*(1), 37-44.

Pretorius, E., De Klerk, G., & Van Rensburg, H. (1993). *The traditional healer in South African health care*: Human Sciences Research Council.

Price, M. (1986). Health care as an instrument of apartheid policy in South Africa. *Health Policy and Planning, 1*(2), 158-170.

Puchalski, C. M. (2001). The role of spirituality in health care. *Baylor University Medical Center Proceedings*

14(4), 352–357.

Puckree, T., Mkhize, M., Mgobhozi, Z., & Lin, J. (2002). African traditional healers: what health care professionals need to know. *International Journal of Rehabilitation Research, 25*(4), 247-251.

Ramachandran, V., & Stach, B. A. (2013). *Professional Communication in Audiology*: Plural Publishing.

Ranger, T. (1982). The church and healing: Papers read at the twentieth summer meeting and the twenty first winter meeting of the Ecclesiastical History Society. In W. J. Sheils (Ed.). Oxford.

Reed, Antia, S. D., & Kreimeyer, K. H. (2008). Academic status of deaf and hard-of-hearing students in public schools: Student, home, and service facilitators and detractors. *J Deaf Stud Deaf Educ, 13*(4), 485-502.

Reed, P. (1992). An emerging paradigm for the investigation of spirituality in nursing. *Research in Nursing and Health, 15*, 349-357.

Reilly, D. T. (1983). Young doctors' views on alternative medicine. *Br Med J (Clin Res Ed), 287*(6388), 337-339.

Resciniti, J. L. (2013). The Great Self-Advocacy Wave! Mom Teaches Most Important Lesson:" Explain!". *Odyssey: New Directions in Deaf Education, 14*, 40-42.

Richter, M. (2003). Traditional medicines and traditional healers in South Africa. *Treatment action campaign and AIDS law project, 17*, 4-29.

Rickhi, B., Moritz, S., Reesal, R., Xu, J. T., Paccagnan, P., Urbanska, B., & Quan, H. (2011). A spiritual teaching program for depression: A randomized controlled trial. *Journal of Psychiatry in Medicine, 42*(3), 315-329.

Robert, R. (2008). *A concise history of South Africa*: Cambridge University Press.

Roeser, R. J., Valente, M., & Hosford-Dunn, H. (2007). *Audiology: Diagnosis*: Thieme.

Rosner, F. (2007). *Contemporary biomedical ethical issues and Jewish law*: KTAV Publishing House, Inc.

Ross. (1994). Spiritual aspects of nursing. *Journal of Advanced Nursing, 19*, 349-447.

Ross. (2007). A tale of two systems: beliefs and practices of South African Muslim and Hindu traditional healers regarding cleft lip and palate. *The Cleft palate-craniofacial journal, 44*(6), 642-648.

Ross. (2009). Integral healthcare: the benefits and challenges of integrating complementary and alternative medicine with a conventional healthcare practice. *Integrative medicine insights, 4*, 13.

Ross, & Fowler, K. B. (2008). Cytomegalovirus: A major cause of hearing loss in children. *The ASHA leader, 13*(6), 14-17.

Roy, C. (1984). *Intorduction to Nursing: An Adaptation Model*. Englewood Cliffs, New Jersey: Prentice Hall.

Sachedina, A. (2005). End-of-life: the Islamic view. *The lancet, 366*(9487), 774.

SACIG. (2017). South African Cochlear Implant Group. Retrieved 17 July 2017, from http://www.sacig.org.za/patients-corner/implant-programs/

Salas-Provance, M. B., Erickson, J. G., & Reed, J. (2002). Disabilities as viewed by four generations of one Hispanic family. *American Journal of Speech-Language Pathology, 11*(2), 151-162.

Sallis, J. F., Owen, N., & Fisher, E. (2015). Ecological models of health behavior. *Health behavior: theory, research, and practice. 5th ed. San Francisco: Jossey-Bass*, 43-64.

Sandelowski, M. (2000). Focus on research methods-whatever happened to qualitative description? *Research in nursing and health, 23*(4), 334-340.

Schalock, R. L. (2000). Three decades of quality of life. *Focus on autism and other developmental disabilities, 15*(2), 116-127.

Schraer-Joiner. (2014). *Music for Children with Hearing Loss: A Resource for Parents and Teachers*: Oxford University Press.

Segal, E. A., Gerdes, E. K., & Seiner, S. (2010). *An Introduction to the Profession of Social Work: Becoming a Change Agent: Becoming a Change Agent*: Cengage Learning.

Serooe, T., & Pillay, D. (2016). *Perspectives of audiologists with respect to traditional healers in South Africa*. University of the Witwatersrand.

Sewpaul, V. (1999). Culture religion and infertility: A south African perspective. *British Journal of Social Work, 29*(5), 741-754.

Sharpe, N. F., & Carter, R. F. (2006). *Genetic Testing: Care, Consent and Liability*: Wiley.

Shekedi, A. (2005). *Multiple Case Narrative: A Qualitative Approach to Studying Multiple Populations*: John Benjamins Publishing.

Shepherd, R. (1955). The south african bantu education act. *African Affairs, 54*(215), 138-142.

Shortell, S. M., Gillies, R. R., Anderson, D. A., Erickson, K. M., & Mitchell, J. B. (1996). Remaking health care in America. *Hospitals & health networks, 70*(6), 43-44, 46, 48.

Shortell, S. M., Gillies, R. R., Anderson, D. A., Mitchell, J. B., & Morgan, K. L. (1993). Creating organized delivery systems: the barriers and facilitators. *Journal of Healthcare Management, 38*(4), 447.

Sileo, K. M., Kintu, M., Chanes-Mora, P., & Kiene, S. M. (2016). "Such behaviors are not in my home village, I got them here": A qualitative study of the influence of contextual factors on alcohol and HIV risk behaviors in a fishing community on Lake Victoria, Uganda. *AIDS and Behavior, 20*(3), 537-547.

Sims, C. (1987). *Spiritual care as part of holistic nursing* (Vol. 34): Imprint.

Singer, M. (1995). Beyond the ivory tower: Critical praxis in medical anthropology. *Medical Anthropology Quarterly, 9*(1), 80-106.

Singh, & Devine, M. (2013). *Rural Transformation and Newfoundland and Labrador Diaspora: Grandparents, Grandparenting, Community and School Relations*: SensePublishers.

Singh, Raidoo, D. M., & Harries, C. S. (2004). The prevalence, patterns of usage and people's attitude towards complementary and alternative medicine (CAM) among the Indian community in Chatsworth, South Africa. *BMC Complementary and Alternative Medicine, 4*(1), 3.

Sisk, T. (2017). *Democratization in South Africa: The elusive social contract*: Princeton University Press.

Siwela, M., & Jansen, C. (2016). Conflicting Voices in HIV/AIDS Education of the South African Youth: School Culture Versus South African Traditional Healers Using Ancestral Worship. *International Journal of Criminology and Sociology, 5*, 123-142.

Sixsmith, J., Boneham, M., & Goldring, J. E. (2003). Accessing the community: Gaining insider perspectives from the outside. *Qualitative health research, 13*(4), 578-589.

Sloan, R. P., & Bagiella, E. (2001). Spiritual and medical practice: A look at the evidence *American Family Physician, 63*, 33-34.

Smith. (2010). *Islam in America*: Columbia University Press.

Smith, A. B. (1990). On becoming herders: Khoikhoi and San ethnicity in southern Africa. *African Studies, 49*(2), 51-73.

Smith, R. J., Bale, J. F., & White, K. R. (2005). Sensorineural hearing loss in children. *The lancet, 365*(9462), 879-890.

Spencer, P., & Marschark, M. (2003). Cochlear implants. *Oxford handbook of deaf studies, language, and education*, 434-448.

Spicker, P., Leguizamon, S. A., & Gordon, D. (2007). *Poverty: an international glossary* (Vol. 1): Zed Books.

Spiegler, W. (2007). *Sha'arei Refuah Gates of Jewish Healing*: Lulu. com.

Stach, B. A. (2003). *Comprehensive Dictionary of Audiology, Illustrated*: Thomson/Delmar Learning.

Stein, & Jabaley, T. (1981). *Early identification and parental counseling: Deafness and mental health* New York: Grune & Stratton.

Steinberg, A., Bain, L., Li, Y., Delgado, G., & Ruperto, V. (2003). Decisions Hispanic families make after the identification of deafness. *Journal of Deaf Studies and Deaf Education, 8*(3), 291-314.

Steiner, F. R. (2016). *Human ecology: How nature and culture shape our world*: Island Press.

Storbeck, C., & Calvert-Evans, J. (2008). Towards integrated practices in early detection of and intervention for deaf and hard of hearing children. *American annals of the deaf, 153*(3), 314-321.

Strandberg-Larsen, M., & Krasnik, A. (2009). Measurement of integrated healthcare delivery: a systematic review of methods and future research direction. *International Journal of Integrated Care, 9*, 1.

Sukati, N. A., Mndebele, S. C., Makoa, E. T. s., Ramukumba, T. S., Makoae, L. N., Seboni, N. M., . . . Holzemer, W. L. (2005). HIV/AIDS symptom management in Southern Africa. *Journal of Pain and Symptom Management, 29*(2), 185-192.

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist, 42*, 24-33.

Sumner, R., Burrow, A. L., & Hill, P. L. (2015). Identity and purpose as predictors of subjective well-being in emerging adulthood. *Emerging Adulthood, 3*(1), 46-54.

Sussman, G. (2006). The referendum as an electoral device in national party politics, 1917–60. *Politikon, 33*(3), 259-275.

Suyuti, a.-. (1999). As-Suyuti's Medicine of the Prophet: Ta-Ha Publishers Ltd London, England.

Swanepoel, Johl, L., & Pienaar, D. (2013). Childhood hearing loss and risk profile in a South African population. *International journal of pediatric otorhinolaryngology, 77*(3), 394-398.

Swanepoel, Störbeck, C., & Friedland, P. (2009). Early hearing detection and intervention in South Africa. *International journal of pediatric otorhinolaryngology, 73*(6), 783-786.

Swanepoel, D. W. (2006). Audiology in South Africa: audiología en sudáfrica. *International Journal of Audiology, 45*(5), 262-266.

Symon, G., & Cassell, C. (2012). *Qualitative Organizational Research: Core Methods and Current Challenges*: SAGE.

Tanner, D. C. (2007). *Medical-legal and forensic aspects of communication disorders, voice prints, and speaker profiling*: Lawyers & Judges Publishing Company.

Tarakeshwar, Pearce, M. J., & Sikkema, K. J. (2005). Development and implimentation of a spiritual coping group intervention for adults living with HIV/AIDS: A pilot study. *Mental Health, Religion & Culture, 8*(3), 179-190.

Tarakeshwar, N., Vanderwerker, L. C., & Paulk, E. (2006). Religious coping is associated with the quality of life of patients with advanced cancer. *Journal of Palliative Medicine, 9*, 646-657.

Ten Have, P. (2007). *Doing conversation analysis*: Sage.

Tharpe, A. M., & Seewald, R. (2016). *Comprehensive Handbook of Pediatric Audiology, Second Edition*: Plural Publishing, Incorporated.

Theunissen, M., & Swanepoel, D. (2008). Early hearing detection and intervention services in the public health sector in South Africa. *International Journal of Audiology, 47*(sup1), S23-S29.

Thompson, M., & Thompson, G. (1991). Early identification of hearing loss: listen to parents. *Clinical Pediatrics, 30*(2), 77-80.

Triegaardt, J. (2014). Pursuing a social development agenda in the context of globalisation: a South African perspective. *Social Work/Maatskaplike Werk, 45*(1).

Tucci, D. L., Merson, M. H., & Wilson, B. S. (2010). A summary of the literature on global hearing impairment: current status and priorities for action. *Otology & Neurotology, 31*(1), 31-41.

Tucker, B. P. (1998). Deaf culture, cochlear implants, and elective disability. *Hastings Center Report, 28*(4), 6-14.

Van den Bergh, B. R., Mulder, E. J., Mennes, M., & Glover, V. (2005). Antenatal maternal anxiety and stress and the neurobehavioural development of the fetus and child: links and possible mechanisms. A review. *Neurosci Biobehav Rev, 29*(2), 237-258. doi: 10.1016/j.neubiorev.2004.10.007

van der Spuy, T., & Pottas, L. (2008). Infant hearing loss in South Africa: Age of intervention and parental needs for support. *Int J Audiol, 47*(sup1), S30-S35.

Van Heyningen, E. (2009). The Concentration Camps of the South African (Anglo-Boer) War, 1900–1902. *History Compass, 7*(1), 22-43.

Van Rooyen, J. (2000). *The new Great Trek: The story of South Africa's white exodus*: Pretoria: University of South Africa.

van Wyk, J. (2016). Should we blame Calvinism for the development of apartheid in South Africa? A perspective from the Reformed Churches in South Africa: A case study. *In die Skriflig/In Luce Verbi, 50*(1), 9 pages.

VandeCreek, L., Ayres, S., & Bassham, M. (1995). Using INSPIRIT to conduct spiritual assessments. *Journal of Pastoral Care & Counseling, 49*(1), 83-89.

Varghese, S. B. (2010). Cultural, ethical, and spiritual implications of natural disasters from the survivors' perspective. *Critical care nursing clinics of North America, 22*(4), 515-522.

Vearey, J. (2014). Healthy migration: A public health and development imperative for south (ern) Africa. *SAMJ: South African Medical Journal, 104*(10), 663-664.

Vernikos, J. (2004). *The G-Connection: Harness Gravity and Reverse Aging*: Joan Vernikos.

Von Holdt, K. (2010). Nationalism, bureaucracy and the developmental state: the South African case. *South African Review of Sociology, 41*(1), 4-27.

Von Holdt, K., & Murphy, M. (2007). Public hospitals in South Africa: stressed institutions, disempowered management. *State of the Nation*, 312-341.

Waetjen, T. (1999). The'home'in homeland: gender, national space, and Inkatha's politics of ethnicity. *Ethnic and Racial Studies, 22*(4), 653-678.

Wainwright, W. J. (2017). *Religion and morality*: Routledge.

Walker, C. (1991). *Women and resistance in South Africa*: New Africa Books.

Warwick, P. (1983). *Black people and the South African war 1899-1902*: Cambridge University Press.

Watermeyer, B. (2006). *Disability and social change: A South African agenda*: HSRC Press.

Watson, J. (1985). *Nursing: The Philosophy and Science Caring*. Bolders, Colorado: Colorado Associated University Press.

Wells, K. (2011). *Narrative Inquiry. Pocket guides to social work research methods*: Oxford University Press.

Wendt, W. E. (1976). 'Art Mobilier'from the Apollo 11 Cave, South West Africa: Africa's Oldest Dated Works of Art. *The South African Archaeological Bulletin*, 5-11.

Whitney, I., Nabuzoka, D., & Smith, P. K. (1992). Bullying in schools: Mainstream and special needs. *Support for learning, 7*(1), 3-7.

WHO. (1948). *Constitution of the World Health Organization*

WHO. (1995). Constitution of the world health organization.

WHO. (2001). Legal status of traditional medicine and complementar.

WHO. (2013). International Classification of functioning, disability and health: ICF. Geneva: WHO; 2001. *Also available from: URL: http://www. who. int/classifications/icf/en [cited 2014 Jan 9]*.

Wieder, A. (2013). *Ruth First and Joe Slovo in the war against apartheid*: NYU Press.

Wilkinson, D., Gcabashe, L., & Lurie, M. (1999). Traditional healers as tuberculosis treatment supervisors: precedent and potential [Planning and Practice]. *The International Journal of Tuberculosis and Lung Disease, 3*(9), 838-842.

Willems, P. J. (2003). *Genetic Hearing Loss*: CRC Press.

Williams, G. F. (2011). *The diamond mines of South Africa: Some account of their rise and development*: Cambridge University Press.

Willis, J. W. (2008). *Qualitative research methods in education and educational technology*: IAP.

Wilson, & Cleary, P. D. (1995). Linking clinical variables with health-related quality of life: a conceptual model of patient outcomes. *Jama, 273*(1), 59-65.

Wilson, L. (2012). *Steve Biko*: Ohio University Press.

Wisker. (2007). *The Postgraduate Research Handbook: Succeed with your MA, MPhil, EdD and PhD*: Palgrave Macmillan.

Wisker, G., Morris, C., Cheng, M., Masika, R., Warnes, M., Trafford, V., . . . Lilly, J. (2010). Doctoral learning journeys: Final report. *Higher Education Academy*.

Witztum, E., & Buchbinder, J. T. (2001). Strategic culture sensitive therapy with religious Jews. *International Review of Psychiatry, 13*(2), 117-124.

Woods, D. (2004). *Rainbow Nation Revisited: South Africa's Decade of Democracy*: André Deutsch.

Worotynec, Z. S. (2004). Contrived or inspired: Ability/disability in the children's picture book. *Disability Studies Quarterly, 24*(1).

Yoshinaga-Itano, C., Sedey, A. L., Coulter, D. K., & Mehl, A. L. (1998). Language of early-and later-identified children with hearing loss. *Pediatrics, 102*(5), 1161-1171.

Young. (2016). Simon van der Stel. from http://www.sahistory.org.za/people/simon-van-der-stel

Young, & Koopsen. (2010). *Spirituality, health, and healing: An integrative approach*: Jones & Bartlett Publishers.

Young, & Tattersall, H. (2007). Universal newborn hearing screening and early identification of deafness: Parents' responses to knowing early and their expectations of child communication development. *J Deaf Stud Deaf Educ, 12*(2), 209-220.

Young, A., Carr, G., Hunt, R., McCracken, W., Skipp, A., & Tattersall, H. (2006). Informed choice and deaf children: Underpinning concepts and enduring challenges. *Journal of Deaf Studies and Deaf Education, 11*(3), 322-336.

Zuberi, T., Sibanda, A., & Udjo, E. O. (2016). *The Demography of South Africa*: Taylor & Francis.