



Universiteit  
Leiden  
The Netherlands

## **Resilience from childhood to young adulthood: retrospective perspectives of deaf and hard of hearing people who studied in regular schools**

Eichengreen, A.; Zaidman-Zait, A.; Most, T.; Golik, G.

### **Citation**

Eichengreen, A., Zaidman-Zait, A., Most, T., & Golik, G. (2021). Resilience from childhood to young adulthood: retrospective perspectives of deaf and hard of hearing people who studied in regular schools. *Psychology & Health*, 1-19. doi:10.1080/08870446.2021.1905161

Version: Publisher's Version

License: [Creative Commons CC BY-NC-ND 4.0 license](#)

Downloaded from: <https://hdl.handle.net/1887/3242864>

**Note:** To cite this publication please use the final published version (if applicable).



## Resilience from childhood to young adulthood: retrospective perspectives of deaf and hard of hearing people who studied in regular schools

Adva Eichengreen, Anat Zaidman-Zait, Tova Most & Gelena Golik

To cite this article: Adva Eichengreen, Anat Zaidman-Zait, Tova Most & Gelena Golik (2021): Resilience from childhood to young adulthood: retrospective perspectives of deaf and hard of hearing people who studied in regular schools, Psychology & Health, DOI: [10.1080/08870446.2021.1905161](https://doi.org/10.1080/08870446.2021.1905161)

To link to this article: <https://doi.org/10.1080/08870446.2021.1905161>



© 2021 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group



Published online: 29 Mar 2021.



Submit your article to this journal [↗](#)



Article views: 581



View related articles [↗](#)



View Crossmark data [↗](#)

# Resilience from childhood to young adulthood: retrospective perspectives of deaf and hard of hearing people who studied in regular schools

Adva Eichengreen<sup>a,b</sup>, Anat Zaidman-Zait<sup>a</sup>, Tova Most<sup>a,c</sup> and Gelena Golik<sup>a</sup>

<sup>a</sup>The Department of Counselling and Special Education at the Jaime and Joan Constantiner School of Education, Tel Aviv University, Tel Aviv, Israel; <sup>b</sup>The Department of Developmental Psychology at the Institute of Psychology, Leiden University, Leiden, The Netherlands; <sup>c</sup>The Department of Communication Disorders at the Stanley Steyer School of Health Professions, Tel Aviv University, Tel Aviv, Israel

## ABSTRACT

**Objective:** Most deaf and hard of hearing (DHH) youth grow up in hearing familial and educational environments, posing unique risks for their socio-emotional well-being. The study's objective was to explore protective processes contributing to resilience among DHH individuals in different life periods.

**Design:** We conducted semi-structured interviews with 23 DHH young adults on their life-long coping with having a hearing loss (HL).

**Main outcome measures:** Thematic analysis identified, according to participants' retrospective perceptions, processes that supported their positive adjustment from childhood up to early adulthood.

**Results:** Themes were organised at three ecological levels: individual, including five subthemes (e.g. certain attitudes to HL); family, including various types of parental support; and community, including four subthemes (e.g. extra-curricular activities). Family and community level resources enabled and nurtured personal attitudes and coping abilities. The perceptions of which personal attitudes and contextual resources were helpful changed from childhood to young adulthood.

**Conclusions:** Findings show how resilience is heterogeneously promoted in the unique context of DHH individuals living in hearing environments. They also show interactions between the individual, family and wider society and the dynamics of coping resources across time. Findings indicate the importance of considering DHH individuals' coping choices in their specific life context.

## ARTICLE HISTORY

Received 3 November 2020

Accepted 12 March 2021

## KEYWORDS

Deaf and hard of hearing; resilience; protective processes; coping resources

## Introduction

Resilience, defined as positive adaptation despite adversity (Luthar, 2006), has been extensively studied in various at-risk populations (e.g. Kuru & Ungar, 2020; Malee et al., 2019; Masten & Obradović, 2006; Raghavan & Griffin, 2017; Suárez-Orozco et al., 2018), with particular attention to protective processes. Protective processes can

**CONTACT** Adva Eichengreen  [adva.eichengreen@gmail.com](mailto:adva.eichengreen@gmail.com)  Department of Developmental Psychology, Leiden University, P.O. Box 9555, 2300 RB Leiden, The Netherlands.

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

© 2021 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group

This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

modify or prevent negative effects of aversive life circumstances and according to the multidimensional approach to resilience are often divided into individual, family, community and social levels, with interactions between levels (Luthar, 2006). However, protective processes and adaptive outcomes are considered context-dependent, and it is generally recognised that more research is required to illuminate the unique contextual experiences of various populations (Luthar, 2006; Ungar, 2004, 2015). One such population is the deaf and hard of hearing (DHH) who communicate in spoken language and are part of hearing familial and educational settings. DHH children and adolescents often face limited access to communication, social rejection and stigma, which, in turn, may impede their linguistic, social and mental health development (Calderon & Greenberg, 2012; Rieffe et al., 2015; Theunissen et al., 2014). To date, limited research considers the protective processes which may assist DHH youth and adults in overcoming these adversities (e.g. Antia et al., 2011; Young et al., 2011). Further, little is known of the meaning of resilience to people who are DHH. More research is needed on DHH individuals' perspectives on their own resilience, including resources and processes that are relevant to their lived experience (Young et al., 2011) and embedded in specific contexts and life circumstances. Before addressing the research on resilience in DHH individuals, we briefly describe the unique contexts and potential adversities with which many DHH youth cope.

DHH children are increasingly educated in hearing environments. Medical and technological advances enable early detection of hearing loss (HL) and facilitate effective auditory-verbal habilitation (Houston & Bradham, 2011). Given a world-wide increase in legislation for inclusive education, many DHH children now study in mainstream education settings. However, they are often the only ones with HL in their class (Leigh et al., 2009; Wauters and Knoors, 2008), and despite technological advances, they face communication difficulties, especially in group interactions or when there is background noise (Punch and Hyde, 2011). Further, the vast majority of DHH children are born to hearing parents (Mitchell & Karchmer, 2004), with no prior knowledge of HL. Communication barriers in the family (Calderon & Greenberg, 2012), parental stress (Hintermair, 2006; Zaidman-Zait & Most, 2005) or exclusion from peer interactions at school (e.g. Xie et al., 2014; Zaidman-Zait and Dotan, 2017) may negatively affect the development of DHH children's socio-emotional skills, sense of belonging and sense of self-identity (Israelite et al., 2002; Rieffe et al., 2018). They may experience stigma and discrimination and feel different or devalued for their deafness, even in their own nuclear families (Berkowitz & Jonas, 2014).

Considering the adversities faced by many DHH youth, research on resilience in the context of HL has been relatively scarce (Young et al., 2011). Yet there have been some important insights into the social and cultural constructs of resilience, risk factors and successful outcomes integrated within the context of the DHH population (Masten & Obradović, 2006; Ungar, 2004; Young et al., 2011). Young et al. (2011) describe how deafness may be perceived as a cause of risk, and protective processes can be individualised and reduced to individual-based traits which enable 'overcoming the disability' in 'extraordinary' people, thus missing the role of social barriers and institutional discrimination. Alternatively, risk can be conceived as stemming from the interaction between DHH people and disabling environments, with resilience defined as 'the successful navigation of the experience of being deaf in a world that creates risks that

might impede self-fulfillment, safety, and well-being' (Young et al., 2011, p. 12). Similarly, researchers can define successful outcomes in terms of integration in the hearing community (e.g. school achievements), or alternatively define resilience as the ability to achieve a positive sense of a deaf identity, which, at times, may imply a preference for the linguistic and cultural norms of the Deaf community (Young et al., 2011).

While previous studies may have differed in their resilience definitions, there is a growing body of knowledge on protective processes in the lives of DHH children and adults. These processes are outlined here within the multidimensional ecological framework of resilience (Bronfenbrenner & Morris, 2006; Luthar, 2006), a framework common to most of the studies reviewed here. The *individual level* consists of personal traits or processes enabling positive growth in the face of risk. These are also strongly influenced by larger familial and social contexts and expressed, for example, in adaptive emotion regulation and internal locus of control, or in the case of minorities, in ethnic pride and biculturalism (Luthar, 2006; Suárez-Orozco et al., 2018; Ungar, 2015). As most DHH children grow up in hearing environments, they have fewer opportunities to develop positive bicultural or Deaf identities, i.e. develop a sense of belonging to the Deaf community (Leigh, 2017). Studies on DHH youth or adults have highlighted protective capabilities, such as a sense of humour, optimism, outgoing personality, good communication and social skills, commitment to goals, self-reliance and problem-solving skills (Antia et al., 2011; Charlson et al., 1999; Rogers et al., 2003). In the context of communication barriers and isolation, certain coping strategies have been found to reduce distress; these range on a spectrum from self-distancing to self-advocating (Lytle et al., 2011; Luckner, 2011; Martin & Bat-Chava, 2003; Rogers et al., 2003; Sheridan, 2011; Steinberg, 2000). In addition, while having good communication skills is important regardless of communication mode (e.g. spoken or sign language), having good skills in spoken language is related to less loneliness and more successful interactions with hearing peers while studying in mainstream schools (Most, 2007; Antia et al., 2011).

The *family level* refers to the quality of parent-child interactions and parenting styles (Luthar, 2006). In the HL context, resilience-supporting parents are warm, supportive and involved, with high expectations of the child's performance and mentoring the child when s/he faces social difficulties (Antia et al., 2011; Luckner, 2011; Sheridan, 2011). The use of sign language in the family is another factor (Luckner, 2011), as is having additional siblings with HL or positive acceptance of HL in the family (Eichengreen & Zaidman-Zait, 2020).

The *community level* includes systems such as supportive peer relationships, informal mentors, schooling and involvement in structured extra-curricular activities (Luthar, 2006; Masten & Obradović, 2006). In the context of HL, schools have a responsibility to reduce communication barriers, provide programs facilitating social and educational inclusion, and cooperate with service providers and families (Antia et al., 2011; Charlson et al., 1999; Luckner, 2011; Lytle et al., 2011; Rogers et al., 2003). Positive peer relationships foster socio-emotional well-being, in relation to both hearing (Antia et al., 2011) and DHH peers (Israelite et al., 2002; Kent & Smith, 2006; Lytle et al., 2011; Sheridan, 2011), inside and outside the school setting (Antia et al., 2011; Lytle et al., 2011).

Finally, the *socio-cultural level* includes societal laws, cultural values (Masten & Obradović, 2006), institutional policies and access to political resources (Ungar, 2015). Changes of social norms and structures, such as access to communication in the larger

society, more positive cultural perceptions of deaf people, access to the Deaf community and deaf role-models (Listman et al., 2011; Lytle et al., 2011; Sheridan, 2011), may play an important role in eliminating risk and increasing resilience in DHH individuals.

Alongside knowledge on protective processes in the lives of DHH people, empirical research has been limited, especially for DHH youth and young adults who use spoken language and study/have studied in mainstream schools. Only a few studies have focused on the perspectives of mainstreamed DHH persons in the context of resilience (Charlson et al., 1999; Luckner, 2011; Lytle et al., 2011). Additional research is also needed on the meanings DHH individuals assign to resilience and protective processes (Young et al., 2011). Finally, resilience is commonly perceived at fixed ecological levels, but it is a fluctuating dynamic process, with new vulnerabilities and strengths emerging and changing over time according to individual development and evolving life circumstances (Luthar, 2006; Masten, 2014). Yet most studies have focused on specific development periods or age groups (childhood, adolescence, adulthood). Consequently, a wider integrative perspective on resilience across the life course is missing (Bonanno, 2013).

Given the above considerations, we applied a qualitative research design to explore young mainstreamed DHH adults' retrospective accounts of the experiences and resources that helped them cope with HL and contributed to their well-being in different life periods. Through this exploration, we aimed to fill gaps in the knowledge about the processes which mainstreamed DHH persons identify as meaningful to their resilience and which are embedded within their daily lived experiences. Further, we uniquely aimed to reach an integrative understanding of the development of protective processes from childhood to young adulthood, including dynamic processes taking place in changing age and life contexts.

## Method

### *Participants*

This research was part of a larger project on emotional implications of habilitation and integration processes in young adults with mild to profound levels of HL (Eichengreen et al., 2016; Eichengreen & Hoofien, 2020). In this study, the inclusion criterion for participation was HL of at least severe level (60db in the better ear). This allowed us to explore various perspectives in a relatively homogenous sample. Fifty-six participants met the inclusion criterion. All had pre-lingual HL, used spoken language as their main or sole mode of communication, grew up in families who used spoken language for communication, and had been individually included in mainstream educational settings, where they were the only ones with HL in their classes. Because of the quality of the interviewer-interviewee dialogue in our study (Malterud et al., 2016), this relatively homogeneous sample presented rich accounts, all suitable for analysis. We thus randomly selected 20 interviews, assuming the uniqueness of the participants' life histories would elicit diverse experiences and perspectives. We subsequently added three more interviews to expand the socio-demographic diversity of the participants, presented in Table 1. The final sample included 23 interviews. All participants used hearing aids during the school years, and six had cochlear-implants at the time of the interviews. Twenty-two percent had

**Table 1.** Participants’ socio-demographic characteristics.

	Median	Interquartile range	Range
Age	23	20.5–25	18–28
Years of education	14	13–16	12–18
Number of siblings	3	2–3	1–10
Parents’ education	3.5	2–4	1–5.5
Socio-economic status	4	4–5	2–7
Speech understanding	2	1.5–3	1–3.5
Speech intelligibility	2	1–3	1–5
	Frequency	Percentage	
Women	15	65.2%	
Religious	6	26.1%	
Parents’ education			
1–1.5	3	13%	
2–2.5	6	26%	
3–3.5	5	21.7%	
4–4.5	8	34.8%	
5–5.5	1	4.3%	
6	0	0%	
Socio-economic status			
1–1.5	0	0%	
2–2.5	1	4.3%	
3–3.5	3	13%	
4–4.5	11	47.8%	
5–5.5	6	26%	
6–6.5	1	4.3%	
7	1	4.3%	

Parent’s education is an average of both parents’ degree of education (1=less than 12 yrs; 2=12 yrs; 3=higher education; 4=first (academic) degree; 5=second degree; 6=third degree or beyond). Socio-economic status is an average of childhood and present status (1=very low; 4=medium; 7=very high). Speech understanding is an average of participants’ estimation of their ability to understand speech in one-on-one and in telephonic conversations (1 = not difficult at all; 5 = extremely difficult). Speech intelligibility is the transcriber’s estimation of the participant’s speech (1=extremely easy to understand; 5=extremely difficult to understand).

another family member (a parent or a sibling) with HL. None of the participants had additional disabilities.

**Procedure**

Ethical approval was obtained from the Ethics Committee of the Hebrew University of Jerusalem. Participants were recruited nationwide through universities, audiology clinics and organisations for and of people with HL in Israel (for further details, see Eichengreen et al., 2016). After participants made initial contact with the first author, they received further information about the research. Following their consent, an interviewer contacted them. Each participant participated in a one-hour interview (range 45–90 min) in a quiet room at the university or at the participant’s home. The interviewer, who was a research assistance for this project, was a psychology student with expertise working with people with HL and had HL herself. She had no previous acquaintance with the interviewees. Following the participant’s consent, the interview was audio-recorded and later transcribed by a professional transcriber. The interviews were semi-structured and focused on familial, social and personal aspects of coping with HL from childhood to adulthood. Participants were asked about the following: the HL diagnosis, habilitation intervention and related experiences; social relationships with both hearing and DHH peers; parental attitudes to HL; communication about HL within the family; and self-perceptions of HL throughout their childhood until young adulthood (see Supporting Information Appendix

1 for the topic guide). The interviews were conducted in Hebrew. Representative quotations were translated into English by the first author, and the translation was reviewed by the second and third authors.

### **Data analysis**

To explore participants' own perspectives and identify shared themes across all participants, we used inductive thematic analysis (Braun & Clarke, 2006), while applying a descriptive (eidetic) phenomenological approach which emphasises that the 'essence' of the phenomenon of interest can be accessed through individuals' perspectives (Hale et al., 2007; Sanders, 2003). Our findings were organised withing an ecological framework and the multilevel model of resilience (Bronfenbrenner & Morris, 2006; Luthar, 2006), taking into account dynamic processes within and between different contexts of the lived experience (Masten, 2014). We followed the six-stage analysis described by Braun and Clarke (2006). All authors had expertise in research and/or work with people with HL in the fields of psychology, education or habilitation. The fourth author was an MA student, and the rest had research experience beyond PhD level. The first author had HL herself, and the other authors were hearing. None of the authors had previous acquaintance with the interviewees. Reflexivity was addressed throughout the analysis by regular discussions between the authors on their assumptions and on the extent to which the analysis was reflective of the data. In the first stage of the analysis, the first and fourth authors read and re-read each interview transcript while registering initial notes. In the second stage, the fourth author coded all aspects relevant to what participants considered helpful for coping with deafness up to this point in their lives. This stage was supervised by the first and second author and involved ongoing discussions. Next, in a collective process, the first, second and fourth authors equated and reorganised codes under relevant themes. They then re-examined all the themes by comparing them to codes in previous stages and to themes generated from other interviews. In the fifth stage, they organised and labelled themes. Last, all authors finalised the organisation of the themes and selected representative quotations that best illustrated them. The coding and organisation of themes were supported by ATLAS.ti.8 software. We determined saturation by looking retrospectively at the extent to which each interview elicited new themes compared to previous interviews (Constantinou et al., 2017). Thematic saturation was achieved at the fifth interview. Following the recommendations to create a defined verbal counting in qualitative research (Sandelowski, 2001), we used the term 'few' to indicate themes mentioned by 3–4 participants, 'some' for those mentioned by 5–7 participants, 'several' for 8–10 participants, 'many' for 11–14 participants and 'most or majority' for 15 or more participants (see also Dyer et al., 2004; van Rooij et al., 2009).

### **Results**

Themes were organised according to individual, family and community levels; each consisted of several protective processes or resources that promoted resilience within that level. The time dimension was included by organising the themes according to various life periods (i.e. childhood, adolescence, young adulthood and across development in general). These classifications are summarised in Table 2.



**Table 2.** Themes of protective factors and number of participants per theme.

Age period referred by the participant	Individual	Family	Community
General across development	Embracing challenges (6) Using Humour (7) Spoken communication skills (10)	<ul style="list-style-type: none"> <li>• Parental support*: (14)Acceptance and full inclusion</li> <li>• Emotional support</li> <li>• Practical involvement</li> </ul>	Supportive adult outside the family* (5)
Childhood	Minimising appearance/importance of HL (9)		<ul style="list-style-type: none"> <li>• Social support:Close hearing friends* (11)</li> <li>• DHH peers (10)After-school group of DHH peers</li> </ul>
Adolescence and young adulthood	Accepting HL (18)		<ul style="list-style-type: none"> <li>• Close DHH friends</li> <li>• Affirmative experiences outside of school (9)</li> </ul>

*Note.*  $N = 23$ .  
 \*The supports of parents, additional adult figures and hearing friends were mentioned as protective factors mainly in relation to childhood and adolescence.

### Individual level

Protective processes for well-being at the individual level consisted of personality characteristics and personal attitudes to HL and communication abilities. These included: embracing challenges, using humour, possessing spoken communication skills, minimising the appearance/importance of HL and accepting HL.

#### Embracing challenges

Seeing difficulties as challenges and wanting to overcome them, especially those related to HL, were described by some participants as personal predispositions. They reflected on their efforts to achieve personal goals (e.g. pursuing academic or vocational achievements), especially in domains that seemed to confront their hearing difficulties:

It was kind of a challenge, to be good at something that, from the conceptual aspect, clashes a little bit with my disability .... I was playing musical instruments .... I also like [learning] languages very much, which is also something that many deaf and hard of hearing people find difficult to deal with, and I get into such challenges. I think that the fact that it is supposed to be more difficult probably makes me want it more. (P3)

#### Using humour

The importance of humour in alleviating communication difficulties and related frustrations was brought up by some participants. They reported that adopting a humouristic attitude enabled them to ‘keep the situation in proportion’ and regain a sense of control. They also mentioned that humour enabled to lessen the embarrassment of their hearing peers and motivated peers to help them further understand the conversation. For example, one of the participants described the following exchange: ‘People have a problem... they come and tell you - *brrr-brrr-brrr* [mimics an unclear fast talk] – what? – *brrr-brrr-brrr* – what? Every time – what? – *Nothing, doesn’t matter* – Oh, THIS you say clearly...[laughs]’ (P18).

### *Possessing spoken communication skills*

Participants identified spoken communication ability as a key facilitating factor in interactions with hearing people. Having residual hearing, using amplification aids, being able to speech read and having clear articulation were described by several participants as very helpful in preventing communication difficulties, social rejection and stigma. They expressed appreciation for the intensive habilitation they had undergone and were proud of their speech and hearing abilities. For example:

I practiced [articulation] with a speech-therapist ... and suddenly people were astonished that I pronounced the words correctly [laughing], I felt awesome. It was so good that I became the reader of the class. And I thought: wow, I am hard of hearing and I won the duty to read the story to the whole class. So I can, I am really ordinary, I am even better than the others. It was a significant achievement for me. (P10)

### *Minimising the appearance/importance of HL*

During childhood, participants reported on being helped by minimising the appearance of their HL. Several felt that controlling the visibility of HL, for example, by not talking about it or by using very small hearing aids, prevented social stigmatisation and improved their self-confidence in peer interactions. Others simply did not perceive the HL as a significant part of their identity; they reported not thinking about it or feeling it was not a major issue. As one participant mentioned, not feeling different was an important part of their self-perception:

During childhood I felt that I have [hearing loss] but it is not significant, it does not belong to me. I pretty much ignored it, as if I am an ordinary girl like everyone else; that is how I grew up. I am happy about it, I always gave myself the feeling that I am an ordinary girl. (P10)

Perception of HL as a non-issue was mentioned as helpful throughout the life-span, but an active minimisation of HL in self-identity and self-disclosure was mentioned mainly in relation to childhood. In one exception, a participant who belonged to an ultra-orthodox community said she belonged to a DHH social group during childhood but decided during adolescence to detach from them and present herself as completely hearing. She felt this turning-point was very important in building her self-confidence and social relationships and explained this by the high stigmatisation of DHH people prevalent in her community.

### *Accepting the HL*

Acceptance of HL was highlighted as an important catalyst of well-being and self-confidence. Most participants described a gradual ongoing process, starting in adolescence, of an increasing awareness of HL alongside the ability to accept it. Some participants reported accepting difficulties as limitations and avoiding situations which might be too stressful or frustrating, reorienting their focus to other social, academic or vocational goals. For others, acceptance meant being happy about their HL and seeing advantages in it, such as exposure to sign-language, having silence or developing skills such as creativity, sensitivity to detail or tolerance of differences. Beyond this, they simply felt good about who they were: 'If I hadn't had the hearing loss, .... I wasn't me, the one who I am today. And I love being this way' (P9). This positive

acceptance could also happen in the face of significant stressors, such as peer bullying, and helped mitigate their influence.

Thinking about their adolescence and young adulthood, some participants said openness about HL and assertiveness, such as asking for clarifications or ensuring auditory accessibility, were effective ways to influence others' awareness of and reactions to HL:

Let's assume a situation where we are several people walking in the street and you walk on the side and you don't hear .... [N]ot in my case, I push myself, I walk in the middle .... My friends already automatically [adapt themselves]. if I stand on the side then someone says – 'oh, one moment' - passes me and stands next to my other side. It is clear to them that otherwise I will just bother them all the time with 'I don't hear you' and 'what are you saying?' [laughing] ... I just feel confident about it, I have no fear to talk about it. (P3)

## Family level

### Parental support

Mothers, or both parents, were described by many participants as key agents in providing support throughout the life span, especially during childhood and adolescence. Parents were reported to provide *acceptance and full inclusion in the family*. Participants reflected on feeling accepted by parents, loved, appreciated and perceived as no different from their siblings. They described parents who believed in their ability to succeed and, at the same time, made necessary adaptations to meet their communication needs:

If there is a family meal ... they always made sure that I will be involved and hear. ... If they see that I didn't listen and there was something interesting, then they will repeat on it for me even if I didn't ask .... [I]t happens daily .... If there is something on TV without subtitles and it's difficult for me to understand, then they will help me to understand it. (P8)

Parental *emotional support* was also mentioned by some participants, who felt they could share their difficulties with their parents. They described their parents as listening, encouraging, giving advice and sometimes even actively assisting, e.g. making sure they would not be in the same class as a bully. This generated a feeling of being protected against external impingements, as one participant described. *Practical involvement* of parents was also reported on and cherished, whether in relation to habilitation training, financial support for HL assistive devices or ensuring assistance at school.

## Community level

The community level included the support of an adult outside the family, hearing and DHH peers and affirmative experiences with inclusive frameworks and individuals outside the school context.

### Supportive adult outside the family

Certain adult figures, such as a speech therapist, a religious leader in the community or an ambulant teacher, gave support which was life-long remembered, according to

the participants. Some described how these adults formed a close relationship with them and gave assistance that exceeded their original duty, for example, by convincing their parents to send them to regular education. The following participant described the emotional support she received from her ambulant teacher:

I used to lash out a lot [in school] ... at this time I didn't have my regular ambulant teacher, she left to sabbatical and I... she was someone to whom I could come and always tell her what bothers me, and she always had the advice... and in that year she was not there .... The new teacher did not know how to contain the bullying [I experienced], what to advise me to do so it won't happen again ... and I remember that when my regular teacher returned I felt so good. (P13)

### *Close hearing friends*

The importance of having close hearing friends was highlighted for childhood and adolescence. According to many participants, not only did these friendships fulfil social needs but also at times they prevented social difficulties, for example, when friends protected them from potential bullies. During adolescence, friends helped create the first contact with new peers, something particularly important in noisy venues such as parties. Participants described their friends as helpful, aware and adapted to their communication needs. A major feature of the relationships was acceptance of the HL:

There was this very good friend in high school ... who accepted me from the start. It also gave me something, awareness ... I can be an ordinary girl, there is no difference. All you need is patience. The fact that she was ... mature and we were like-minded, it gave me the feeling that – yes, there are people who have this maturity, and if they have awareness I can be in their company. From her I learnt that I don't have to account to anyone. Whoever does not accept me – fine, that's their right. But whoever does accept me, I open [my] world to them. (P19)

### *Friendships with DHH peers*

Social relationships with DHH peers were reported by several participants as important for their social well-being and self-perception. During childhood, participants met DHH peers in organised group activities. They described having a sense of belonging and fun: 'I loved it very much, I felt very much that I belonged.... I really felt good... I really enjoyed it. I wish I had this [later on]' (P19). During adolescence and early adulthood, participants described relationships with DHH peers as close and intimate, devoid of communication barriers, and providing a space for sharing HL-related experiences. They said this mutual sharing enabled them to reconnect to deafness in a positive way, for example: 'He taught me to detach from the world of hearing and enjoy nature in an unmediated way, only through sensations' (P6). According to other participants, DHH friends provided a special understanding and a sense of identification, supporting their sense of self-identity in the hearing culture:

We are messaging or talking all the time... it is very important because finally you find someone who is like you ... [The relationship with the DHH friends gave me] a deep sense of identification. First of all, they understand what it is like to be...me. They also tasted the hearing world.... It has been very difficult for me, until today, to say, 'Yes, I am hearing impaired, yes, I have hearing aids, accept me as I am.' ... and they give me

the support that it is alright... as there are some others like this, who get along outside there [laughing]. (P13)

### **Affirmative experiences outside school**

During adolescence and early adulthood, affirmative experiences outside the school context were reported to provide important opportunities for personal growth, according to some of the participants. Participants reflected on how transitioning out of the school system and confronting new people forced them to develop new strategies to cope with their HL. This, in turn, enhanced their confidence in their ability to deal with HL in various situations: 'You understand that you can cope with everything and that it is just there, you can find solutions to everything' (P3). Others described engaging in social frameworks (e.g. community volunteering organisations, workplaces, defence force, university) that were more nurturing and inclusive than their school setting. They felt valued for their capabilities, and sometimes accepted for the first time:

[In school] it was sad, helpless, despairing sometimes. So in order not to feel it all the time, I was volunteering at the library, then I felt – wow – I am helping, I am appreciated [by] the librarians and sometimes by the students ... then I felt really good. (P12)

According to the participants, the first encounter with mature or open-minded people generated a significant change in their self-perception and their view of the future: 'There are other people in the world' (P6). A few felt that because of attitudinal changes in society, people have become more interested in learning about HL and more aware of the need for adaptations. This, they said, encouraged them as young adults to practice self-assertive strategies.

## **Discussion**

This study examined retrospective perspectives of mainstreamed DHH young adults on the protective processes that supported their coping with HL and promoted their well-being from childhood to young adulthood. Participants identified processes on individual, family and community levels; findings showed these levels interacted and changed in different life periods, thus suggesting the dynamic, context-dependent characteristics of resilience development. Participants' perspectives on coping resources promoting resilience were diverse. In what follows, we outline the results by ecological level, noting the interrelations between ecological levels and time periods.

Personal abilities, such as a sense of humour, self-advocacy skills and good spoken communication skills, were helpful coping resources in hearing environments, especially in the context of regular school settings. These findings are consistent with previous research findings on resilience in children with or without HL (e.g. Antia et al., 2011; Charlson et al., 1999; Ungar, 2015). A unique personal factor that emerged in our study was the tendency to embrace challenges, including challenges specific to having an HL, such as musical hobbies. This may be related to the idea of 'overcoming disability', part of a 'medical model' (Oliver, 1990), which views disability as a problem that resides within the individual and needs to be fixed, 'normalised', and overcome to enable full integration within society. Some participants expressed their appreciation of parents and professionals who assisted them in the habilitation process, were proud of their speech and hearing skills, and felt lucky not to have a 'deaf

accent'. They felt their acceptance by hearing peers depended on these skills. In addition, some emphasised the importance of disguising the appearance of their HL or not drawing attention to it during childhood. Others simply did not feel the HL was important in their self-perception. The possibility of feeling just like everyone else was perceived as very important to their well-being. These findings support previous research on the tendency of DHH children who grow up in a hearing environment to have a 'hearing' identity (Leigh, 2017) or to not experience their HL as an important part of their identity (Ohna, 2004). A quantitative study that included our participants (XX) found a positive association between participants' minimisation of HL in their identity and having close relationships with hearing peers. The qualitative findings of our study indicate that at least some of our participants perceived this association as causal; i.e. their minimisation of their HL contributed to their ability to socialise with hearing peers.

While the need to assimilate within a hearing social environment can be interpreted as expressing a negative view of deafness, it may also reflect the need to be accepted by others and to have an ordinary self-identity (i.e. to feel essentially similar to others). Naturally, in a society intolerant of differences, a child does not wish to be viewed through the lens of disability or 'otherness'. Adults with disabilities also do not necessarily consider disability as central to their self-definition (Watson, 2002). Furthermore, a preference to keep a disability non-explicit, especially in the case of invisible physical or sensory disabilities, does not necessarily indicate a lack of self-acceptance. Rather, it can express an autonomous choice to protect privacy or avoid social stigma (Samuels, 2003). A post-modern outlook on the construction of deaf identities emphasises the ever-changing salience of various aspects of identity, depending on the specific social and cultural context in which the individual is interacting (McIlroy & Storbeck, 2011). Our research findings show that in the developmental context of childhood and in the social context of growing up in a hearing family, school and community, HL may not have a prominent role in identity, and minimisation of its visibility/importance can provide advantages for the child. As one participant suggested, this may also be the case during later periods if HL in a particular cultural community is perceived as highly stigmatic.

Interestingly, from adolescence onwards, minimisation was no longer mentioned by most of our participants as helpful. Rather, they emphasised the importance of developing awareness of their HL and accepting it as part of their identity. This change may be partly explained by a growing ability to deploy complex cognitive coping strategies, such as cognitive reappraisal of a situation (Compas et al., 2017). An increase in cognitive complexity may assist DHH adolescents develop an awareness of communication difficulties and help them find adaptive coping strategies. Heightened awareness of HL during adolescence could also result from an increase in verbal interactions with hearing peers under non-adaptive conditions (e.g. group gatherings; Israelite et al., 2002; Ohna, 2004), or it may reflect the importance of peer interactions to identity development during this period (Steinberg & Morris, 2001). New educational and vocational challenges also emerge with age, and efforts to follow speech, which worked well enough during childhood, may no longer be sufficient (Harmon, 2013). Some participants felt it helped them to accept certain limits and to change their

values and goals accordingly. Others gradually adopted a positive view of deafness. While the transition to deaf or bicultural identities has been described elsewhere (Leigh, 2017; McIlroy & Storbeck, 2011), our findings suggest processes of self-acceptance can take place without acculturation into the Deaf community.

Participants' personal resources depended on social environments which enabled and nurtured the development of these resources in different life periods. As Luthar (2006) points out, individual resources always develop within and are intertwined with social and cultural contexts. Participants' perceptions of helping resources during childhood were dominated by support given by parents and hearing peers, while during adolescence and young adulthood, close relationships with DHH peers and wider extra-curricular social circles became more influential. In general, contextual support, mentioned by the participants, featured practices which fully included the participants and enabled them to feel non-different, attended to their needs, accepted their HL, provided emotional support during difficult times or offered practical assistance.

Our findings support previous research on the protective role of parents (Antia et al., 2011; Luckner, 2011; Sheridan, 2011), hearing peers (Antia et al. 2011) and DHH peers (Israelite et al., 2002; Kent & Smith, 2006; Lytle et al., 2011; Sheridan, 2011) in fostering resilience in DHH children. The potentially protective role of medical or educational professionals was another helpful resource mentioned by our participants; in some cases, they became unofficial mentors, providing children and their parents with socio-emotional guidance or support. Our findings provide a unique understanding of *how* all these protective processes contribute in the context of hearing environments. For example, even if parents do not introduce sign language to the family communication, they can still make adjustments to fully include the child in everyday interactions. Further, while relationships with hearing peers are generally known to be important (e.g. Xie et al., 2014), our study suggests peers not only satisfy the child's social needs but they also provide an extra auxiliary shield or aids in various contexts. Above all, participants said their peers' accepting and inclusive attitude to the HL helped them develop a positive self-perception.

DHH peers contributed to participants' well-being, but the nature of their contribution differed in childhood and later periods. During childhood, when contact was limited to afternoon meetings, participants described a sense of belonging and fun. In these accepting environments, participants could be released from daily speech and hearing training (Decker & Vallotton, 2016) or ongoing mental and physical efforts to fit into the hearing environment (Eichengreen & Hoofien, 2020) and enjoy playfulness and 'time to be kids' (Gibson, 2012), a very important component of well-being and development (Yogman et al., 2018). From adolescence onwards, participants' descriptions of relationships with DHH peers focused on closeness and intimacy, in line with theories of age-related socio-emotional development (Steinberg & Morris, 2001). In this new developmental context, DHH friends were described by participants as companions in the process of identity development, providing an important focal point and identification as the participants searched for their self-definition as DHH persons.

Of special interest was the participants' view of the role of extra-curricular non-school activities in providing opportunities for personal growth. At times, the



encounter with new people was a 'challenging factor' (Ungar, 2004), i.e. a factor supporting resilience by facilitating the development of new coping strategies. Because these situations were manageable, they helped participants build their adaptive capacity and self-confidence in facing such situations in the future. At other times, extra-curricular activities balanced negative experiences in schools; participants discovered that 'other people' existed, people who viewed them in a non-stigmatic way and appreciated their abilities. The potential of extra-curricular activities to give DHH youth opportunities to strengthen socialisation skills and self-confidence has been noted elsewhere (Antia et al., 2011; Lytle et al., 2011). For some of our participants, these represented their first encounters with inclusive environments and, as such, were crucial for their self-perception. Our findings highlight the potential of extra-curricular activities to be 'beneficial turning points' and provide life-changing opportunities (Rutter, 1999). They challenge the closed structures of schools, suggesting schools should create more opportunities for stigmatised children to express their abilities by extending their social circles and collaborating with various agents in the community.

The socio-cultural level was nearly absent in the participants' descriptions of protective factors. A few mentioned a positive attitudinal change in society, which they felt in their encounters with new people as young adults. Since the turn of the century, Israeli society has been going through a significant transformation in its attitudes to persons with disabilities, a change seen in social activism, legislation and policy (e.g. Ben Moshe & Colligan, 2007; Mor et al., 2016). Traditional disabling cultural norms still exist (e.g. Bitman & John, 2019; Broyer, 2017) and can explain some participants' medical perspective on deafness. At the same time, this cultural shift in awareness of and openness to the needs and rights of people with disabilities may have positively influenced participants' social interactions by the time they were young adults, thereby fostering their resilience.

### **Limitations and future directions**

While the findings of this study contribute to the understanding of the dynamic and contextual nature of protective processes in DHH individuals, the study has several limitations. The sample mostly consisted of higher-education students and is not representative of the entire DHH population. For instance, a tendency to embrace challenges may be typical of people with academic capabilities or aspirations. Future studies would benefit from exploring the perspectives of people from a wider range of socio-economic and cultural backgrounds, as well as intersectional identities. In addition, the data were based on the retrospective perspectives of young adults. Future longitudinal studies, from childhood to an old age, would enable a more direct integrative exploration of lived experiences. Another concern is that the interview structure, with its focus on intrapersonal and interpersonal aspects of coping with HL, may have limited the scope of the participants' accounts. Future investigations should focus directly on resilience and pay close attention to the socio-cultural context. Finally, future research would benefit from a detailed investigation of the fit between specific coping strategies and varied situational demands related to HL.



## Conclusions and practical implications

The retrospective perspectives of the participants in this study shed interesting light on the changes in and stability of protective processes. Internal perceptions of HL, in particular, dynamically changed across age periods and socio-cultural contexts. The nature of support received from various social circles changed with age as well. These findings exemplify and support a dynamic perspective on resilience (Masten, 2014) and suggest the need to include the time dimension in ecological models of human development (Bronfenbrenner & Morris, 2006). Findings also suggest the heterogeneous nature of adaptive coping strategies. From minimising the appearance of HL to being assertively open about it, from trying to embrace challenges to accepting challenges as limitations – clearly, no single solution suited everyone in our study. Ungar (2015) has described how in minority groups, factors which otherwise seem non-adaptive may actually be protective in a specific socio-cultural context. Similarly, the coping choices of DHH children and their families should be set against their specific life context. That being said, DHH children and their families would benefit from being exposed to various coping possibilities. Resilience research points to the contribution of having a repertoire of coping strategies which are flexibly used according to specific situational demands (Bonanno, 2013; Cheng et al., 2014; Rutter, 1999). This coping flexibility is associated with psychological adjustment, especially in persons with limited functions, opportunities or resources, such as the elderly or those of low socio-economic status (Cheng et al., 2014). While our ability to generalise the findings is limited because of the qualitative design and focus on a subgroup within the DHH population, the study's integrative perspective points to potential benefits for DHH individuals who are able to cope flexibly across different life periods and social contexts.

## Acknowledgements

The authors would like to thank the participants for authentically sharing their experiences and perspectives on coping with HL.

## Disclosure statement

No potential conflict of interest was reported by the authors.

## Data availability

The data are not publicly available because they contain information that could compromise the privacy of research participants.

## Funding

The work on this study was supported by European Union's Horizon 2020 research and innovation program under the Marie Skłodowska-Curie grant agreement [grant no. 707404].

## References

- Antia, S. D., Reed, S., & Shaw, L. (2011). Risk and resilience for social competence: Deaf students in general education classrooms. In Zand, D. H., & Pierce, K. J. (Eds.), *Resilience in deaf children: Adaptation through emerging adulthood* (pp. 139–167). New York: Springer Science & Business Media. [https://doi.org/10.1007/978-1-4419-7796-0\\_6](https://doi.org/10.1007/978-1-4419-7796-0_6)
- Ben Moshe, L., & Colligan, S. (2007). The state of disability in Israel/Palestine: An introduction. *Disability Studies Quarterly*, 27(4). <https://doi.org/10.18061/dsq.v27i4.41>
- Berkowitz, M.C. & Jonas, J.A. (2014). Deaf and Hearing Siblings in Conversations. *Jefferson*, North Carolina: McFarland & Company Inc.
- Bitman, N., & John, N. A. (2019). Deaf and hard of hearing smartphone users: Intersectionality and the penetration of ableist communication norms. *Journal of Computer-Mediated Communication*, 24(2), 56–72. <https://doi.org/10.1093/jcmc/zmy024>
- Bonanno, G. A. (2013). Meaning making, adversity, and regulatory flexibility. *Memory (Hove, England)*, 21(1), 150–156. <https://doi.org/10.1080/09658211.2012.745572>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Bronfenbrenner, U., & Morris, P. A. (2006). The bioecological model of human development. In W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology, Vol. 1: Theoretical models of human development* (6th ed., pp. 793–828). New York: Wiley.
- Broyer, N. R. (2017). Reinforcing Zionist ableism in Israeli wheelchair folk dancing. *Research in Drama Education: The Journal of Applied Theatre and Performance*, 22(3), 332–338. <https://doi.org/10.1080/13569783.2017.1326807>
- Calderon, R., & Greenberg, M. (2003). Social and emotional development of deaf children. In *Oxford handbook of deaf studies, language and education* (pp.177–189).
- Calderon, R., & Greenberg, M. T. (2012). Social and Emotional Development of Deaf Children: Family, School, and Program Effects. In Marschark, M. & Spencer, P.E. (Eds.), *The Oxford Handbook of Deaf Studies, Language, and Education: Second Edition* (Vol. 1). Oxford Handbooks Online: Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780199750986.013.0014>
- Charlson, E. S., Bird, R. L., & Strong, M. (1999). Resilience and success among deaf high school students: Three case studies. *American Annals of the Deaf*, 144(3), 226–235. <https://doi.org/10.1353/aad.2012.0186>
- Cheng, C., Lau, H. P. B. O., & Chan, M. P. S. A. (2014). Coping flexibility and psychological adjustment to stressful life changes: A meta-analytic review. *Psychological Bulletin*, 140(6), 1582–1607. <https://doi.org/10.1037/a0037913>
- Compas, B. E., Jaser, S. S., Bettis, A. H., Watson, K. H., Gruhn, M. A., Dunbar, J. P., Williams, E., & Thigpen, J. C. (2017). Coping, emotion regulation, and psychopathology in childhood and adolescence: A meta-analysis and narrative review. *Psychological Bulletin*, 143(9), 939–991. <https://doi.org/10.1037/bul0000110>
- Constantinou, C. S., Georgiou, M., & Perdikiogianni, M. (2017). A comparative method for themes saturation (CoMeTS) in qualitative interviews. *Qualitative Research*, 17(5), 571–588. <https://doi.org/10.1177/1468794116686650>
- Decker, K. B., & Vallotton, C. D. (2016). Early intervention for children with hearing loss: Information parents receive about supporting children's language. *Journal of Early Intervention*, 38(3), 151–169. <https://doi.org/10.1177/1053815116653448>
- Dyer, S. J., Abrahams, N., Mokoena, N. E., & van der Spuy, Z. M. (2004). 'You are a man because you have children': Experiences, reproductive health knowledge and treatment-seeking behaviour among men suffering from couple infertility in South Africa. *Human Reproduction (Oxford, England)*, 19(4), 960–967. <https://doi.org/10.1093/humrep/deh195>
- Eichengreen, A., Hoofien, D., & Bachar, E. (2016). Empirically based suggested insights into the concept of false-self defense: Contributions from a study on normalization of children with disabilities. *Journal of the American Psychoanalytic Association*, 64(1), 107–132.
- Eichengreen, A., & Hoofien, D. (2020). Late emotional effects of rehabilitation during childhood and their impact on coping with deafness in adulthood. *Journal of Health Psychology*, 25(4), 522–537. <https://doi.org/10.1177/1359105317719581>

- Eichengreen, A., & Zaidman-Zait, A. (2020). Relationships among deaf/hard-of-hearing siblings: Developing a sense of self. *The Journal of Deaf Studies and Deaf Education*, 25(1), 43–54. <https://doi.org/10.1093/deafed/enz038>
- Gibson, B. (2012). The politics of walking. *Nordic Network on Disability Research*. Retrieved December 1st, 2012, from <http://nndr.org/>
- Hale, E. D., Treharne, G. J., & Kitas, G. D. (2007). Qualitative methodologies I: Asking research questions with reflexive insight. *Musculoskeletal Care*, 5(3), 139–147. <https://doi.org/10.1002/msc.109>
- Harmon, K. C. (2013). Growing up to become hearing: Dreams of passing in oral deaf education. In Brune, J.A., & Wilson, D.J. (Eds.), *Disability and passing: Blurring the lines of identity* (pp. 167–198). Philadelphia: Temple University Press.
- Hintermair, M. (2006). Parental resources, parental stress, and socioemotional development of deaf and hard of hearing children. *Journal of Deaf Studies and Deaf Education*, 11(4), 493–513. <https://doi.org/10.1093/deafed/enl005>
- Houston, K. T., & Bradham, T. S. (2011). Parent engagement in audiologic habilitation. *The ASHA Leader*, 16(8), 5–6. <https://doi.org/10.1044/leader.FTR4.16082011.5>
- Israelite, N., Ower, J., & Goldstein, G. (2002). Hard-of-hearing adolescents and identity construction: Influences of school experiences, peers, and teachers. *Journal of Deaf Studies and Deaf Education*, 7(2), 134–148. <https://doi.org/10.1093/deafed/7.2.134>
- Kent, B., & Smith, S. (2006). They only see it when the sun shines in my ears: Exploring perceptions of adolescent hearing aid users. *Journal of Deaf Studies and Deaf Education*, 11(4), 461–476. <https://doi.org/10.1093/deafed/enj044>
- Kuru, N., & Ungar, M. (2020). Refugee children's resilience: A qualitative social ecological study of life in a camp. *Journal of Refugee Studies*, 1–18. <https://doi.org/10.1093/jrs/feaa092>
- Leigh, I. W. (2017). The complexities of deaf identities. In Bagga-Gupta S., Hansen, A.L., Feilberg, J. (Eds.), *Identity revisited and reimagined: Empirical and theoretical contributions on embodied communication across time and space* (pp. 207–220). eBook: Springer. [https://doi.org/10.1007/978-3-319-58056-2\\_10](https://doi.org/10.1007/978-3-319-58056-2_10)
- Leigh, I. W., Maxwell-McCaw, D., Bat-Chava, Y., & Christiansen, J. B. (2009). Correlates of psychosocial adjustment in deaf adolescents with and without cochlear implants: A preliminary investigation. *Journal of Deaf Studies and Deaf Education*, 14(2), 244–259. <https://doi.org/10.1093/deafed/enn038>
- Listman, J., Rogers, K. D., & Hauser, P. C. (2011). Community cultural wealth and deaf adolescents' resilience. In Zand, D. H., & Pierce, K. J. (Eds.), *Resilience in deaf children: Adaptation through emerging adulthood* (pp. 279–297). New York: Springer Science & Business Media. [https://doi.org/10.1007/978-1-4419-7796-0\\_11](https://doi.org/10.1007/978-1-4419-7796-0_11)
- Luckner, J. (2011). Promoting resilience: Suggestions for families, professionals, and students. In Zand, D. H., & Pierce, K. J. (Eds.), *Resilience in deaf children: Adaptation through emerging adulthood* (pp. 207–226). New York: Springer Science & Business Media. [https://doi.org/10.1007/978-1-4419-7796-0\\_8](https://doi.org/10.1007/978-1-4419-7796-0_8)
- Luthar, S. S. (2006). Resilience in development: A synthesis of research across five decades. In Cicchetti, D., & Cohen, D. J. (Eds.), *Developmental psychopathology* (2d ed., Vol. 3, pp. 739–795). New Jersey: John Wiley & Sons. <https://doi.org/10.1002/9780470939406.ch20>
- Lytle, L. R., Oliva, G. A., Ostrove, J. M., & Cassady, C. (2011). Building resilience in adolescence: The influences of individual, family, school, and community perspectives and practices. In Zand, D. H., & Pierce, K. J. (Eds.), *Resilience in deaf children: Adaptation through emerging adulthood* (pp. 251–277). New York: Springer Science & Business Media. [https://doi.org/10.1007/978-1-4419-7796-0\\_10](https://doi.org/10.1007/978-1-4419-7796-0_10)
- Malee, K. M., Kerr, S., Paul, R., Puthanakit, T., Thongpibul, K., Kosalaraksa, P., Ounchanum, P., Kanjanavanit, S., Aupibul, L., Ngampiyaskul, C., Luesomboon, W., Wongsawat, J., Vonthanak, S., Ly, P. S., Chettra, K., Suwanlerk, T., Sophonphan, J., Valcour, V., Ananworanich, J., & Mellins, C. A. (2019). Emotional and behavioral resilience among children with perinatally acquired HIV in Thailand and Cambodia. *AIDS*, 33(Supplement 1), S17–S27. <https://doi.org/10.1097/QAD.0000000000002182>

- Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, 26(13), 1753–1760. <https://doi.org/10.1177/1049732315617444>
- Martin, D., & Bat-Chava, Y. (2003). Negotiating deaf-hearing friendships: Coping strategies of deaf boys and girls in mainstream schools. *Child: Care, Health and Development*, 29(6), 511–521. <https://doi.org/10.1046/j.1365-2214.2003.00371.x>
- Masten, A. S. (2014). Global perspectives on resilience in children and youth. *Child Development*, 85(1), 6–20. <https://doi.org/10.1111/cdev.12205>
- Masten, A. S., & Obradović, J. (2006). Competence and resilience in development. *Annals of the New York Academy of Sciences*, 1094, 13–27. <https://doi.org/10.1196/annals.1376.003>
- McIlroy, G., & Storbeck, C. (2011). Development of deaf identity: An ethnographic study. *Journal of Deaf Studies and Deaf Education*, 16(4), 494–511. <https://doi.org/10.1093/deafed/enr017>
- Mitchell, R. E., & Karchmer, M. A. (2004). Chasing the mythical ten percent: Parental hearing status of deaf and hard of hearing students in the United States. *Sign Language Studies*, 4(2), 138–163. <https://doi.org/10.1353/sls.2004.0005>
- Mor, S., Ziv, N., & Eichengreen, A. (2016). Disability studies in Hebrew: An emerging academic field. In: S. Mor, N. Ziv, A. Kanter, A. Eichengreen and N. Misrahi (Eds.). *Disability Studies: A Reader*. Jerusalem: The Van Leer Institute, pp. 11–54.
- Most, T. (2007). Speech intelligibility, loneliness, and sense of coherence among deaf and hard-of-hearing children in individual inclusion and group inclusion. *Journal of Deaf Studies and Deaf Education*, 12(4), 495–503. <https://doi.org/10.1093/deafed/enm015>
- Ohna, S. E. (2004). Deaf in my own way: Identity, learning and narratives. *Deafness & Education International*, 6(1), 20–38. <https://doi.org/10.1179/146431504790560609>
- Oliver, M. (1990). *The Politics of Disablement: A Sociological Approach*. New York: St. Martin's Press.
- Punch, R., & Hyde, M. (2011). Social participation of children and adolescents with cochlear implants: a qualitative analysis of parent, teacher, and child interviews. *Journal of Deaf Studies and Deaf Education*, 16(4), 474–493. <https://doi.org/10.1093/deafed/enr001> 21372111
- Raghavan, R., & Griffin, E. (2017). Resilience in children and young people with intellectual disabilities: A review of literature. *Advances in Mental Health and Intellectual Disabilities*, 11(3), 86–97. <https://doi.org/10.1108/AMHID-01-2017-0002>
- Rieffe, C., Broekhof, E., Eichengreen, A., Kouwenberg, M., Veiga, G., Da Silva, B. M. S., Van Der Laan, A., & Frijns, J. H. M. (2018). Friendship and Emotion Control in Pre-Adolescents With or Without Hearing Loss. *Journal of Deaf Studies and Deaf Education*, 23(3), 209–218. <https://doi.org/10.1093/deafed/eny012> 29733358
- Rieffe, C., Netten, A. P., Broekhof, E., & Veiga, G. (2015). The role of the environment in children's emotion socialization. In Marschark M., & Knoors H. E. T. (Eds.), *Educating deaf learners* (pp. 369–388). London, UK: Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780190215194.003.0016>
- Rogers, S., Muir, K., & Evenson, C. R. (2003). Signs of resilience: Assets that support deaf adults' success in bridging the deaf and hearing worlds. *American Annals of the Deaf*, 148(3), 222–232. <https://doi.org/10.1353/aad.2003.0023>
- Rutter, M. (1999). Resilience concepts and findings: Implications for family therapy. *Journal of Family Therapy*, 21(2), 119–144. <https://doi.org/10.1111/1467-6427.00108>
- Samuels, E. (2003). My body, my closet: Invisible disability and the limits of coming-out discourse. *GLQ: A Journal of Lesbian and Gay Studies*, 9(1–2), 233–255. <https://doi.org/10.1215/10642684-9-1-2-233>
- Sandelowski, M. (2001). Focus on research methods real qualitative researchers do not count: The use of numbers in qualitative research. *Research in Nursing & Health*, 24(3), 230–240. <https://doi.org/10.1002/nur.1025>
- Sanders, C. (2003). Application of Colaizzi's method: Interpretation of an auditable decision trail by a novice researcher. *Contemporary Nurse*, 14(3), 292–302. <https://doi.org/10.5172/conu.14.3.292>
- Sheridan, M. A. (2011). Whose literacy is it, anyway? Strengths-based guidelines for transforming the developmental environments of deaf children and adolescents. In Zand, D. H., &

- Pierce, K. J. (Eds.), *Resilience in deaf children: Adaptation through emerging adulthood* (pp. 229–249). New York: Springer Science & Business Media. [https://doi.org/10.1007/978-1-4419-7796-0\\_9](https://doi.org/10.1007/978-1-4419-7796-0_9)
- Steinberg, L., & Morris, A. S. (2001). Adolescent development. *Annual Review of Psychology*, 52, 83–110. <https://doi.org/10.1146/annurev.psych.52.1.83>
- Suárez-Orozco, C., Motti-Stefanidi, F., Marks, A., & Katsiaficas, D. (2018). An integrative risk and resilience model for understanding the adaptation of immigrant-origin children and youth. *The American Psychologist*, 73(6), 781–796. <https://doi.org/10.1037/amp0000265>
- Theunissen, S. C. P. M., Rieffe, C., Netten, A. P., Briare, J. J., Soede, W., Schoones, J. W., & Frijns, J. H. M. (2014). Psychopathology and its risk and protective factors in hearing-impaired children and adolescents: A systematic review. *JAMA Pediatrics*, 168(2), 170–177. <https://doi.org/10.1001/jamapediatrics.2013.3974>
- Ungar, M. (2004). A constructionist discourse on resilience: Multiple contexts, multiple realities among at-risk children and youth. *Youth & Society*, 35(3), 341–365. <https://doi.org/10.1177/0044118X03257030>
- Ungar, M. (2015). Practitioner review: Diagnosing childhood resilience—a systemic approach to the diagnosis of adaptation in adverse social and physical ecologies. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, 56(1), 4–17. <https://doi.org/10.1111/jcpp.12306>
- van Rooij, F. B., van Balen, F., & Hermanns, J. M. A. (2009). The experiences of involuntarily childless Turkish immigrants in the Netherlands. *Qualitative Health Research*, 19(5), 621–632. <https://doi.org/10.1177/1049732309333242>
- Watson, N. (2002). Well, I Know this is Going to Sound Very Strange to You, but I Don't See Myself as a Disabled Person: Identity and disability. *Disability & Society*, 17(5), 509–527. <https://doi.org/10.1080/09687590220148496>
- Wauters, L. N., & Knoors, H. (2008). Social integration of deaf children in inclusive settings. *Journal of Deaf Studies and Deaf Education*, 13(1), 21–36. <https://doi.org/10.1093/deafed/enm028> 17573356
- Xie, Y.-H., Potměšil, M., & Peters, B. (2014). Children who are deaf or hard of hearing in inclusive educational settings: a literature review on interactions with peers. *Journal of Deaf Studies and Deaf Education*, 19(4), 423–437. <https://doi.org/10.1093/deafed/enu017> 25052819
- Yogman, M., Garner, A., Hutchinson, J., Hirsh-Pasek, K., Golinkoff, R. M.; Committee on Psychosocial Aspects of Child and Family Health; Council on Communications and Media. (2018). The power of play: A pediatric role in enhancing development in young children. *Pediatrics*, 142(3), e20182058. <https://doi.org/10.1542/peds.2018-2058>
- Young, A., Rogers, K. D., Green, L., & Daniels, S. (2011). Critical issues in the application of resilience frameworks to the experiences of deaf children and young people. In Zand, D. H., & Pierce, K. J. (Eds.), *Resilience in deaf children: Adaptation through emerging adulthood* (pp. 3–24). New York: Springer Science & Business Media. [https://doi.org/10.1007/978-1-4419-7796-0\\_1](https://doi.org/10.1007/978-1-4419-7796-0_1)
- Zaidman-Zait, A., & Dotan, A. (2017). Everyday Stressors in Deaf and Hard of Hearing Adolescents: The Role of Coping and Pragmatics. *Journal of Deaf Studies and Deaf Education*, 22(3), 257–268. <https://doi.org/10.1093/deafed/enw103> 28334795
- Zaidman-Zait, A., & Most, T. (2005). Cochlear implants in children with hearing loss: Maternal expectations and impact on the family. *Volta Review*, 105, 129–150.