Parental responses to recommendations made in educational psychology reports of primary school children

by

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September 2018

DECLARATION OF ORIGINALITY

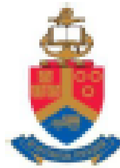
I declare that this mini-dissertation titled "**Parental responses to recommendations made in educational psychology reports of primary school children**" which I hereby submit for the degree Masters in Educational Psychology at the University of Pretoria, is my own work and has not previously been submitted by me for a degree at this or any other tertiary institution.

....

Ms. K. Shrestha

September 2018

ETHICS CLEARANCE CERTIFICATE



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TO WHOM IT MAY CONCERN

This serves to confirm that the editing of the dissertation **"INVESTIGATING PARENTAL RESPONSES TO RECOMMENDATIONS MADE IN EDUCATIONAL PSYCHOLOGY REPORTS OF PRIMARY SCHOOL CHILDREN"** by Ms K Shrestha, was completed by a member of the editing staff of Post Graduate Friend, who is affiliated to the Professional Editors' Guild of South Africa (PEG).

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"Every accomplishment starts with a decision to try"

- Anonymous

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"Resilience is key"

Dr E. Swanepoel[1]

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ABSTRACT

A study conducted in America found that 50% of parents do not follow through with the recommendations made in their children's psychological reports. Possible reasons include the lack of managed care and expensive psychological assessments. In South Africa, Alexander Forbes Health has reported that fewer South Africans are claiming for mental health treatment since 2011, despite the fact that mental health challenges are increasing, thus supporting the American notion that not all recommendations are followed through.

This study seeks to investigate South African parental responses to recommendations made by educational psychologists after assessment, using Bronfenbrenner's bio-ecological systems theory, the Health Belief model and the Therapeutic Alliance theory as a foundation. A quantitative approach was followed with self-developed electronic-questionnaires sent to survey parental responses to recommendations at a training facility for educational psychologists. 47 e-questionnaires were sent out, and 13 parents responded.

Descriptive analysis revealed that eight of the thirteen caregivers followed through with more than half to all of the suggested recommendations, challenging the results of the above-mentioned study. The high rate of compliance might be attributed to the training model followed at the training facility.

Challenges experienced by 66.67% of the caregivers were that time, finances and medical aid funds were unavailable. 5% of the caregivers indicated that stigma or judgement from significant others held them back to follow through with the suggested recommendations.

A contribution of the study lies in the model derived to understand parental adherence to recommendations. A major limitation is the small number of responses.

Keywords: Parents; Recommendations; South Africa; Responses; Feedback; Educational psychologist; Children in primary school; Training facility

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CHAPTER ONE

INTRODUCTION, CONTEXTUALISATION AND OVERVIEW OF THE INTENDED RESEARCH

1.1 INTRODUCTION AND BACKGROUND

A child's foundation of care and support is usually his or her parents[2] or, in some cases, guardians (Goldman, Salus, Wolcott & Kennedy, 2003). The care and support parents usually want to provide for their children include physical support, such as nutrition and healthcare (Halpenny, Nixon & Watson, 2010), emotional support in order to minimise and prevent current and future emotional challenges (McCormick, Cappella, O'Connor & McClowry, 2013; Shaw, Krause & Chatters, 2004), social support and personal support (Williamson, Creswell, Butler, Christie & Halligan, 2016). Maslow's (1943) hierarchy of needs suggests that providing support and care for one's children is a factor of motivation in parents (Griffin, Ledbetter & Sparks, 2014; Maslow, 1943). Once parents become aware that their children have psychological challenges which exceed their own capacity, support is usually sought from psychologists (Tharinger et al., 2008b).

However, research conducted in the United States of America has found that 50% of parents do not follow through with the recommendations made in their children's psychological reports (Geffken, Keeley, Kellison, Rodrigue & Storch, 2006). Turret (2016) states that possible reasons for this low level of follow through could be the lack of managed care provided to the clients, the increased use of psychiatric medication, and the high costs involved during psychological assessments. Applied to South Africa, with a health care system that is struggling to provide care to its population of 50 million plus residents (Maillacheruvu & McDuff, 2014), with a high level of unemployment (Azia, Mukumbang & van Wyk, 2016), and high costs involved in consulting specialists (Young, Wheeler, McCoy & Weiser, 2014), one cannot help

[2] For the purpose of this study the terms parent, guardian, caregiver and primary caregiver are used interchangeably.

but wonder what percentage of South African parents follow through with the recommendations in their children's psychological reports.

Mental health claims from medical aid providers in South Africa appear to support the American notion that not all recommendations for psychological support are followed through. According to Hlabangane (2016), Alexander Forbes Health has reported that fewer South Africans are claiming for mental health intervention since 2011, despite the fact that mental health challenges, such as depression and bipolar mood disorder, to name a few, are on the rise (South African Depression and Anxiety Group,2018). It thus appears that although South Africans visit mental health practitioners and receive diagnoses, they do not always follow through with the recommended interventions.

Swart and Pettipher (2016) highlight the importance of South African families' access to healthcare services as access thereof has a profound effect on the child's health and psychological development. Usually only families with a higher level of socio-economic status have the means to access healthcare facilities that provide psychological care. Those families who are in that position can join a medical aid scheme that allows for psychological care, such as Discovery Health, Bonitas and Momentum Health, to name a few (Independent Financial Consultants, 2016). It thus becomes evident that families who are unable to become members of such a medical scheme to provide assessment, continuous feedback and intervention, may be at risk of not following through on the recommendations.

Feedback and recommendations following assessments conducted by a psychologist are consistently provided to the parents or caregivers (Tharinger et al., 2008a); therefore, it is the responsibility of the psychologist to convey the results and recommendations clearly, reasonably and empathetically (Tharinger et al., 2008a). It is especially important to emphasise the necessity to follow through with the recommendations (O'Connell, Feehan & Quinn, 2003) and provide skills and tools to aid in strengthening the parents so that they may continue to facilitate support for their children in the absence of the psychologist (Scheel, Davis & Henderson, 2012).

Parents are often fearful and concerned about the entire assessment process (Bostrom, Broberg & Hwang, 2009) and these emotions could be supported through reassuring them that the results will be useful in supporting their children (Tharinger et al., 2008a). Once parents feel comfortable, reassured and consoled about the value

of the assessment, they are usually more likely to follow through with the recommendations that are made in the psychological reports for their children (Tharinger et al., 2008a). Against the background of psychological assessment and feedback, the rationale for this study is presented next.

1.2 RATIONALE

Psychological assessments may be complex and may expose deep-seated emotions within parents and their children prior to, during and post-assessment (Tharinger et al., 2008b). Research has also shown that parents who received reassurance, respect and compassion from the psychologist were better able to cope throughout the process (Williamson, Creswell, Butler, Christie & Halligan, 2016) as well as to make more favourable decisions regarding the recommendations in the psychological report (Tharinger et al., 2008b).

A study conducted in the United States of America over the last twenty five years, has revealed that once psychological assessments are more personalised and include higher collaboration between the psychologist and client, as well as frequent feedback sessions, there appears to be an overall positive response from the clients to the assessment process and the recommended therapy sessions (Turret, 2016). This form of reassurance from the psychologist allows parents to realise the usefulness of the assessments and thus bring about positive change in their children's development and overall well-being should recommendations be followed through (Green & Walker, 2007).

Based on the above mentioned findings, the research for this mini-dissertation will focus on identifying and understanding the various responses that South African parents have to recommendations made in educational psychology reports. This will be achieved by exploring, amongst other considerations, the families' context, their interactions, the available time, finances and medical resources that they have at their disposal. The parents' experiences with the assessment process will also be investigated through the use of an electronic questionnaire. The findings of this study could possibly aid in achieving an understanding of the reasons behind the various responses that the parents have to recommendations in educational psychology reports, as well as the opportunity for educational psychologists to improve their

assessment and feedback, to facilitate more favourable decisions being made by the parents. Additionally, should parents fulfil the recommendations made in psychological assessments, it could lead to the improved current and future wellbeing of the clients. Ultimately, this study intends to understand parental responses to educational psychological recommendations in South Africa, in order to improve mental wellness of children through improved service provision. Having provided the rationale for conducting this study, the purpose of this study follows.

1.3 PURPOSE OF THE STUDY

Seen against the backdrop of the American study that reports limited follow through of psychological recommendations (Geffken et al., 2006), the purpose of this study is to investigate parental responses to the recommendations made in educational psychology reports for children in primary school at the training centre for educational psychologists at the Groenkloof campus of the University of Pretoria, South Africa. Ultimately, the research aims to make suggestions as to how educational psychologists can improve or change their feedback in order to ensure that parents respond favourably to the recommendations and follow through with the recommendations in order to support their children and improve the overall wellbeing of the clients and their families. The research questions that this study will attempt to answer, appear below.

1.4 RESEARCH QUESTIONS

Primary research question

What are parents' responses to the recommendations made in educational psychology reports for their primary school children at a training centre for educational psychologists in Pretoria?

Secondary research questions

1. What are the general responses made by parents in South Africa to recommendations made by psychologists?
2. What are the outcomes of the actions taken by the parents of children in primary schools to the recommendations made in educational psychology reports?

3. What are possible modifications or adjustments educational psychologists can make in their feedback and recommendations in order to increase the possibility that parents make favourable decisions?

The working assumptions for conducting a study to answer the stated research questions are discussed next.

1.5 WORKING ASSUMPTIONS

The main assumption I carry into this study is that parents want the best for their children. I use the term "best" to carry the meaning that parents want their children to perform optimally for their unique potential. This will hopefully be reached by following through with the recommendations made in educational psychology reports as this may facilitate the achievement of the optimal state of wellness in their children. I also assume that the diagnoses, on which recommendations are based, are correct.

1.6 CONCEPT CLARIFICATION

1.6.1 Parents/guardians/caregivers

According to the South African Children's Act 38 of 2005 (Republic of South Africa [RSA], 2005), parents are regarded as the biological mother and father of the child. Due to circumstances such as adoption or death of a biological parent, a parent can also be a step-parent or a legal guardian (Bain, 2009).

1.6.2 Responses

Based on the study by Vaplon (2015), I understand a response[3] to be an individual's production of feelings and thoughts that are triggered by a particular event or experience. In this study, responses are viewed such that parents have a choice to respond in various ways to recommendations.

1.6.3 Recommendations and feedback

Recommendations are made once the results of the assessments are obtained and integrated (Tharinger et al., 2008b), and usually include recommendations for the parents. Such recommendations include parental guidance strategies to facilitate

[3]I am aware of the stimulus-response theory (Whitehead, 2013); however, I am not viewing "response" as a follow-up to a particular stimulus but as authentic communication (Lasley, 2005).

support of the child/client such as recommendations for play therapy (Henderson &Thompson, 2011), learning support and study methods; and the school, such as strategies for teachers to facilitate support in the learning environment (Lerner & Johns, 2012), as well as referrals to specialists in related fields. These referrals could include referrals to occupational therapists, speech therapists, paediatricians, and psychiatrists (American Psychological Association [APA], 2010). Recommendations are usually made during feedback, a process consisting of reporting back the results obtained from the assessment, and aims to facilitate support (Spiller, 2009).

1.6.4 Educational Psychologists

According to the Government Gazette (2011), the Health Professionals Council of South Africa (HPCSA) stipulates that educational psychologists' scope of practice[4] include assessment, diagnosis and intervention. Making recommendations for intervention, that is support, is specifically what educational psychologists do. Working with primary school children is also included in the scope of practice.

1.6.5 Children in Primary school

The South African Schools Act 84 of 1996 (RSA, 1996) stipulates that children between the ages of seven to fifteen are expected to register and regularly attend school (Dulcan, 2016). Therefore, primary school children should commence school in Grade 1 at age six years, turning seven years, and complete primary school in Grade 7, aged between 12 and 13 years (Department of Basic Education, 2017).

1.6.6 Training facility

At the University of Pretoria, the Department of Educational Psychology offers training of educational psychologists. Final year Master Degree students in Educational Psychology conduct interviews with parents at the training facility, do assessments and feedback sessions, and write comprehensive reports containing the results of and recommendations for the specific client (University of Pretoria, 2017).

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[2] The Scope of Practice is currently under review, following the 2016 court case (Justice Alliance of South Africa v. ReLPAG, 2016).

1.7 RESEARCH PARADIGMS

1.7.1 Epistemology

A paradigm consists of a group of assumptions, attitudes, ideas and practices which contribute to an individual's or a community's way of thinking and view of reality (Maree, 2010; McGregor & Murnane, 2010). Additionally, a paradigm includes the composition and the framework of scientific information and assumptions which serve as a platform for researchers to think about and conduct research (Antwi & Hamza, 2015). For the purpose of this study a positivist paradigm is followed. Sefotho (2015) states that a positivist research paradigm is aligned with quantitative research methods, and in that sense measures of objectivity are maintained (Aliyu, Bello, Kasim & Martin, 2014) and subsequent individual or group behaviour could be predicted (Maree, 2010). However, due to the planned sample size in this study, I am aware that making such predictions is not possible. Precision is enhanced through this objectivity as well as through the use of scientific methods to systematise the data gathered, thus revealing and postulating reality as a set of truths and presenting it empirically (Antwi & Hamza, 2015).

The positivist paradigm forms the primary frame of this study as it focuses on collecting quantitative data from the parents (Sefotho, 2015), specifically through the use of an electronic questionnaire developed by the researcher (Maree, 2010; McMillan & Schumacher, 2001), to investigate the various responses that parents have regarding recommendations made in educational psychology reports, whilst continually taking into account the context of the families (Swart & Pettipher, 2016). Positivist researchers maintain a form of detachment from the respondents, a term used in a quantitative study to refer to individuals who participate in the research, thus, ensuring that objectivity is maintained with the goal of making unbiased conclusions and avoiding personal influence on the findings (Edirisingha, 2012). Furthermore, the use of this research paradigm is to strengthen and contextualise the quantitative data received from the parents by using a questionnaire (Antwi & Hamza, 2015). In contrast to the advantages of objectivity and precision, one challenge of the positivist paradigm is that questions cannot be asked to probe the answers of the respondents. One way to address this challenge is to allow for a few open-ended questions in the questionnaire where respondents could mention ideas, facts and/or feelings which in

their opinion have not been addressed by the other questions. These contributions by the respondents may augment the quantitative data and is discussed in detail in Chapter Three.

1.7.2 Methodological approach

This proposed study will use a quantitative research approach (Flick, 2011) through the use of an electronic questionnaire (Creswell, 2014; McMillan & Schumacher, 2001). Turner (2015) reiterates that precision throughout the quantitative research process is achieved because reliable measurement instruments are used and control is practiced through appropriate sampling techniques and design. Challenges of a quantitative approach go hand in hand with challenges of the positivist paradigm, and are discussed in Chapter Three. The research design used in this study is presented next.

1.7.3 The research design

This study will be guided by a survey research design which is described by Creswell (2014) as the means to provide quantitative or statistical depictions of beliefs, perspectives and inclinations of a population by investigating and analysing a sample of that population through the use of an electronic questionnaire (McMillan & Schumacher, 2001). The purpose of the survey that the researcher conducted with the sample is to obtain results about shared beliefs, values and attitudes to depict assumptions and is generated as a means to inform further generalisations to the population (De Leeuw, Hox & Dillman, 2011). Through the use of the electronic questionnaire in this study, the beliefs and feelings of the parents regarding the recommendations will be investigated by using pre-coded questions (De Vos, Strydom, Fouche & Delport, 2011). A discussion of sampling the parents for this study follows below.

1.7.4 Sampling

The sample selected by the researcher should be a “minimised representation” of the whole population which has been distinctly and empirically defined (Flick, 2011, p. 77; McMillan & Schumacher, 2001). As the study investigates parental responses to recommendations in educational psychology reports at the training facility at the Groenkloof Campus of the University of Pretoria, the researcher has to locate parents who were willing to provide information on their experiences (Etikan, Musa & Alkassim,

2015), by gaining access, through permission from the head of the training facility, to the confidential client files stored at the training facility at Groenkloof Campus of the University of Pretoria.

For the purpose of this study, purposive sampling will be employed. According to Ritchie, Lewis, Nicholls and Ormston (2014), this form of sampling is chosen when the researcher wants to explore, investigate and gain in-depth understanding of chosen key criteria from an identified sample early on in the research process. The sample selected by the researcher for this study is parents of children in primary school, who have undergone the psychological assessment process at the training facility at the Groenkloof Campus of the University of Pretoria in 2015 and 2016. Specific inclusion criteria include recent client files (2015 and 2016[5]) pertaining to emotional and scholastic assessments only, clients in primary school and parents with access to e-mail. Specific exclusion criteria include career guidance or subject choice guidance files, files older than two years, clients in secondary school and parents without access to e-mail. The specific years chosen for the case files are recent, assuming that the responses given by parents will probably remain accurate and detailed as they would not yet have forgotten much of their experiences of the assessment process and the recommendations (Flick, 2011; McMillan & Schumacher, 2001). It is also assumed that clinical cases over two years form a good representation of possible cases. The reason for including only primary school learners in this study is because they are the focus of the study and their parents are the primary decision makers in following recommendations, as opposed to secondary school learners who often have more input in recommendations followed.

Since the researcher is currently a registered student in MEd Educational Psychology at the University of Pretoria, access to these files can be granted once ethical clearance is obtained (De Vos et al., 2011). Thus, contact with the parents and the data the researcher seeks to obtain could be accessed through convenience sampling, which is a variant of purposive sampling (Flick, 2011). Flick (2011) explains that convenience sampling is employed when the cases that are chosen by the researcher are the “most easily accessible under the given circumstances” (p. 76) which is time-effective and requires only limited resources to be accessed and utilised. Purposive

[5] Data collection was conducted during 2017, hence 2017 reports could not be included.

sampling allows for advantages such as feasibility because the dedicated research period, finances and effort might be focussed to bring about accuracy in the findings, precise instruments and detailed information with regard to the specificity of this research study (De Vos et al., 2011). However, this form of sampling may be viewed as being too dependent on the researcher's individual judgements (De Vos et al., 2012; McMillan & Schumacher, 2001). Elaboration on purposive sampling may be found in Chapter Three. The data collection instrument answered by the parents in the sample group is presented next.

1.7.5 The data collection instrument

The electronic questionnaire (e-questionnaire) will commence with a series of biographical questions which records the parents' age, gender, income bracket, the number of family members supported by this income, language spoken at home, marital status, number of family members per household, as well as the support systems in place in order to determine the profile of the sample and find possible associations between these biographical variables and other explored variables (Maree, 2016). The e-questionnaire will be designed in an easy-to-read manner consisting of multiple choice questions and two open-ended questions (Maree, 2016). I will ensure that questions are short and specific, simple to understand and ordered from general to specific questions (Salkind, 2010). The questionnaire is developed by the researcher in order to include the variables under research but also leaves room for other possibilities that were not accounted for by the researcher. These may include the various challenges that were faced as well as individualised experiences of the assessment and feedback processes (Welman, Kruger & Mitchell, 2005). Possible advantages of an e-questionnaire are cost and time-effectiveness as well as the convenience for both the parent and researcher (Maree, 2016). However, this form of questionnaire may run the risk of low response rates, uncontrolled environments in which the e-questionnaire is completed, the researcher being unable to assist the parents whilst completing the e-questionnaire and that parents may allow somebody else to complete the questionnaire (De Vos et al., 2011; Maree, 2016).

1.7.6 Validity and reliability

Validity may be defined as the degree to which the findings obtained by the research precisely represents the actual happenings within the given situation (Welman et al., 2005). This requires that the questionnaire that is developed and employed as the

instrument for data collection, to investigate the parental responses, actually measures parental responses. Consequently, this is referred to as construct validity of the scores obtained from the questionnaire (Heale & Twycross, 2015). Reliability of the research findings stipulate the need for consistency in the ability of the questionnaire to measure or assess (Heale & Twycross, 2015); thus, it should investigate the parental responses in the same manner, under the same conditions with the same parents each time it is administered (Biddix, 2009). Expert validity will be sought thus, construct validity and reliability may be improved (De Vos et al., 2011; Welman et al., 2005). For elucidation and results in this regard, refer to Chapters Three and Four.

The researcher intends to seek expert validity after developing the e-questionnaire and ask three academic peers and five educational psychologists in private practice to read the proposed e-questionnaire and comment on its relevance, length, applicability of question items, and comprehensiveness. Only after these results have been incorporated, will the e-questionnaire be administered (De Vos et al., 2011; Welman et al., 2005).

1.7.7 Data collection process

Electronic questionnaire

Data collection will be carried out using the above mentioned electronic questionnaire (e-questionnaire) designed by the researcher, including two open-ended questions at the end of the e-questionnaire, which will give the parents the opportunity to answer in their own words (De Vos et al., 2011). E-questionnaires allow the researcher to obtain quantitative data and statistically analyse and make meaning of the data in order to interpret it (Creswell, 2014). The researcher is aware that the positioning of the questions is important to consider as the "halo effect" suggests that answers are influenced by the question immediately before; therefore, to avoid this it is vital that more general questions are placed at the beginning of the e-questionnaire and more specific questions at the end (Flick, 2011).

The parents will be sent an invitation to answer the e-questionnaire via e-mail and will be provided with a link to the e-questionnaire. This allows the researcher to come into direct contact with the parents in a non-intrusive manner (Andrews, Nonnecke & Preece, 2003). The invitation allows the researcher to explain the purpose of the e-mail, the scope of the study, and ethical guidelines (Maree, 2010). By completing the

e-questionnaire, the respondents are agreeing to informed and voluntary consent, as well as confidentiality and other ethical requirements, as specified and explained in the e-mail **(refer to Appendix D)**. Sue and Ritter (2012) state that questionnaires conducted via e-mail are cost-effective, convenient for the researcher and parents, and are created and set up swiftly.

Additional advantages of employing an e-mailed questionnaire to the parents are, minimal time consumption for the parents whilst completing it, and because the questions will be presented clearly, misunderstandings and vagueness are vastly reduced (Burcu, 2000). By employing an e-mailed questionnaire, the researcher is able to reach all the parents who are willing to participate even though they may not be living in Pretoria or the surrounding suburbs, provided that they have internet access. Consequently, the response rate obtained in this way is usually higher, as the digital format is more convenient (Flick, 2011). Challenges include non-responsiveness, which is often dealt with by e-mailing strategically timed reminders (Creswell, 2014; Maree, 2016). The goal was to collect the data over two weeks during the month of May 2017.

Field notes and reflective journal

I will make use of field notes throughout the research process as this ensures that my proposed study will be effective, the research methods will be more efficient and I could grow as a researcher. The field notes in this study will be used in conjunction with a personal reflective journal **(Appendix F)** and will focus on my reflections of the research process, the questionnaire administered, and the conversations, if any, with the respondents (De Vos et al., 2011; Wolfinger, 2002). In addition, field notes will also assist me in planning the next phase or step in the research process and improve on the end product (Maree, 2010). Prominent news articles pertaining to psychologists or medical aids operating at the time of the data collection, may, for example, influence the parents' responses. Once the data have been collected the researcher will proceed with the analysis of data as described below.

1.7.8 Data analysis

Firstly, the researcher will create a data matrix or numerical value for all the responses for every case (Flick, 2011). In addition, the responses to the open-ended questions at the end of the questionnaire will be categorized and then labelled with numerical

values (De Vos et al., 2011). Errors are typical at this stage of the study, therefore the data should be rigorously checked and cleaned (Shamoo & Resnik, 2015) before being entered into the statistical software application for data analysis (De Vos et al., 2011). For the purpose of this study, descriptive analysis of the data will be employed (De Vos et al., 2011) as the frequencies and percentages of responses are then calculated and ranked. The frequency distribution is obtained and the central tendency (typical response) can be found, allowing the researcher to calculate the dispersions of the results, which may include the mean, median and mode of the responses (Flick, 2011).

Additionally, the researcher attempts to represent the data obtained in an unbiased manner by following the standards specified for acceptable methods of quantitative data analysis (Shamoo & Resnik, 2015). The data interpretation will hopefully clarify the possible responses, for example, in order of frequency of occurrence, parents have to rank recommendations in educational psychology reports of their primary school children and show areas where educational psychologists could improve the feedback process.

1.8 ETHICAL CONSIDERATIONS

Every study of this nature should adhere to ethical considerations which are clarified next. For this research, the Research Ethics Committee in the Faculty of Education at the University of Pretoria will be evaluating and permitting any research to proceed once the researcher has adhered to the stipulated guidelines (University of Pretoria [UP], 2017). Additionally, the guidelines of the Health Professions Council of South Africa (HPCSA), Form 223 (HPCSA, 2004), will be adhered to.

Informed consent and voluntary participation will be adhered to by the researcher and the parents (Maree, 2010), as well as the principle of no harm done to respondents (HPCSA, 2004).The researcher will contact the parents via e-mail, giving a detailed and formal explanation of the study (Mouton, 2001). These details include the aim of the proposed research, the approximate time the parents will spend in answering the e-questionnaire, the course of action in the study, any advantages, dangers or disadvantages they may be subjected to (De Vos et al., 2011) and the credibility of the researcher (Welman et al., 2005).

Confidentiality, privacy and anonymity of the results and findings of the study as well as the protection of the parents and children's' identities are important (Maree, 2010; Mouton, 2001). Parents' rights are respected at all times, and they may refuse to participate in this study at any time, at which time they withdraw from the study without penalty (De Vos et al., 2011; Flick, 2011). The identities of the respondents and the information shared in the e-questionnaire will remain confidential and anonymous; and the results and findings of the study will be shared and illustrated in an anonymous and truthful way (De Vos et al., 2011). Thus the results will be portrayed in a clear and unbiased manner whilst keeping raw data confidential (Maree, 2010).

The researcher will ensure that both the children and their parents are in no way exposed to physical danger and psychological harm (Welman et al., 2005). Should any underlying issues come to the fore during the research period, various options will be made clear to the parents who are willing to be involved, be it referrals or debriefing sessions (Maree, 2010). Consequently, the researcher ensures the parents that services of this manner will be made available to them (De Vos et al., 2011).

1.9 DISSERTATION OUTLINE

Chapter One: Introduction, contextualisation and overview of the intended research

This chapter introduced the research topic and presented the background to the study. The primary research question and subsequent secondary research questions were then provided. The paradigmatic perspectives on knowledge and methodology put the research into context. The research methodology and design were then presented with reference made to the sample, data collection and analysis.

Chapter Two: Literature review

The second chapter will provide a detailed account of the literature on parental responses to psychological reports and their experiences of the psychological assessment process. These concepts are then integrated within the conceptual framework.

Chapter Three: Research design and methodology

The third chapter will supply a detailed discussion on the particular research methods, design and instruments used in data gathering, including the advantages and challenges associated with each.

Chapter Four: Research results and findings

Chapter Four will present the results and findings of the data analysis according to the appropriate statistical techniques. Results attained in the present study will be validated by literature, and correlated with the literature review in Chapter Two.

Chapter Five: Research conclusion and recommendations

The final chapter will engage in a discussion and explanation of the findings. The research questions will be answered and the possible contributions and limitations of the present study will also be explored.

1.10 SUMMARY

Chapter One introduced the research topic, and gave a South African contextualisation of the topic. The topic was focused into a purpose of the study, with the corresponding primary and secondary research questions. For the sake of clarity, working assumptions were highlighted and concepts described. The epistemological and methodological paradigms flowing from the research topic were introduced (positivism and quantitative paradigms respectively), followed by the research design, sampling, instruments, data collection and data analysis. Efforts to uphold the validity and reliability of the research were introduced as well as efforts to maintain ethical integrity.

Visually the research process to be followed in this study can be depicted as in Figure 1, showing the intended content of each chapter, the anticipated flow of the research process and the directionality among the steps of the research process. Each chapter will contain a description of the intended content as well as the relation to the other research steps.

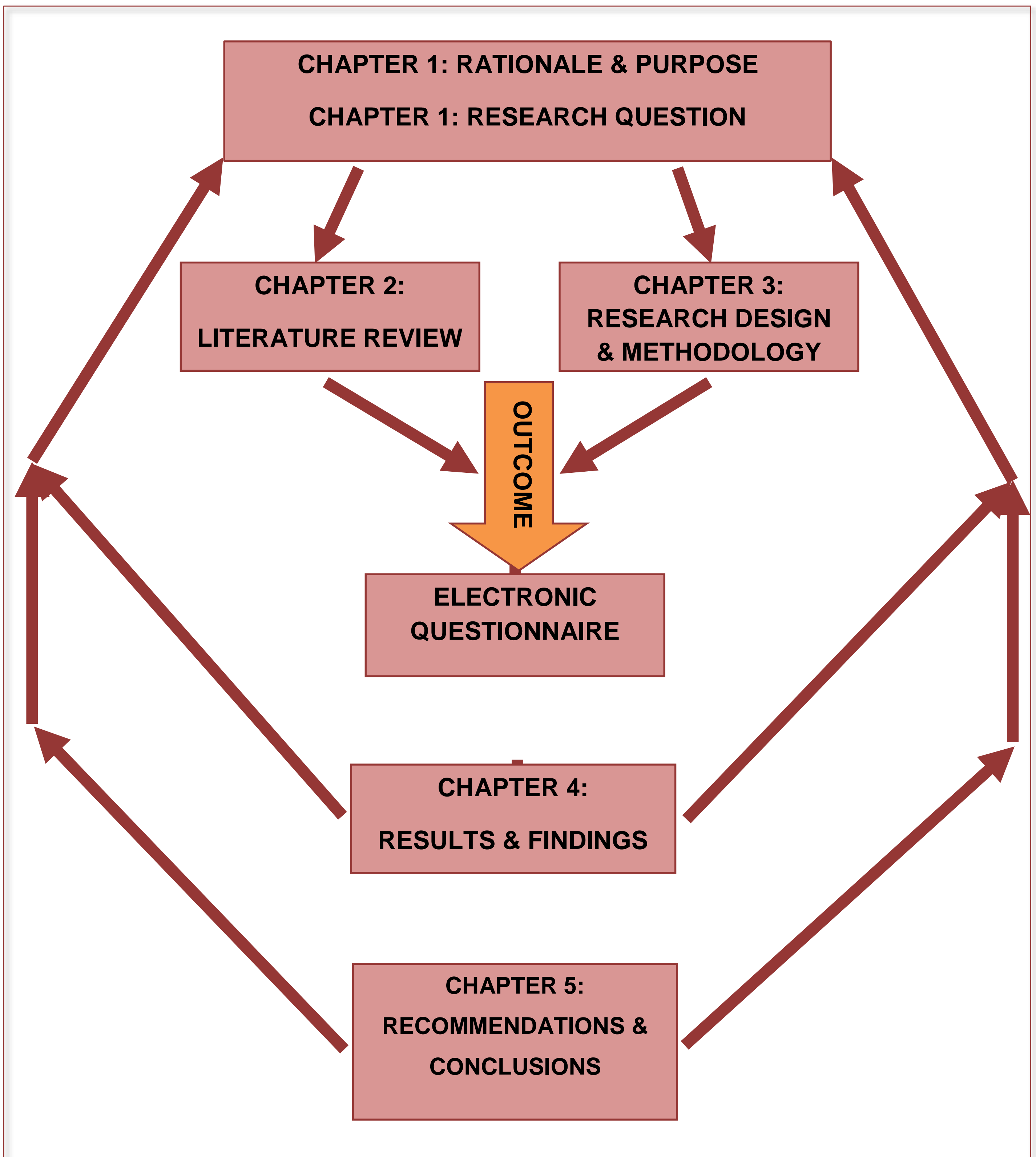

Figure 1.1: Visual representation of the research process

Chapter Two follows, giving an overview of salient literature regarding international and national research relating to the topic under study, and also presenting the theoretical framework underlying the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter One introduced and contextualised the primary research question. Guided by the primary research question, Chapter Two will explore some of the available salient literature regarding parental responses to recommendations given by educational psychologists. Since there is a paucity of literature on parental responses to recommendations by educational psychologists, the literature review incorporated parental responses to recommendations given by medical and other professionals, in order to glean information which may cast light on the current study. International and national research studies were consulted. From such a comprehensive literature review, the applicable theories underlying the research question will surface. Chapter Two will, therefore, also include an investigation into the various theories which are applicable to this study as this forms the theoretical standpoint/s that I wish to base my research on.

2.2 INTERNATIONAL RESEARCH REGARDING RECOMMENDATIONS

2.2.1 Medical doctors and other professionals

For several decades, medical doctors have been apprehensive about the fact that 20% of their patients[6] do not follow through on their suggested recommendations (Reinberg, 2017). In a study conducted in the United States of America in 2011, it was reported that 2% of the patients admitted to a hospital had left against medical advice and a further 20% of patients did not seek to fulfil their prescriptions (Koven, 2013). This study, amongst many others, brought about the issue of why patients do not follow through with these recommendations. It was stated that non-compliance with medical advice/recommendations is a result of patients not being able to fulfil costs incurred,

[6] It is convention that people who consult medical professionals are called 'patients', whereas people who consult mental health care practitioners are called 'clients'. The assumption is that patients are ill with the illness located internally, whereas clients require support as the source/s of the concern can be dealt with systemically.

being afraid, defeated or embarrassed, and some patients have reported that they feel misinformed (Koven, 2013).

Reinberg (2017) adds that most patients reported to have followed through with the recommendations if they communicated thoroughly with the doctor and understood precisely why these recommendations were to be carried out. Another factor that influenced patients in following through with the recommendations made, was if the patients themselves approached their doctor and asked for a referral to a specialist or for recommendations. These patients also stated that due to reasons such as not having enough time at their disposal, their medical conditions rectifying themselves, a poor working relationship with their doctors, as well as disagreeing with the advice they were given, they did not follow through with the recommendations (Lerner, 2014; Reinberg, 2017).

Brin (2017) refers to a study conducted in 2012 and 2016 by The Centre for Disease Control and Prevention (CDC) that one in four adult patients do not follow through with their doctors' recommendations which has led to dire consequences. An astounding 125000 deaths occurred annually, from patients not following through with their recommendations, which in turn elevated the costs incurred by the US health system. A number of factors including socio-economic status, level of education and physical obstacles to drug access have influenced patients in being unable to follow through with their recommendations (Brin, 2017); however, Crane (2014) is of the opinion that miscommunication between the patient and his or her doctor is the core issue which leads to recommendations not being followed.

2.2.2 Mental health practitioners

People seek the guidance of various mental health professionals of their choice to overcome a range of concerns which they may have (Lerner, 2014; Reinberg, 2017); however, a number of factors appear to influence how effective therapeutic visits are and how likely it is that recommendations made by the psychologist or therapist is followed through (Nsamenang & Hirsch, 2015). A study on non-adherence to recommendations made by various healthcare providers in the United States of America was conducted and the results revealed that 15% to 93% of people did not adhere to these recommendations (Nsamenang & Hirsch, 2015). Clients who have sought help are usually under stresses that are linked to whatever condition for which

they may be seeking support (Venzin, 2017); thus the reasons for non-adherence stated in this study included the clients' stress-related forgetfulness, miscommunication between the clients and their therapists as well as disregard for the recommendations altogether (Nsamenang & Hirsch, 2015).

The World Health Organisation (WHO) has stated that following through, adhering or complying with recommendations made by a psychologist or therapist is a multifaceted and dynamic process which is unique to each client, and the following five aspects have been identified as affecting this process, namely

- socio-economic factors, such as lack of familial support, a shortage of finances, a low-level of education, unemployment or poverty;
- therapy-related issues, such as the duration of the session and its complexity;
- healthcare system issues, such as the clients' access to medical aid, their relationship with their therapists, and efficacy of the therapists;
- diseases the client may be affected by, which lead to disability, symptom severity and poor prognosis; and
- lastly, the clients' personal attributes such as their attitude towards the therapy, their knowledge and expectations (Nsamenang & Hirsch, 2015, p.399).

Often, if the clients are afraid for any reason, confused about the therapeutic process or feel sceptical or perhaps even unsure, it leads to feelings of negativity towards the therapeutic process and interventions, thus most likely leading to a low level of motivation and, subsequently, to the non-adherence, non-compliance or non-fulfilment of the suggested recommendations (Nsamenang & Hirsch, 2015).

Baylis, Collins and Coleman (2011) paint an even bleaker picture than Nsamenang and Hirsch (2015). According to Baylis et al. (2011), recent studies have indicated that of the reported 10 – 20 % of children who face mental health challenges, a mere 0.2 % of these children actually receive the assistance that they require, and of the 0.2 % there is a high dropout rate during the therapeutic process. They are of the opinion that these results highlight the magnitude of required effort from psychologists so that children are more effectively engaged in the therapeutic process and particularly that therapy is completed by the child.

The Australian Department of Health proposed that factors such as a collaborative relationship, a strong therapeutic alliance, ample support from the psychologist, putting the client's needs and interests first, and maintaining mutual respect influenced the positive outcome of the therapy (Venzin, 2017). Additionally, Venzin (2017) states that clients were less likely to follow through on recommendations if these went against their personal beliefs or values and if the client felt judged, ashamed or emotionally unsafe with their therapists. Thus, from international research it appears that understanding the impact of an individuals' ability, their socio-economic status, their hopefulness, their knowledge of the challenges with which they are faced as well as customised, realistic and dedicated support plans, set the stage for their adherence which is an essential step in their overall well-being (Mayer, 2007; Nsamenang & Hirsch, 2015).

2.3 NATIONAL RESEARCH REGARDING RECOMMENDATIONS

2.3.1 Medical doctors and other professionals

According to Barnett et al. (2013), a study conducted in 2010 in Cape Town, South Africa, on adherence and barriers to adherence to treatment for HIV/AIDS reported that 20000 people out of a total population of 500 000 in that area were receiving antiretroviral treatment (ART). These patients reported that the lack of knowledge on the medication and the treatment process, fear of the rumoured side effects, poor support levels from the clinic staff, poor living conditions, lack of familial support and forgetfulness led to them not adhering to the requisite treatment and discontinuing their treatment.

Added to the barriers to adhering to the ART programme identified by Barnett et al. (2013), are a lack of financial resources as a result of unemployment, poor nutrition due to food scarcity, inability to afford transport to visit health clinics and receive treatment, stigma and lack of familial and social support (Azia, Mukumbang & Van Wyk, 2016; Young, Wheeler, McCoy & Weiser, 2014). Healthcare providers have not been supportive, do not handle their clients' cases with confidentiality and have been disrespectful towards their patients in many cases (Azia et al., 2016). Morbidity rates have been reported to increase as a direct result of non-adherence to treatment requirements and recommendations (Azia et al., 2016; Young et al., 2014), which contribute to many financial and social challenges of the remaining family members.

Furthermore, patients are often afraid of the treatment that they are recommended to self-administer, as they are unsure of what their reaction to the medication may be (Barnett et al., 2013), they have forgotten about what was recommended to them and in some cases, when to take the treatment (Kagee, Remien, Berkman, Hoffman, Campos & Swartz, 2011). Additionally, others reported to being doubtful about any medical treatment of a general nature, which led to their discontinuation of the treatment, without seeking medical help (Medical Protection workbook, 2015).

The question remains whether such factors influence parental responses to recommendations in educational psychology reports for primary school learners as well.

2.3.2 Mental health practitioners

Based on the US study (Geffken et al., 2006) which sparked interest in the current study, my literature study led me to search for similar studies conducted in the South African context. However, thus far, the literature only reveals the processes used and the manner in which counsellors deliver difficult news to parents (Auger, 2006); and the way in which parents respond to diagnoses such as type 1 diabetes in their children (Sedigheh & Mahmoud, 2012), cerebral palsy (Huang & Kellett, 2010), or autism spectrum disorder (Abbott, Bernard & Forge, 2013), to name a few. Literature does not reveal what are parents' responses to educational psychology recommendations in the South African context.

Barnwell (2016), a South African psychologist, stated that mental health services in South Africa continue to be a luxury for those in rural areas and are available only to those in more affluent, urban areas despite the apparent necessity of these healthcare services in rural areas. He adds that although non-adherence is a recurring challenge in the therapeutic process, reasons for this behaviour are not entirely the clients' fault but also the mental healthcare system's fault, which remains unable to meet the clients' needs. According to Theron et al. (2015), South African citizens who consulted with medical practitioners, often presented with mental health issues such as depression and anxiety. Individuals were usually unable to follow through with the recommendations made to seek mental health support as they were totally unaware of mental health facilities, they did not have support from their families and they lacked formal education due to disadvantaged circumstances (Theron et al., 2015; Tola et al.,

2016). Non-adherence is affected quite significantly by factors such as the distance an individual must travel in order to receive health care, the stigma in the community, alteration of living conditions, marital status and socio-economic status (Tola et al., 2016). Additionally, unmarried individuals were less likely to adhere to recommendations made, than those individuals who were married (Theron et al., 2015).

2.3.3 Conclusion

From the literature review both globally and locally, it may be concluded that non-adherence could mainly be ascribed to socio-economic factors and issues with inter- and intrapersonal relationships. However, the literature is mute regarding adherence and non-adherence to recommendations made in educational psychology reports, hence the impetus for the current study. The theoretical framework underpinning this study is discussed next.

2.4 THEORETICAL FRAMEWORK UNDERLYING PARENTS' FOLLOW THROUGH OF RECOMMENDATIONS

2.4.1 Introduction

I have selected Urie Bronfenbrenner's bio-ecological systems theory (Bronfenbrenner, 1994) as one foundation of my proposed study, as the systems proposed in the theory facilitates a closer look at the socio-economic context of the children and their parents (Krishnan, 2010), as well as the intricacies of the various influencing factors, interactions and interrelationships among the child, parent/s and their environment (Swart & Pettipher, 2016) which could influence adherence to recommendations. I have also selected Bordin's therapeutic alliance theory (Johnson & Wright, 2002) to further elucidate the interpersonal relationships which may influence adherence to recommendations. Bordin's therapeutic alliance theory encompasses the influence of a child's context in the therapeutic process and its direct influence on the outcomes of the therapy. Lastly, I initially selected Maslow's hierarchy of needs theory (Maslow, 1943) where motivation is understood as an intrapersonal factor which may further elucidate adherence to recommendations. The relationships among the components of the three theories are represented in Figure 2.1

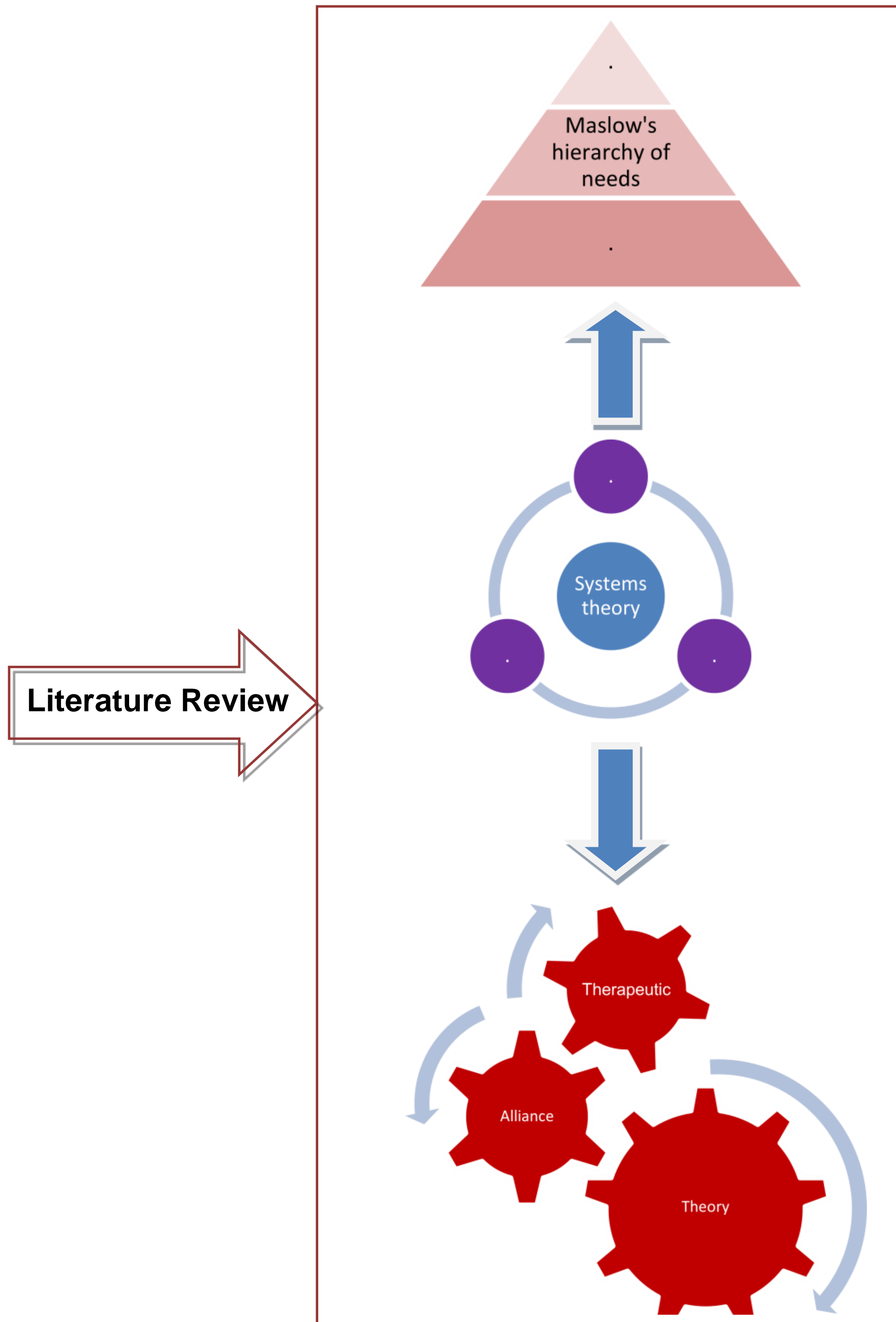

Figure 2.1: The interrelationship among the components of the bio-ecological, motivation and therapeutic alliance theories relevant to adherence to psychological recommendations

2.4.2 Bronfenbrenner's bio-ecological systems theory

"To understand a tree, it is necessary to study both the forest of which it is a part as well as the cells and tissue that are part of the tree." (Levine & Perkins, 1997, p. 113 in Visser, 2010, p. 23).Similarly, the bio-ecological theory allows us to navigate our way through major systems as well as minute processes which could potentially influence parental responses to recommendations; therefore, the value of the bio-ecological theory lies in its contribution to understanding the systems, that is, the individual, their families and their practices as systems (Swart & Pettipher, 2016) involved in adherence, as well as some of the interpersonal relations which may be involved in adherence.

(1) Systems

A number of ecological levels make up the social environment/system. The microsystem comprises a pattern of activities, tasks and responsibilities, and interpersonal relationships experienced between the individual and family which include single parent families, peers, and school within the immediate environment (Bronfenbrenner, 1994; Swart & Pettipher, 2016). This system also takes into consideration supportive factors such as the support from extended family members, the importance and role of ancestral relationships (Pillay, 2014), finances, food, as well as risk factors such as violence and substance abuse (Swart &Pettipher, 2016). The mesosystem refers to a system of microsystems (Bronfenbrenner, 1994), that is, the relationship between one or more microsystems, but also provides the structure upon which various accessible assets are discovered within the immediate environment (Swart &Pettipher, 2016). The exosystem refers to non-direct influences such as the parents' workplace, health and education system which may influence parent-child and teacher-child relationships due to work stressors and circumstances (Swart &Pettipher, 2016; Tudge et al., 2009). The macro system holds cultural beliefs, values, and ideologies (Bronfenbrenner, 1994; Smith, 2016) which may influence stigma towards mental health (Azia, Mukumbang & Van Wyk, 2016). Lastly, the chronosystem embodies the concept of time and the manner in which it relates to the above mentioned systems. Additionally, time includes the changes which occur in the environment, as well as the continuity of human development and the change this brings to each of the systems (Swart & Pettipher, 2016).

(2) Inter and intrapersonal relations

Bronfenbrenner's bio-ecological theory positions proximal processes (P), person characteristics (P), context (C) and time (T) at the hub of the theory, thus recognising the dynamics and interactions of these four dimensions in order to understand behaviour (Swart & Pettipher, 2016; Tudge, 2016), in this study the behaviour of adherence or non-adherence of recommendations. The dynamics of these four dimensions are known as Bronfenbrenner's process-person-context-time (PPCT) model (Bronfenbrenner, 1994; Tudge, 2016; Tudge et al., 2009).

Proximal processes (P) may be described as mutual interactions among the individual in the centre of the systems (in this case the parents or caregivers) and other people, objects and symbols in his or her immediate environment. These interactions should be recurring and frequent in order to be influential to the individual (Mahoney, Gucciardi, Mallet & Ntoumanis, 2014; Swart & Pettipher, 2016). For example, a parent who has a spouse who is negative about psychological support, may have had frequent exposure to discussions about challenges in psychological support, thus contributing to non-adherence to recommendations. However, proximal processes alone cannot generate effective functioning, as they are directed and stimulated by the person's characteristics, and context (Bronfenbrenner, 1994).

There are three types of **person characteristics (P)**, namely demand, resource and force characteristics which influence behavioural outcomes (Tudge, 2016). Swart and Pettipher (2016) describe *demand characteristic*s as an instant stimulus to another person, and include factors such as age, race, physical appearance and gender, as these attributes often influence the level of early interaction, as individuals' initial encounters with other persons may be influenced by their expectations that are formed through the demand characteristics. This is applicable to the child's and parent's initial encounter with the psychologist which in turn may affect their level of trust and the bond that is formed during the therapeutic process (Baylis et al., 2011).The quality of the trust and the bond may subsequently influence the adherence to recommendations (Smits, Stinckens, Luyckx & Claes, 2016).

Resource characteristics include factors that influence individuals to interact effectively with their microsystems, and include social and material resources such as finances, housing, food, family and health services (Swart & Pettipher, 2016). These

influence a family’s capacity to engage effectively with the psychologist (Swart & Pettipher, 2016). The resource characteristics are closely influenced by the economic and the social systems related to the parents/caregivers.

Force characteristics include factors such as motivation, persistence and responsiveness which organise and sustain, or conversely, limit or prevent proximal processes within a system (Swart & Pettipher, 2016). Motivation within individuals (Tudge et al., 2009) usually activates their willingness to interact with various people in their immediate environment (Swart & Pettipher, 2016) and their willingness to reach the desired outcomes through the therapeutic process (Baylis et al., 2011). Motivation as a force characteristic will be further elucidated when Maslow’s theory and the therapeutic alliance theory are discussed later in the dissertation.

The “ecology” of human development can initially be understood through analysing an individual’s **context (C)**, that is, their microsystem, mesosystem, exosystem and macrosystem, but human development is not solely dependent upon an individual’s context but also on the proximal processes (Tudge et al., 2009). Thus it may be assumed that an individual cannot develop nor be understood in isolation but rather as a sum of its interrelated sub-systems within a larger system (Smith, 2011). Thus, it is safe to assume that the families’ context, their socio-economic status, their access to health services, and their level of functioning are factors that influence parental responses to the recommendations in psychological reports (Krishnan, 2010).

The **time dimension (T)** is important to consider when studying interactional patterns of individuals (Tudge et al., 2009). Firstly, the amount of time the child and parents spend with the psychologist may affect the development of and the improvement in the child (Mahoney et al., 2013). Furthermore, the rate of change in development and improvement varies throughout the course of the therapeutic process (Tudge et al., 2009) and often does not progress in a linear manner.

Bronfenbrenner’s bio-ecological theory is applicable to this study, as socio-economic, inter- and intrapersonal factors are incorporated in order to understand human behaviour. As culture is not a factor in applying Bronfenbrenner’s theory, this theory appears to be applicable in the South African context, where many cultures co-exist. In my opinion, his description of motivation, however, lacks some detail, hence my search for a better understanding of parents’ adherence to recommendations.

According to Pillay (2014), Bronfenbrenner's ecological systems theory does not address the African human cycle which includes spiritual and ancestral selfhood periods which include particular developmental tasks within an African context. It is thus possible that the African worldview attached to westernised psychology affects their motivation to follow through with recommendations. To clarify certain issues apart from motivation, it was necessary to examine Maslow's Hierarchy of Needs, which is discussed below.

2.4.3 Maslow's hierarchy of needs

Notwithstanding motivation as a force characteristic in Bronfenbrenner's bio-ecological systems theory (Swart & Pettipher, 2016), additionally, I attempted to understand why parents follow through on recommendations. I initially consulted Maslow's hierarchy of needs theory which reiterates the need for parents to provide all forms of care and support to alleviate distress in their children (McLeod, 2014).

According to Maslow (1943), human motivation can be viewed in terms of his hierarchy of needs theory which elaborates on what motivates parents to provide for their children's needs. In addition, parents are motivated to provide for certain needs of their children in terms of a hierarchy, with physiological, safety and social needs forming the basic foundation of these needs. These needs include the provision of safety, healthcare and support for their children (McLeod, 2014). Once one need is provided for, the next need is pursued and this pattern continues until children grow more independent and are able to provide for these needs themselves, as indicated in Burleson and Thoron (2014).

Motivation is required to be authentic in order to keep an individual driven to achieve the desired goal or result which often includes leaving the person feeling more confident, excited about the outcome, and sure that the result will lead to relief or healing, either in the individual himself/herself or the person for whom they are providing care (Ryan & Deci, 2000). Parental involvement combined with self-efficacy suggests that parents believe that if they act in a certain way, make good decisions on behalf of their children and continue to work towards these goals, it will lead to a better state of wellbeing for their children (Keith & Spaulding, 2011; McLeod, 2014). Parental involvement includes helping their children to succeed in school and reach out to the necessary and available resources of support to do so (Burleson & Thoron, 2014).

Besides, parents' motivation is also positively influenced by their past experiences of successful involvement and intervention in their children's lives (Green & Walker, 2007). Figure 2.2 is a visual representation of the interrelationship between parents as a component of the bio-ecological model, and their motivation as a force characteristic, as depicted by Maslow's hierarchy of needs theory.

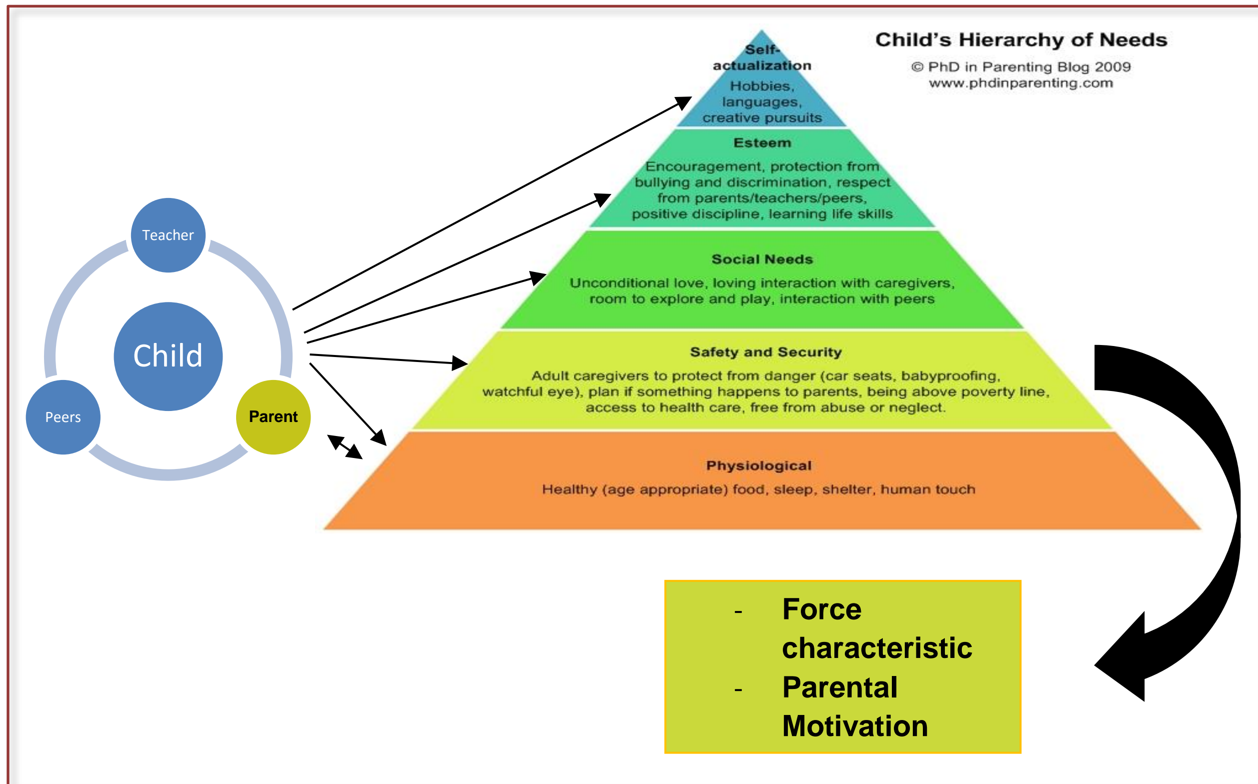

Figure 2.2: The interrelationship between parents and their motivation as depicted by Maslow based on the figure by Parenting Blog (2009).

However, parents' motivation is strongly affected by social, economic and environmental factors (Burleson & Thoron, 2014; Maslow, 1943), consequently, it is imperative to discuss the Health Belief Model (HBM) as a landmark within Maslow's hierarchy of needs theory in order to better understand the influences on motivation.

According to Abraham and Sheeran (2015), Hayden (2009) and Rosenstock (1974), the HBM was developed roughly in the 1950s in the United States of America in order to understand the "health behaviour" of an individual, which involved the actions taken by individuals as they believe the actions will lead to a state of present and future well-being. The theoretical framework of the HBM is made up of several core perceptions or anticipated challenges and experiences that individuals may have on a particular health-related issue that they or a family member may be facing. These perceptions

and experiences include demographic variables, psychological characteristics, anticipated level of severity, possible vulnerability, expected positive outcomes, possible barriers that they may encounter throughout the process, and self-efficacy which ultimately leads to the actions taken. Figure 2.3 below graphically depicts the HBM.

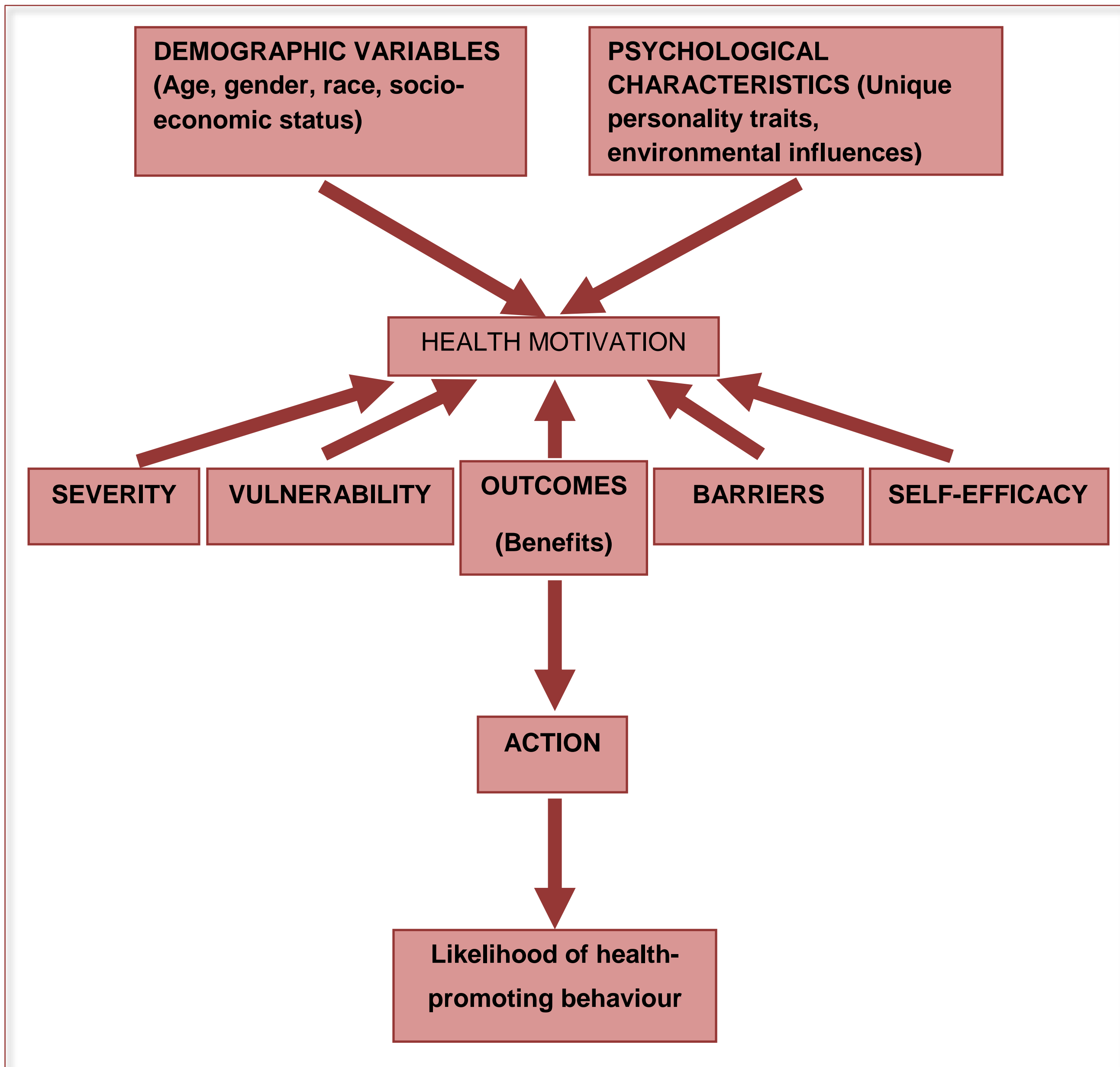

Figure 2.3: The HBM (Abraham & Sheehan, 2015; Rosenstock, 1974)

Figure 2.3 illustrates the HBM and its range of motivating and influential factors which may persuade parents to follow through or, conversely, not to follow through with the recommendations made by healthcare providers (Abraham & Sheeran, 2015). Therefore, it may be assumed that if parents feel that these recommendations are

socio-economically viable, pose promising outcomes and that they are able to handle and overcome the possible barriers, the parents will attempt to adhere to the recommendations (Mayer, 2007; Taylor et al., 2007).

In a simplified version of the HBM, the AIM-model, which stands for ability, information and motivation, provides a comprehensive elucidation of motivation and according to Mayer (2007), adherence and conversely non-adherence could be better understood in terms of the AIM model, as depicted in Figure 2.4. This interactive model states that a client will usually adhere to the recommendations if he or she is physically and mentally able, has access to the necessary information and is self-motivated. However, there are obstacles within each dimension of this model, such as *ability–related obstacles* which refer to the client's physical inabilities such as physical impairments or cognitive impairments; or *information-related obstacles*, such as a client's lack of information on the diagnosis and condition or if he or she is unsure about the intervention methods; or *motivation-related obstacles* such as denial of their diagnosis and fear of possible dependency. The overlaps amongst information and ability of the AIM-model and the demographic variables, psychological characteristics, anticipated level of severity, possible vulnerability, expected positive outcomes, possible barriers and self-efficacy of the HBM is apparent.

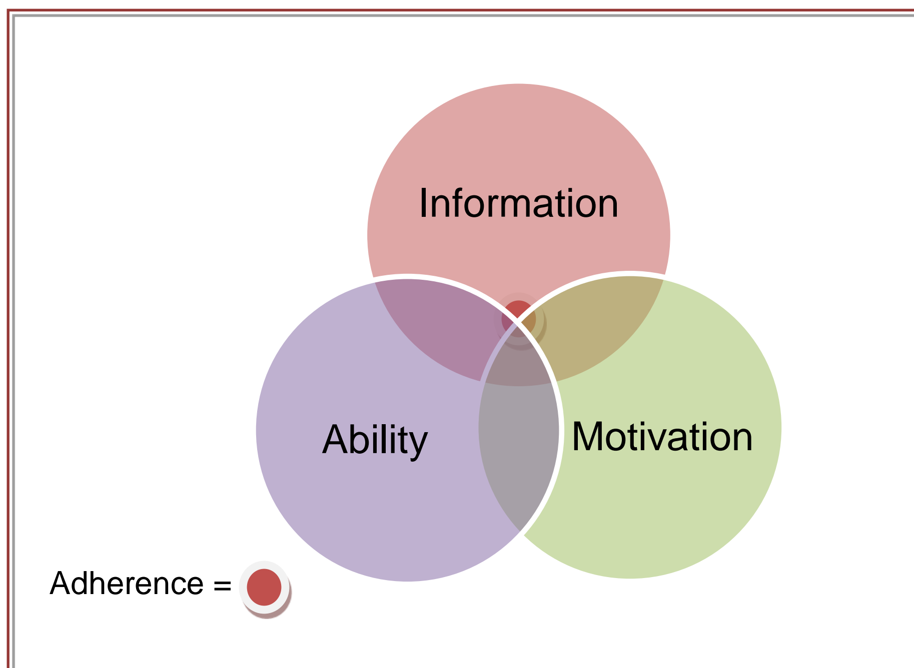

Figure 2.4: The AIM-model, explaining adherence to recommendations (Mayer, 2007).

Although Maslow's theory of hierarchical needs could be criticised for disregarding that some individuals tend to put the need of others before their own basic needs, he paved the way for the HBM which incorporates more factors in decision making regarding matters of health and wellbeing. Based on additional criticism regarding the lack of relevance to the African context (Pillay, 2014), I choose to disregard Maslow's theory in favour of the Health Belief and AIM-models in understanding parental adherence/non-adherence to recommendations made in educational psychology reports (See Figure 2.5 for a revised conceptual framework as previously presented in Figure 2.1).

2.4.4 Bordin's therapeutic alliance theory

In an effort to encompass the child's context and the reasons behind seeking therapy, I sought the therapeutic alliance theory (Bordin, 1979) and its applicability to this study. This theory highlights the important and pivotal role that the therapeutic alliance plays in the therapeutic process (Baylis et al., 2011).

The term therapeutic alliance may be understood as the quality and nature of contact, communication (Kazdin, Whitley, Moira & Marciano, 2006) and mindful collaboration (Johnson & Wright, 2002) between the psychologist and the child (and caregivers) in therapy (Kazdin et al., 2006). Therefore, owing to the fact that the therapeutic alliance is central to the entire therapeutic process (Baylis et al., 2011), the strength of the therapeutic alliance has a firm association with positive outcomes that may be reached throughout the therapeutic process (Haugen, Werth, Foster & Owen, 2016).

Following assessments conducted by a psychologist, feedback and recommendations that are consistently provided to the parents (Tharinger et al., 2008a; Turret, 2016), it is the responsibility of the psychologist to convey this information clearly, reasonably and empathetically (Geffken et al., 2006; Tharinger et al., 2008). It is especially important for the psychologist to convey the necessity to follow through with the recommendations (O'Connell, Feehan & Quinn, 2003) and provide skills and tools to aid in supporting the parents so that they may continue to facilitate support for their children in the absence of the psychologist (Scheel, Davis & Henderson, 2012). Consequently, it is important to remember that children are referred for therapy by a teacher or parent, thus children often attend therapy involuntarily, which makes building a therapeutic alliance with the child more challenging than with an adolescent

or adult who are more informed about the process and have chosen to undergo therapy voluntarily (Baylis et al., 2011).

Children may feel vulnerable and distressed pre-therapy and during the initial stages of the therapeutic process (Black et al., 2006) as they are expected to trust a strange adult whom they may view as a figure of authority and thus find it intimidating and even frightening (Baylis et al., 2011). Therefore, parental involvement is crucial in order to comfort and guide the child to assist him/her in understanding the process as clearly as possible (Green, 2009).

This leads to the importance in understanding the child's home environment, school context, peer relationships and the possible challenges that are currently being faced, as only once this is clearly communicated by the parents and teachers to the psychologist, can an initial stance be taken on the therapeutic process that follows (Kazdin et al., 2006). Green (2009) adds that parents model social relationships through interactions with their children, which become the basis for forming an attachment style between the parent and the child. This attachment and patterns of social interactions also set the tone for the child's attitude with the psychologist (Green, 2009) and is a factor that affects the strength of the therapeutic alliance (Kazdin et al., 2006). Thus, in forming a therapeutic alliance with the child who is the client in this study, additionally, the psychologist should form an alliance with the parents or caregivers (Baylis et al., 2011). Moreover, these two separate alliances ought to be a congruent match for successful interventions to be established to support the child outside of therapy (Johnson et al., 2002). There must be an overall consensus between the psychologist and the child as well as the psychologist and the parents or guardians with the therapeutic process (Baylis et al., 2011) in terms of goals (Smits, Stinckens, Luyckx & Claes, 2015), tasks and the emotional bond (Goldberg, Davis & Hoyt, 2013).

According to Baylis et al., (2011) the psychologist should exhibit personality characteristics which exude warmth, empathy, compassion, active listening, flexibility and honesty towards the client as well as towards the parents (Black et al., 2005).Although the therapeutic alliance is initiated by the psychologist, it is the clients that set out the foundation for the alliance through their unique personality and needs (Black et al., 2005). If the client is readily able to identify and recognise the challenges

and remains motivated throughout the therapeutic process, the alliance is thus strengthened and more positive outcomes are usually expected (Baylis et al., 2011). Congruency in agreement must be maintained among the psychologist, child, parents and healthcare schemes in order to ensure that there are no further implications that may hamper or interrupt the therapeutic process, therapeutic alliance and overall progress (Johnson et al., 2002; Kazdin et al., 2006).

Recommendations based on psychological assessments are focussed on the children's specific individual challenges. As a result, their stress levels could subsequently be reduced, and improvements in their functioning and overall well-being could be achieved if recommendations are carried out. Thus, the necessity of favourable parental decisions to these recommendations is highlighted (Turret, 2016) as parents take full legal responsibility on the best interest for their children and make decisions on their behalf (Cumming, Mawdsley & De Waal, 2011).

The ultimate goal of creating and maintaining a strong therapeutic alliance is to improve and maintain the client's optimal functioning and well-being (Haugen et al., 2016). According to Kazdin et al. (2006), research has proved that forming a strong therapeutic alliance with the parents of the child in therapy leads to more positive outcomes as the psychologist is able to enable parents to improve their parenting practices at home as well as providing the parents with the skills to react appropriately to their children's behaviours and challenges.

2.5 SYNTHESIS

Bronfenbrenner (1994) incorporated the socio-economic systems and interpersonal and intrapersonal relations in general development and behaviour. The HBM and AIM models attempted to focus attention on the motivation of parents, specifically in understanding adherence to recommendations, and the therapeutic alliance theory focuses attention on what happens specifically in a therapeutic relationship.

Based on the criticism and relevance of the theories described above, Figure 2.5, designed by the researcher, is a conceptual framework depicting the relations among the relevant theories which allow us to understand adherence or non-adherence of recommendations. It could be regarded as a possible model for understanding adherence to recommendations.

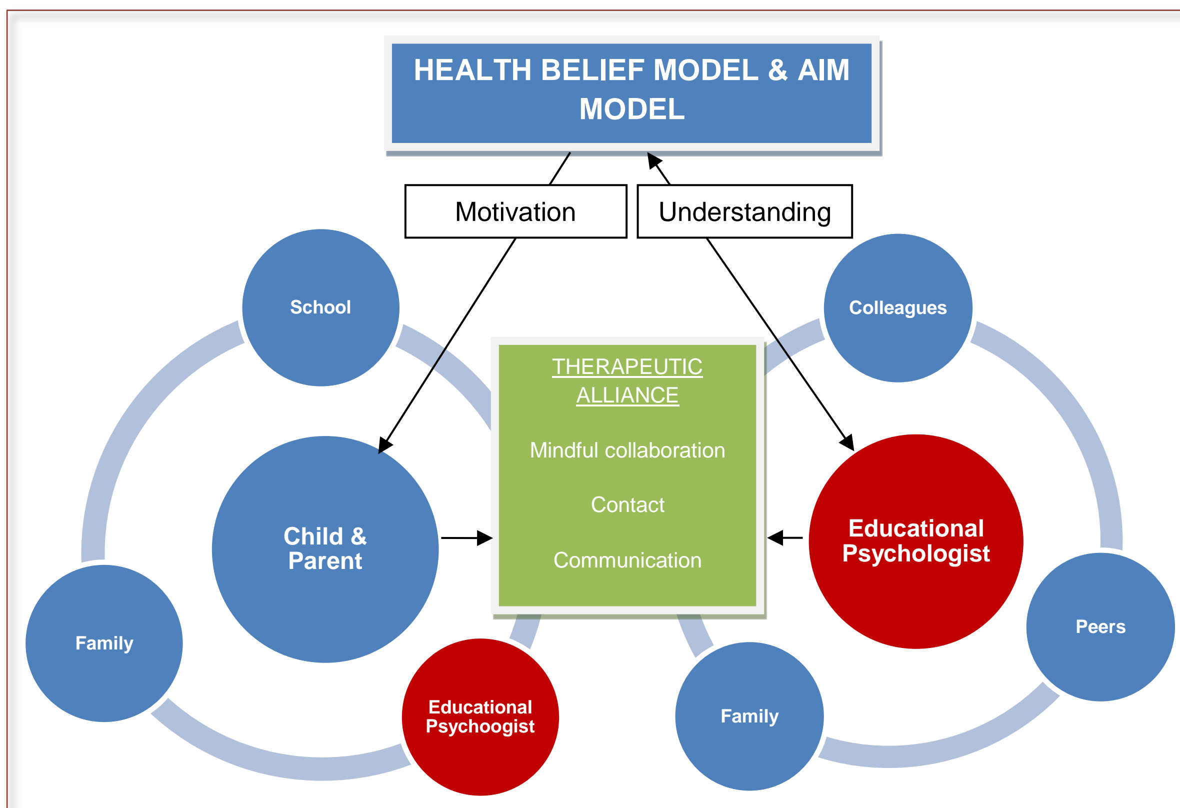

Figure 2.5: The proposed model for understanding adherence to recommendations

From the literature, it appears as if the parents' context, as explained by Bronfenbrenner, in conjunction with the psychologist's context, is linked by the therapeutic alliance theory, in other words, the contact, communication and mindful collaboration between the client (parent/child) and the educational psychologist can co-determine adherence/non-adherence. Additionally, the motivation for adherence/non-adherence of the client (parent/child) can be explained by the HBM and AIM models. Understanding of the HBM and AIM models by the educational psychologist could increase motivation and hence adherence to recommendations.

2.6 CONCLUSION

From the literature study it is apparent that reasons for adherence or non-adherence to recommendations exist internationally in the medical and mental health fields. Reasons for adherence or non-adherence to recommendations in South Africa exist only in the medical fields, and not in the mental health fields of work. Understanding parents' behaviour regarding adherence or non-adherence to recommendations after educational psychology assessments will contribute considerably to improve the mental health of children when recommendations are followed through.

Chapter Three contains the research methodology employed to investigate parental adherence/non-adherence to recommendations in educational psychology reports.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The primary research question which drives the study investigates parental responses to recommendations made in educational psychology reports of primary school children at a training facility in Pretoria. Based on the primary research question, the literature review in Chapter Two summarised international and national studies pertaining to parental responses to recommendations by medical practitioners and mental healthcare workers. Emanating from the literature review, Bronfenbrenner's bio-ecological systems theory, motivation as an influential factor through the Health Belief Model and AIM-model, and lastly, Bordin's therapeutic alliance theory were selected as theoretical foundations for this study.

In this chapter, based on the primary research question, I discuss the preferred research methodology and design used in this study in order to answer the related primary and secondary research questions. This chapter contains a discussion of the chosen theoretical and epistemological paradigms, a description of the research design as well as the procedures employed in sampling the participating parents. The data collection methods used, the measuring instrument, and the process of data analysis will conclude this chapter.

3.2 RESEARCH PARADIGM

3.2.1 Epistemology

Taylor and Medina (2013) explain a paradigm as a broad and all-inclusive belief system, perspective, or structure which serves as a guiding tool for research and practice in a specific setting. This belief system serves as a lens through which individuals and communities think and view reality (McGreggor & Murnane, 2010). Epistemology as a paradigm explains the origin of knowledge (Cohen, Manion & Morrison, 2007; McMillan & Schumacher, 2001). In this study positivism will be used as the guiding tool for research and practice. The positivist research paradigm

articulates that reality exists outside of the researcher and thus should be explored through the meticulous process of scientific inquiry (Gray, 2014).

Positivism maintains objectivity throughout the research process (Taylor & Medina, 2013) which ensures that accuracy is sustained when utilising methods of quantitative data collection (Antwi & Hamza, 2015), whilst maintaining that the researcher remains separated from the respondent (Edirisingha, 2012). Additionally, positivism is associated with phenomena, such as understanding human behaviour, that are both observable and measureable (Cohen et al., 2007; Salkind, 2010), as well as predictable in the future (Maree, 2010). Cohen et al. (2007) explain that the positivistic paradigmatic approach may aid in highlighting that science is most likely the clearest way in which knowledge is illustrated; therefore, relationships may be established, predicted, generalised and even replicated. As a research paradigm positivism consists of quantitative research methods (Sefotho, 2015) and will form the structure of this study as quantitative data is collected through the use of an electronic questionnaire designed by the researcher (McMillan & Schumacher, 2001), which is aimed at capturing the various parental responses to the recommendations made in the educational psychology reports.

In contrast to the advantages of objectivity and precision, a possible challenge of the positivistic research paradigm is that generalisations of the results can only roughly portray the truth but cannot prove or disprove the truth (Gray, 2014). Cohen et al. (2007) highlight another challenge of the positivistic research paradigm by suggesting that human behaviour is extremely intricate, thus measuring and understanding it objectively is not entirely possible. The researcher agrees with this statement and realises that the results of the study will only portray part of the reality of human behaviour regarding the adherence to recommendations. Another challenge of the positivist paradigm is that questions cannot be asked to probe answers in an electronic questionnaire. One way to address this challenge is to allow for a few open-ended questions in the questionnaire where respondents may mention ideas, facts and/or feelings which in their opinion have not been addressed by the other questions. These contributions by the respondents may augment the quantitative data (Creswell, 2014; Maree, 2016).

3.2.2 Methodology

Conducting research in the educational field often involves using methods that are either qualitative or quantitative in nature (Muijs, 2004). A manner in which a clear distinction can be made between these two research approaches is that quantitative research collects directly measurable data, making it possible to construct generalisations (Bacon-Shone, 2015) with positivism as the underlying philosophy of quantitative research (Salkind, 2010). Frels and Onwuegbuzie (2013) state that quantitative research approaches are useful in answering questions pertaining to who, how many, where and how often, that is, as the rates and frequencies of the chosen variables and phenomena in the particular research. Quantitative studies generate measurable numerical results of certain characteristics of the sample of interest which may be generalised to the overall population and parallel circumstances, thus allowing justifiable predictions to be made (Creswell, 2014).

Maree and Pietersen (2016) describe quantitative research as an organised and logical process which objectively gathers and utilises numerical data from a sample of a larger population in order to generalise the obtained results to the larger population. Quantitative research typically utilises mathematical procedures for statistical investigation (Salkind, 2010).

Some advantages of quantitative research include the swiftness with which it can be administered and evaluated (Choy, 2014). In this study the electronic questionnaire does not require the researcher's time to be administered and responses are quickly recorded and tabulated (Maree & Pietersen, 2016) by the qualtrics[7] programme. Furthermore, the numerical data is gathered legitimately and meticulously using correct methods and can thus be critically analysed which often increases the validity and reliability of the instruments used and the results obtained (Choy, 2014).

However, large-scale research is often challenging due to the lack of, or limited finances available for resources (Choy, 2014), as well as the potential risk of not receiving sufficient responses to the electronic questionnaire from the respondents (Maree & Pietersen, 2016). An additional challenge is that quantitative research does

[7] Qualtrics is a refined, yet uncomplicated, digital research programme to develop and distribute surveys for any audience using any pathway; used in over 2000 universities and 90 countries. (Qualtrics, 2018).

not account for a deeper understanding of the respondents and their experiences, views and contexts (Rahman, 2017; Salkind, 2010). However, for the purpose of this study, the electronic questionnaire (e-questionnaire) is designed to gain as much detail of the parents' responses to make informed recommendations possible. The e-questionnaire consists of very specific questions, based on theories and options, to elaborate upon, should their specific experience not be provided; consequently, open-ended questions are included at the end of the questionnaire. Open-ended questions attempt to bridge the gap and aim to gain a deeper understanding of the parents' responses to recommendations.

3.3 RESEARCH DESIGN

3.3.1 Survey Design

The survey design is specifically selected for this study. It is described by Creswell (2014) as a quantitative and numerical depiction of movement and development, thoughts and beliefs of a larger population through studying a sample within that particular population. Data gathered from this representative sample and subsequent results obtained enable the researcher to depict generalisations and deductions about the entire population (Creswell, 2014; Welman, Kruger & Mitchell, 2005). The survey design is an aspect of non-experimental research as samples are not selected randomly nor is the overall aim of the research to plan and implement interventions (Welman et al., 2005).

Non-experimental designs guide descriptive research studies where respondents are selected to take part in the research and their responses are captured at a particular time (Maree & Pietersen, 2016). Furthermore, non-experimental designs do not involve any data manipulation (such as ANOVA) and surveys are most commonly used in order to gather quantitative information from the sample in order to explore certain research topics (Maree & Pietersen, 2016; Salkind, 2010). Samples of the respondents in survey research are usually selected before the administration of an electronic questionnaire or carrying out interviews (McMillan & Schumacher, 2001) which are designed and employed to gather the respondents' thoughts, feelings, experiences and biographical information (Maree & Pietersen, 2016; McMillan & Schumacher, 2001).

Some of the advantages of using the survey research design include the collection of a substantial volume of data from the respondents in a short time, whilst being cost-effective (Creswell, 2014). Moreover, survey research designs contain a significant degree of flexibility as the researcher has a variety of ways to collect the data, for example, using questionnaires or face-to-face interviews, electronically or via post, depending on the most convenient, appropriate and reliable method as decided upon by the researcher (Muijs, 2004). This study makes use of the survey research design through the employment of an electronic questionnaire (Maree & Pietersen, 2016) whereby parents' experiences, thoughts, feelings and demographics (Creswell, 2014; McMillan & Schumacher, 2001) are investigated and reported on by using pre-coded questions (De Vos, Strydom, Fouche & Delport, 2011).

As previously mentioned, a lack of probing could be challenging, which was dealt with by including open ended questions in the survey. Some contextual influences, for example a negative news report dealing with psychological services, might also influence respondents collectively. The researcher aimed to read newspapers and social media during the time of data collection and make relevant notes of possible contextual influences in a reflective journal. To address the challenge of respondents not returning the survey, timeous reminders were sent, gently prompting respondents to complete the survey before a certain date. Currently, an international study indicated the expected response rate of electronic surveys to be 33% (Nulty, 2008). For the purpose of this study even a low response rate would be used to demonstrate research skills.

3.3.2 Sampling and selection of respondents

Sampling is understood as the careful selection of respondents from a larger population in order to generate information that could be clearly and empirically verified (Creswell, 2014; Flick, 2011) and generalised to the population it represents (De Vos et al., 2011). The sampling frame is determined by the research question as it outlines the various characteristics that need investigation (Wahyuni, 2012). This study aims to investigate parental responses to the recommendations made in educational psychology reports at the training facility for educational psychologists at the Groenkloof Campus, University of Pretoria; therefore the researcher selected parents by accessing confidential files, through obtaining permission from the head of the training facility and ethics committee, containing the clients' psychological reports

and their parents' contact details (Etikan, Musa & Alkassim, 2015). This is an example of utilising the purposive sampling technique in order to select the appropriate sample (Ritchie, Lewis, Nicholls & Ormston, 2014).

Purposive sampling may also be known as "judgemental sampling" as the researcher judges which sample contains the respondents with the best/most attributes and characteristics of the larger population which it represents (De Vos et al., 2011). Often purposive sampling requires the use of pilot studies to determine precisely which population sample is needed for the study (Latham, 2007). Additionally, purposive sampling often makes rich and detailed information available to the researcher to accurately and meticulously investigate the research questions (Ritchie et al., 2014), as the data yielded by the purposive sample are often most appropriate.

The following criteria were adhered to when selecting parents for the electronic questionnaire:

1) The client files were recent. Only files from 2015 and 2016 were used to ensure that the cases were recent enough for the respondents to remember well. By thus supporting memory, it is expected that respondents' answers would be reliable.

2) The client was in primary school at the time of assessment; this ensured that the clients' parents or primary caregivers had to have given consent for the assessment and were thus responsible for following through with the recommendations made in the educational psychology reports. This is in contrast to assessments which involve high school learners who take more co-responsibility for support and recommendations being carried out.

3) The parents have access to e-mail; the survey was conducted electronically via the programme Qualtrics and this requires the availability of the parents' e-mail addresses.

4) The client underwent emotional and scholastic assessment; the researcher did not wish to include career choice files as this would indicate that the learner was not in primary school but in high school.

Challenges of purposive sampling may include that only a small sample is available from whom to gather information for use in the research and subsequently to make generalisations (Gledhill, Abbey & Schweitzer, 2008). Gledhill et al. (2008) state that

another possible challenge of purposive sampling includes the "gatekeeper effect" (p. 87) as the researchers remain solely in charge of who may best suit their study before conducting the study; thus possibly introducing bias to the sample. By overtly stating the selection criteria, the researcher attempted to prevent any form of bias in the selection of the sample.

3.4 RESEARCH METHOD

3.4.1 Development of the electronic questionnaire

The survey design makes use of various types of questionnaires depending on the type of data that the researcher wishes to collect. The format of an electronic questionnaire (e-questionnaire) was selected for the purpose of investigating parental responses to recommendations made in the educational psychology reports (Creswell, 2014; McMillan & Schumacher, 2001). An e-questionnaire will be easy to send to respondents, easy to complete, easy to collate the answers, and cost-effective.

(1) General instrument description

Maree and Pietersen (2016) state that the overall appearance of the electronic questionnaire should be user friendly with a neat font. The font should also be easily readable. They add that instructions should be unambiguous and easy to understand exactly what is being requested from the respondents. Instructions should also explain how to move forward in the questionnaire and must contain the estimated time it should take to complete it in full with an automated message at completion to thank the parents. The ideal time required for the completion of the questionnaire should not exceed 30 minutes for adults; this electronic questionnaire was set at approximately 15 to 20 minutes (Salkind, 2010; Sue & Ritter, 2012).

(2) Description of questions

In keeping with the neat and unambiguous layout of the questionnaire, the question sequence should also maintain this lucidity by beginning with easy-to-answer questions that do not require much reading and understanding. It is incumbent upon the researcher to ensure that the questions are grouped together in a manner that keeps various themes together and, thus, keeps a logical order of the questions

(Maree & Pietersen, 2016; McMillan & Schumacher, 2001). In addition, the questions should be clearly separated from the response options to maintain clarity. Measures should be taken to ensure that only one question is in fact asked in each question, as overlapping or stacking questions into a single question becomes a stressful experience for the respondents (De Vos et al., 2011; Salkind, 2010). Therefore, easy to read questionnaires, logically ordered questions and an overall well-organised questionnaire supports the respondents to enjoy completing the questionnaire and remain focussed on one topic at a time; thus increasing validity and reliability of the results obtained (Salkind, 2010).

(3) Description of response categories

The multiple-choice questions consist of three or more possible responses but do not exceed six options, as statisticians advise to avoid too many options as respondents may struggle to rank these effectively (De Vos et al., 2011; Welman et al., 2005). A few advantages of multiple-choice questions in an electronic questionnaire include making coding and statistical analysis easier and acquiring sensitive information without making respondents feel uneasy. These types of questions are generally quicker and easier to answer as the response options are provided with an extra option for respondents to add a choice/s that was not provided (Maree & Pietersen, 2016).

(4) Specific instrument description

The above guidelines for questionnaire development were applied and the e-questionnaire was purposefully developed by the researcher for self-completion by the parents. It commences with a brief and welcoming title (Mathers et al., 2009) with instructions listed, which clearly explain how the e-questionnaire should be completed and the expected time for completion (Maree & Pietersen, 2016; Mathers et al., 2009). Next follows a series of multiple choice biographical questions which include the parents' age, gender, home language, and annual income (Salkind, 2010). These biographical questions are easy to answer, non-threatening and non-controversial; therefore, the parents are eased into the questionnaire as respondents should not feel interrogated or uneasy (Maree & Pietersen, 2016; Salkind, 2010). The responses to the biographical questions will allow a profile of the sample to be drawn up in comparison to the larger population, enabling the researcher to determine whether or not the sample is representative of the larger population (De Vos et al., 2011) and to

search for possible links between biographical variables and other relevant variables in the study (Maree & Pietersen, 2016).

The content of the intended e-questionnaire is based on the theories explained in Chapter Two, and includes questions and answer options investigating the socio-economic context of the client, the proximal processes, the motivation for follow through and the therapeutic alliance between the educational psychologist and the client and his/her parents. Open-ended questions provide the opportunity for respondents to add content not already contained in the questions and answer options. The main research question, namely '*What are parents' responses to the recommendations made in educational psychology reports for their primary school children at a training centre in Pretoria?*' strongly influenced the choice of questions. (Refer to Appendix A which contains the first draft/pilot version of the questionnaire).

The responses recorded on the e-questionnaire are usually completely anonymous to the researcher; thus, each questionnaire is given a unique identifier keeping each parent's identity completely confidential (Delport & Roestenburg, 2011; Mathers et al., 2009). Qualtrics, the platform for the e-questionnaire, however, made each participant's e-mail address visible only to the researcher.

The electronic questionnaire was planned by applying the foundational theories into its design, namely Bronfenbrenner's bio-ecological systems theory, Bordin's therapeutic alliance theory and the Health Belief and AIM models. The electronic questionnaire was set out in three distinct sections. Section A of the electronic questionnaire applied Bronfenbrenner's bio-ecological systems theory in its questions through asking questions related to the caregivers' context, their socio-economic status and their environment as this enables the researcher to draw up a demographic profile. However, this theory is also applied in the questions following in Section B and C in order to gain a deeper understanding of their context and eliminate loop-holes where vital information could be asked by asking similar questions spread throughout the electronic questionnaire. Bordin's therapeutic alliance theory and motivation according to the Health Belief and AIM models are applied throughout the entire electronic questionnaire as the questions remain focussed on inquiring information about the caregivers' experience with the educational psychologist, their

experience in terms of the entire therapeutic process and how useful, applicable to their situation and comprehensible the caregivers found the recommendations.

In summary, the first section thus gathered data on respondents' demographics, the second section on their daily activities, support structures, experiences with the therapeutic process and family functioning, whilst the third section focussed on providing the respondents with the opportunity to clarify anything they thought was not clearly depicted in the questionnaire**.**

3.4.2 Piloting the e-questionnaire

The electronic questionnaire was first piloted, through expert validity being sought, before the respondents were contacted and the link to access the e-questionnaire was sent out. It was piloted to detect any possible flaws or gaps in the content of the e-questionnaire and to clarify any ambiguity in the questions or response sections (McMillan & Schumacher, 2001; Welman et al., 2005). Piloting was also done to increase the content validity of the e-questionnaire (see section 3.4.3).

(1) Sampling of reviewers

Three academics in educational psychology and five educational psychologists in private practice were purposefully selected to comment via e-mail on the e-questionnaire. These educational psychologists were selected based on their years' of experience in private practice, their understanding of research, their willingness to support research and their acquaintance with the supervisor.

(2) Results of the reviews

Only one academic responded. The comments were:

- "The presentation is very nice and subtle, with a good colour scheme. It is also user friendly, depending on the computer literacy levels of the participants."
- "Consider including some form of instruction (a few words) at the top of the page, for example: "Click here to start.""
- "Adding a question such as "How many family members live with you in the same house?" "to the background questions."

- “Consider including one or two non-intrusive introductory questions that lead to the recommendations to avoid a big leap from Q1 Block 1, about working hours, to Q2 about usefulness of the recommendations.”
- “With Questions 2 and 3, it is not clear why different words, useful and helpful, are used. Question 3 is asking the degree of usefulness of the response to Q2.”
- “There should be another question on whether or not the participants actually follow through on the recommendations. I could consider the recommendations helpful/useful but then, do not follow through for any range of personal reasons.”
- “Instead or ‘jargon’ or ‘terminology ’in Q5, perhaps ‘language’?”
- “Consider moving Q8 to the section on background information.”

All the comments were addressed in the revised e-questionnaire.

Only two educational psychologists in private practice responded. Comments were:

- “Adding a question to establish where the initial referral came from.”
- “Include a question requesting the parents to list their top choices of educational psychologists that were considered before deciding on the training facility at the University of Pretoria for the assessment process.”
- “A question enquiring if the parents understood the assessment process, if they understood the outcome of the assessment as well as if they understood the psychology ‘jargon’ that may have been used in the educational psychology report.”

The following changes were made:

- Background/demographic questions were expanded to include a question about afternoon care for the child.
- The official languages were labelled more specifically.
- The questions were reordered to create a better flow and to avoid repetition or influence from the previous question.
- Parents were asked where they had heard about the University of Pretoria training facility for educational psychologists at Groenkloof campus.
- Parents were asked if they were able to attend the feedback session.
- Multiple choice options were expanded and worded in a less-threatening/ interrogative manner.

The final e-questionnaire is contained in Appendix B.

3.4.3 Reliability and Validity

According to Welman et al. (2005), validity of the electronic questionnaire may be evident when the results obtained are accurately representative of the actual happenings under the same circumstances. Therefore, validity refers to the fact that the data collection instrument used actually measures what it is designed to measure, in this case whether the electronic questionnaire which is designed to measure parental responses does in fact measure their responses (Delport & Roestenburg, 2011). Although content validity and criterion validity are acknowledged, the researcher applies construct validity as this is the degree to which the research instrument designed and employed measures all the features of a construct (Heale & Twycross, 2015). More particularly, the researcher draws upon homogeneity (which measures one construct) as the type of evidence which demonstrates that the electronic questionnaire in fact has construct validity (Heale & Twycross, 2015).

Reliability according to McMillan and Schumacher (2001) refers to the stability and consistency of the data collection instrument implemented in the study; this consistency must be evident when the same instrument is used on a different occasion and for a different population sample, thus rendering similar results. Heale and Twycross (2015) mention homogeneity for internal consistency, stability and equivalence as the three elements of reliability. Equivalent questions (different questions probing the same aspect) were not employed in the e-questionnaire. For the purpose of this mini-dissertation the opinions of the experts regarding the e-questionnaire were considered sufficient to provide reliability.

3.4.4 Deployment of the electronic questionnaire

The e-questionnaire followed a two-stage approach, as suggested by Creswell (2014), with the initial e-mail consisting of an early-notice letter introducing the researcher, aims of the study and the ethical considerations that are adhered to and signed by the researcher and her supervisor (Maree, 2016; Mathers, Fox & Hunn, 2009) as well as the e-questionnaire itself. After a week, a follow-up e-mail was sent to the respondents which served as a reminder of the e-questionnaire to be completed, thus resulting in a total of two to three weeks for the researcher to receive all the responses from the

parents who consented to participate (Creswell, 2014). Refer to section 3.4.6 for details regarding the data collection process.

3.4.5 Reflective journal

The researcher kept a reflective journal **(Appendix F)** to focus on her reflections of the entire research process, formulating and carrying out the electronic questionnaire, and the discussions, if any, with the respondents (De Vos et al., 2011; Wolfinger, 2002). No incidences in the mass-media which could have biased the respondents were recorded.

3.4.6 Data Collection Process

Table 3.1 illustrates the data collection process as followed by the researcher.

Table 3.1: The data collection process

STAGES	DESCRIPTION
Ethics Clearance	Permission to continue with the study was requested from the Ethics Committee of the Faculty of Education through a formal ethical clearance application process. See (Page ii) for a copy of the ethics clearance certificate received.
Permission	Following approval and receipt of an ethics clearance certificate, permission was requested from the Head of the Training Facility at the Department of Educational Psychology to gain access to clients' files relating to primary school clients (for the years 2015 and 2016), as safely stored by the Department of Educational Psychology (consent to access these files was granted by the Ethics Committee of the Faculty of Education, see Page ii).
Access to files	One hundred and two client files of 2015 and 2016 were accessed to select respondents according to the criteria mentioned in 3.3.2. The researcher found that only the files of 2016 contained e-mail addresses for the respondents. After gaining permission from the Ethic Committee to telephone the prospective respondents from 2015 (see Page ii for

STAGES	DESCRIPTION
	permission), the prospective respondents were telephoned according to a predetermined script and e-mail addresses requested (see Appendix E for the telephonic script).37 client files fulfilled the selection criteria and therefore 37 respondents were invited to participate (n=37).
Informed Consent	Parents who agreed to participate in the study by responding to the electronic questionnaire, provided consent by completing the questionnaire (see Appendix D for a copy of the e-mail sent to respondents where the research was introduced and consent requested).
Description and clarification of the research process	Parents were given details regarding the purpose of the study and the requirements thereof. Parents were informed that they could ask any questions or raise any concerns that they had. The ethics and consent processes were explained to the parents, they were explicitly informed about their right to withdraw from the study at any point without penalty and they were assured of confidentiality and anonymity throughout. Data collected would not be available to anyone apart from the researcher and her supervisor. The parents were invited to complete the electronic questionnaire with a detailed letter and a link to the e-questionnaire via e-mail.
Attrition	Any parents who decided not to participate and those who did not respond at all were regarded as sample drop-outs. The final number of respondents were n= 16, with n=13 completing the entire e-questionnaire. Although the final number of respondents is too small to generalise findings, the rate of feedback was 43.24% which is considerably higher than the expected return rate for surveys, namely33% according to Nulty (2008). As this is a mini-dissertation of limited scope, the final number of respondents was considered large enough to show research competency.

3.4.7 Data Analysis and interpretation

(1) Introduction

Once a comprehensive literature study has been conducted, the research design and methods have been chosen, access to the participants has been granted, then data can be collected and analysed through primary data analysis. In this study, the researcher searched through existing client case files for the parents' contact details (Fouche & Bartley, 2011). Although data analysis only takes place at a much later stage in the research process, it is essential that the researcher plans how to conduct data analysis using the most appropriate data analysis methods, thus ensuring that the data captured is applicable to the research question (Fouche & Bartley, 2011).

Quantitative data analysis can be a complex process encompassing classification and analysis of the data that is collected. Analysis can be conducted through the use of technology such as computer programmes that are designed specifically for data analysis purposes (Delport & Roestenburg, 2011). Quantitative data analysis involves translating the data that has been collected into a numerical form as this allows statistical analysis to take place which could be conducted manually if the sample size is small (Fouche & Bartley, 2011).

(2) Data analysis

The Qualtrics platform did the analysis and only simple descriptive statistics in the form of percentages of the total number of responses on a specific question were made (Section 1 & Section 2 up to Question 11). See Appendix C for an example of the raw data. Question 12 required ranking of possibilities. Qualtrics gave the different combinations of rankings, together with the percentage of the respondents who selected a specific ranking combination. The responses to the open-ended questions (Section 3: Question 1 & 2) were collated and scrutinised for different themes.

(3) Data interpretation

Each question was interpreted individually according to the percentage: the higher the percentage, the more respondents had selected certain responses, increasing the likelihood that that specific response contributed to answering the investigation regarding parental responses to recommendations made by educational psychologists. After the individual interpretation, the results of certain questions were

combined to give richer answers to the current investigation. Kindly refer to Chapter Four for a full discussion of the results and findings.

3.5 ETHICAL CONSIDERATIONS

Both professional and research ethics are at stake.

3.5.1 Professional Ethics

(1) Social Responsibility

As the researcher in this study, I accept responsibility to attend to pressing issues in this particular South African community through my research process (University of Pretoria Code of Ethics for Research, 1999). By means of this present study, I believe that the results obtained may address some of these issues and highlight some of the challenges that these families face. Therefore, this study was particularly planned in order to meet the requirements of the Research Ethics Committee of the Faculty of Education at the University of Pretoria (University of Pretoria, 2017) by going through thorough rigorous evaluation, and thus permission was received to conduct this research.

(2) Beneficence and Non-maleficence

Flick (2011) states that beneficence and non-maleficence refers to the researcher's responsibility to avoid harming the respondents and that the study should bring about various constructive and identifiable benefits. Apart from ensuring that all parties involved are protected from harm, efforts should be made to ensure their wellbeing (University of Pretoria Code of Ethics for Research, 1999). The welfare of all parties is achieved by taking into consideration the possible consequences of the study and weighing the risks involved as well as the benefits (De Vos et al., 2011). I took the necessary steps to assure the respondents that they are well protected by defending my research proposal and obtaining ethical clearance from the Ethics Committee at the University of Pretoria. Arrangements for referrals were made in case participation in the research triggered underlying challenges.

(3) Respect for the individual

Recognising and maintaining the respondents' autonomy is an ethical responsibility of the researcher (University of Pretoria Code of Ethics for Research, 1999) as every

respondent has the right to remain anonymous at all times (Mouton, 2001). I respected the respondents' responses in the electronic questionnaire and took into account possible differences (such as differences in language, culture and socio-economic status) by using unambiguous basic language and formulating questions according to well-researched guidelines.

(4) Professionalism

My professionalism as a researcher is evident as I remained honest and accountable at all times throughout the research process and the presentation of this study (University of Pretoria Code of Ethics for Research, 1999). As an academic researcher, I will ensure that credit is given to all the authors' academic writing that I consulted throughout my research process. I will ensure to leave an audit trail to verify my research process, data and results.

3.5.2 Research Ethics

(1) Informed and voluntary consent

Informed and voluntary consent from the respondents were achieved by the researcher discussing the purpose and scope of the research with the respondents (Flick, 2011) through a detailed letter of consent to participate in the study (Maree, 2016) which was e-mailed to the respondents together with the electronic questionnaire. Respondents were assured that they could withdraw from the study without any detrimental consequences to them (see Appendix D for the letter to the respondents which contains the informed and voluntary consent).

(2) Anonymity and Confidentiality

I received access to the client files, which are securely stored at the Department of Educational Psychology at the University of Pretoria, only following ethical clearance. Due to the fact that personal information is collected during the research process, each respondent was assured of anonymity and confidentiality so that they could be assured that their responses and identities are protected and that none of their responses can be traced back to them in any way (De Vos et al., 2011; Maree, 2016). Information obtained from the electronic questionnaire using the Qualtrics programme ensures that no responses are traced back to the respondents.

3.6 CONCLUSION

Chapter Three concludes the preparation for conducting research by explaining the research paradigmatic perspective, design and methodology, and preparing the research instrument. Chapter Four will contain the results and findings of the research, followed by an integrated discussion of the findings.

CHAPTER FOUR

RESEARCH RESULTS AND FINDINGS

4.1 INTRODUCTION

Chapter Three provided a discussion of the research design and methodology selected to answer the research question. The outcome of Chapter Three was an e-questionnaire purposefully designed by the researcher, according to well-researched guidelines, to investigate parental responses to recommendations in educational psychologists' reports for primary school children. In Chapter Four, descriptive analysis is used to analyse the data from the e-questionnaire and the results are presented by means of tables, figures and written explanations. The findings follow the results, which are followed by a discussion linking the results and findings to available literature.

4.2 OVERVIEW OF THE RESULTS

4.2.1 Introduction

As discussed in Chapter Three (section 3.2.2 & 3.4.7), the Qualtrics programme made it possible to translate the quantitative data obtained from the electronic questionnaire into numerical values and more specifically into percentages (De Vos et al., 2011). Therefore, descriptive analysis of this data is possible as these percentages and frequencies are then ranked and the dispersion of the results is found (Flick, 2011). This section is discussed in the exact order of the questions in the electronic questionnaire.

SECTION A

4.2.2 Age of respondents

a. Results

Figure 4.1 contains the results for the respondents' ages.

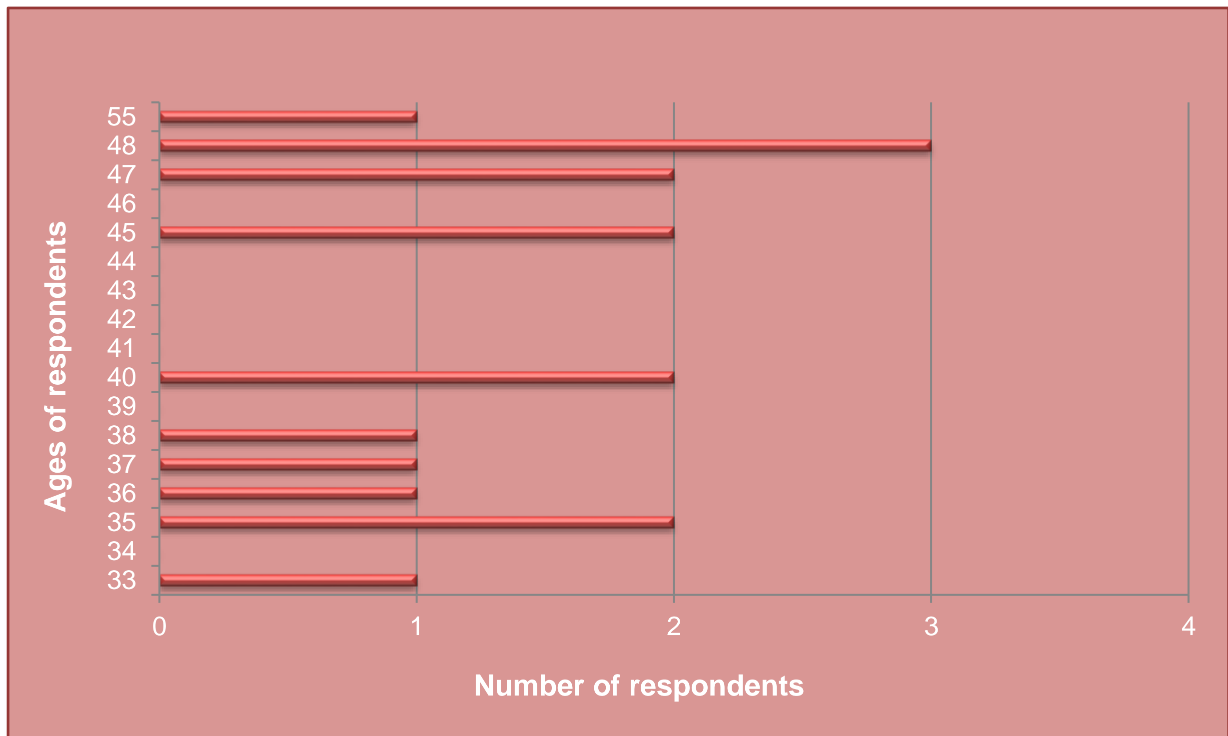

Figure 4.1: Age of Respondents

The bar graph illustrates the various ages of the 16 caregivers (n=16), ranging from 33 years (minimum age) to 55 years old (maximum age).

b. Findings

From the above data it is possible to calculate the average age of this group, which is 42 years. The median is 42.5 years and the mode is 48 years. Eight respondents (50%) were 40 years and younger, and eight respondents (50%) were older than 40 years.

c. Discussion

Having calculated the average age of the respondents to be 42 years old, it may be assumed that these individuals had completed their schooling by the age of 18years,

as stated in Statistics South Africa (STATS SA) (2016). After pursuing tertiary education, which is on average four years of study (STATS SA, 2016), they would then be 22 years old. This therefore suggests that these respondents on average may have been employed or self-employed for approximately 20 years. This in turn suggests that there is a strong possibility that these respondents had been earning a salary for at least 20 years, suggesting that their socio-economic status was adequate and that they may be able to take financial and medical care of their children's needs (Nsamenang & Hirsch, 2015).

4.2.3 Gender of respondents

a. Results

Figure 4.2 shows the bar graph of the number of males and females participating in the study.

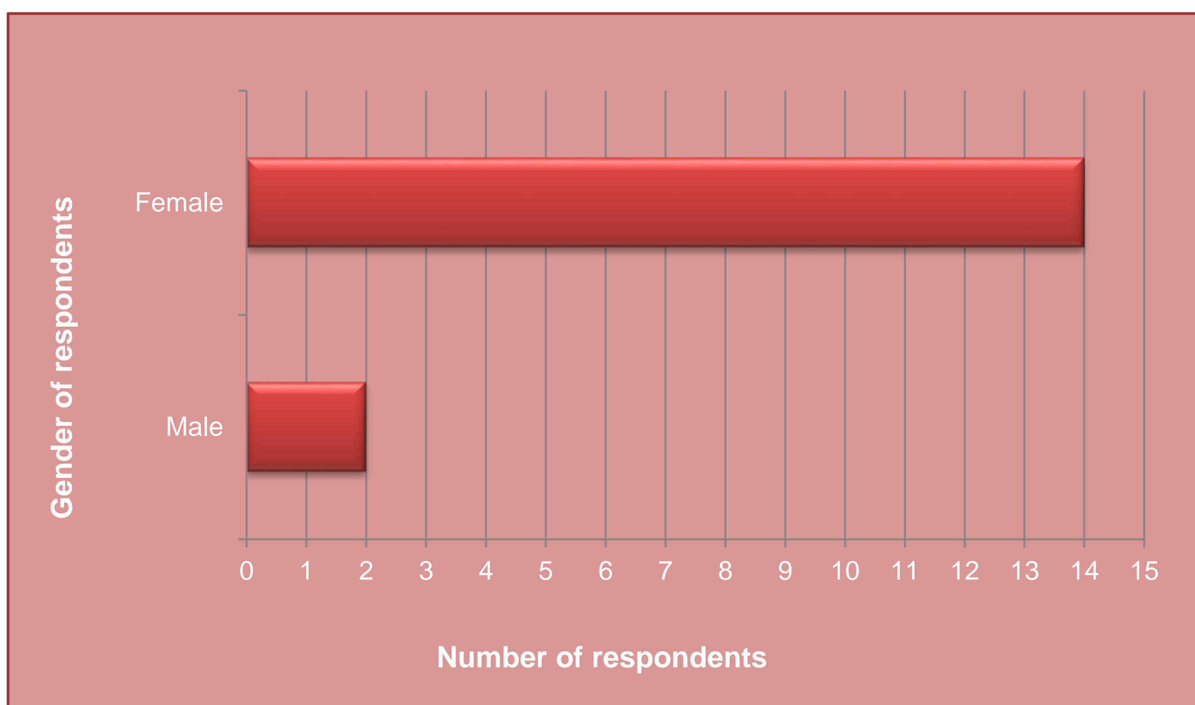

Figure 4.2: Gender of respondents

Fourteen (87.5%) of the 16 respondents (n=16) were female and two (12.5%) of the respondents were male.

b. Findings

The results reveal that there are more females who attempted and successfully completed the questionnaire than males.

c. Discussion

These findings suggest that although most of these caregivers indicated that they were married (see Figure 4.3), the caregiver taking the initiative to complete the electronic questionnaire was a female in 87.5% of the cases. Research conducted in Norway by the Norwegian Social Science Data Services (NSD) shows that there was a clear discrepancy between men and women's willingness to participate in online surveys, with older women being more willing to participate in comparison with younger single men in urban areas (Amundsen & Lie, 2013). Another factor to consider is the possibility that the clients' mothers had taken the responsibility to bring them to the training facility for the assessment and therapeutic processes. This would suggest, as stated in Smith (2012), that perhaps the mothers felt more committed to the process and thus highlights the impact of family roles and how this may have influenced the mothers to complete the electronic questionnaire and share their experiences. Smith (2008) offered an additional possibility for the difference in the male to female ratio: completing an online survey is dependent upon the topic of the survey and how the respondents relate to this topic. Furthermore, women were purported to relate to the online questions as it spoke to their value systems and thus connected this to their emotions and empathy which brought about a higher response rate. The data from this study appears to support the above findings regarding gender, and begs the following question: *Are females (mothers) more compliant than males (fathers) when it comes to following through with recommendations?* According to Ipsos (2012), strong evidence indicates that 25% to 30% of the South African population continue to believe that a woman is the primary caregiver, and not the breadwinner, thus making it possible for the mother to play a more active part of the assessment and feedback process. For this reason, it may be a possibility that more females completed the electronic questionnaire than males.

4.2.4 Marital status

a. Result

Figure 4.3 contains the results for the respondents' marital status.

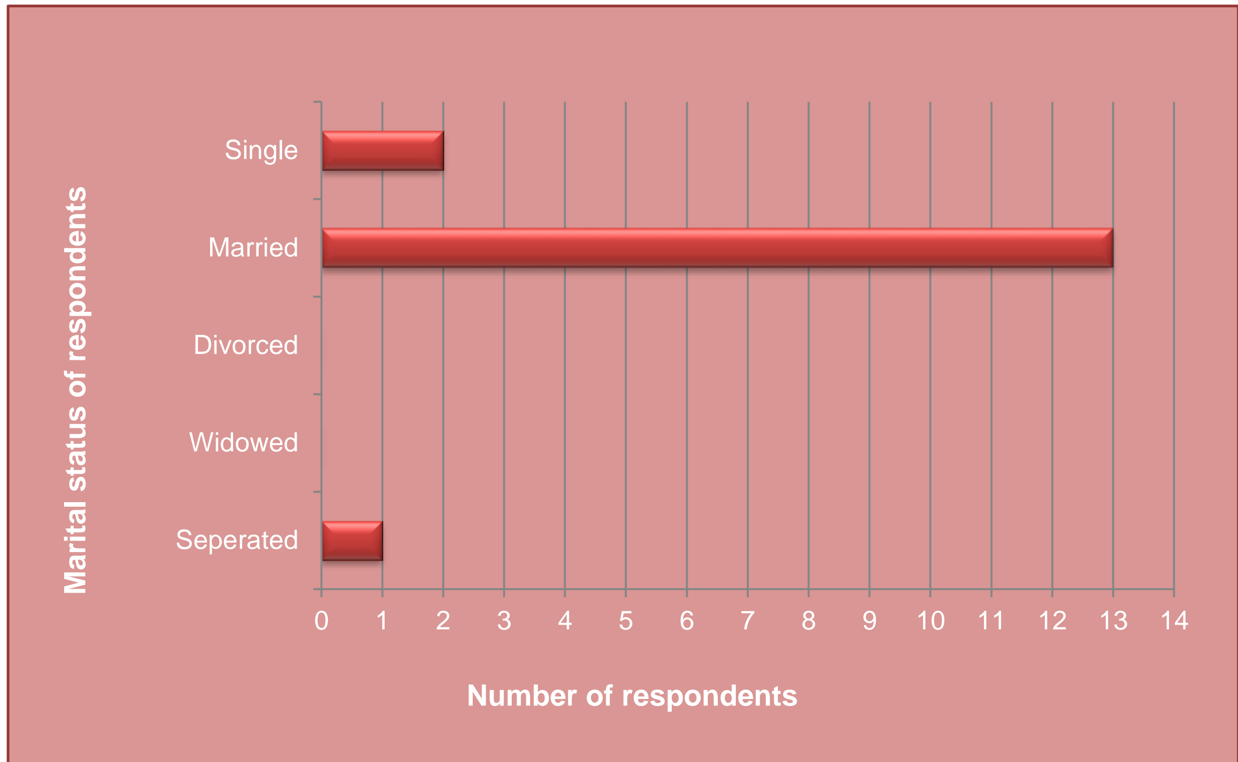

Figure 4.3: Marital status of respondents

Of the 16 respondents (n=16), thirteen of the respondents (81.25%) said that they were married, two were single (12.5%) and one was separated (6.25%).

b. Findings

The above data illustrates that 13 of the 16 children (81.25%) whose files were selected for the research, come from families where the parents are married and living together.

c. Discussion

The majority of the caregivers in this study are married couples, living in the same household. This result supports Tola et al. (2016) and Theron et al., (2015) in that married people are more likely to adhere to recommendations, as stated in 2.3.2. According to Ziehl (2001), urban areas, such as where the training facility is located,

comprise more married couples and nuclear families than non-urban areas. Daniel, Habib and Southall (2003) are of the opinion that major reasons for couples opting to get married and form nuclear families include two incomes which enable greater financial support for all members, greater support ensuring children's well-being and care for the elderly. Once again, it appears that most of the respondents were affiliated with adequate socio-economic systems.

4.2.5 Languages mostly spoken at home

a. Results

Figure 4.4 illustrates the results for the languages mostly spoken at home.

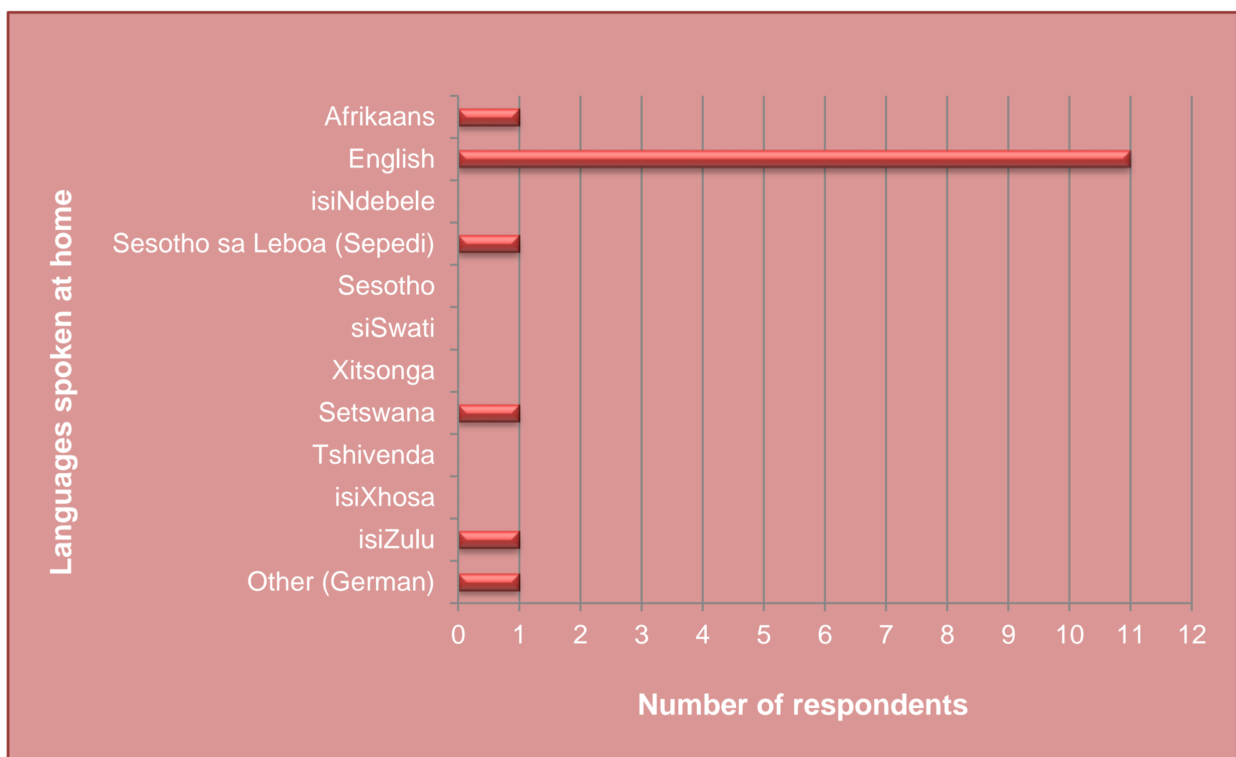

Figure 4.4: Languages spoken at home

According to the data, eleven (68.25%) of the 16 respondents (n=16) spoke English at home. The other five respondents (31.25%) spoke five different languages at home, namely Afrikaans, Sesotho sa Leboa, Setswana, isiZulu and German.

b. Findings

The language found to be most prevalent in the caregivers' homes is English with eleven out of the sixteen (68.75%) caregivers indicating that mostly English is spoken

at home. This finding is in contrast with isiZulu being the language spoken by the most people (11.5 million people) in South Africa (News 24, 2012).

c. Discussion

The Gauteng province, according to Statistics South Africa (2016), has the following data with regard to language prevalence: Afrikaans 10.1%, English 11.3%, Sesotho 12.7%, Setswana 11.0%, isiZulu 23.0%, and Other 1.8%. A possible influence on the high number of caregivers indicating English as the language spoken at home could be due to the fact that the training facility offers the assessment and therapeutic process predominantly in English and Afrikaans. Furthermore, English is the language of formal education and instruction in most schools, institutions and the workplaces (Alexander, 2004; Prah, 2007) which may also be the reason for the high prevalence. It implies that the educational psychologist needs to be proficient in English, as English will be the language in which the proximal processes will take place, as well as the language which will be used in the therapeutic alliance therapy.

4.2.6 Number of family members living in the same house

a. Results

Figure 4.5 shows the results for the number of family members per household.

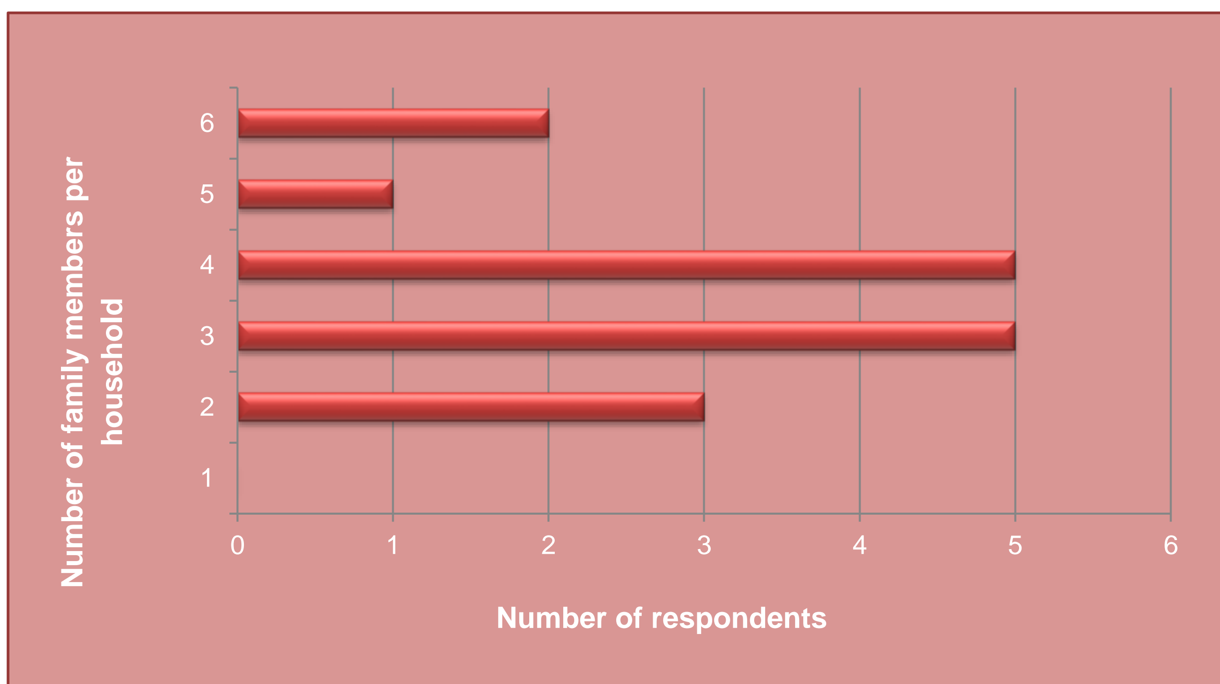

Figure 4.5: Number of family members per household

Of the 16 respondents (n=16), five (31.25%) were part of a household of three people, and five respondents (31.25%) were part of a household of four people. Three of the respondents (18.75%) were part of a household of two, implying one child and one adult in a household. Two of the respondents (12.5%) came from a household of six people, and one respondent (6.25%) came from a household of five people.

b. Findings

It is apparent that ten of the respondents (62.5%) came from three or four member households; the general/standard make-up of each household being a mother, father and the client plus one or two siblings, or other family members. The electronic questionnaire does not account for the ages and relationship to other family members, such as cousin, aunt or uncle, or grandparent.

c. Discussion

In the national survey conducted by Statistics South Africa (2016), the results indicated that the average household size in the Gauteng province is approximately three members per household, providing some support for the results in this study. According to Ziehl (2001), an investigation conducted indicated that approximately half of all South African households are nuclear households; however, thought should be given to taking racial and cultural norms into consideration before deciding upon a conclusion from these findings. There are almost as many extended or multiple household structures in place as nuclear ones, according to Zeihl (2001) and Daniel et al. (2003). Additionally, extended family members often support the primary caregivers, whether financially or even with time. This support is given especially to the children of the nuclear family without the extended members physically living in the household (Elliott, 2008). Refer to 4.3.7 where respondents indicate who provides support to them.

4.2.7 Afternoon care for the child

a. Results

Figure 4.6 presents the results for the afternoon care the respondents utilise.

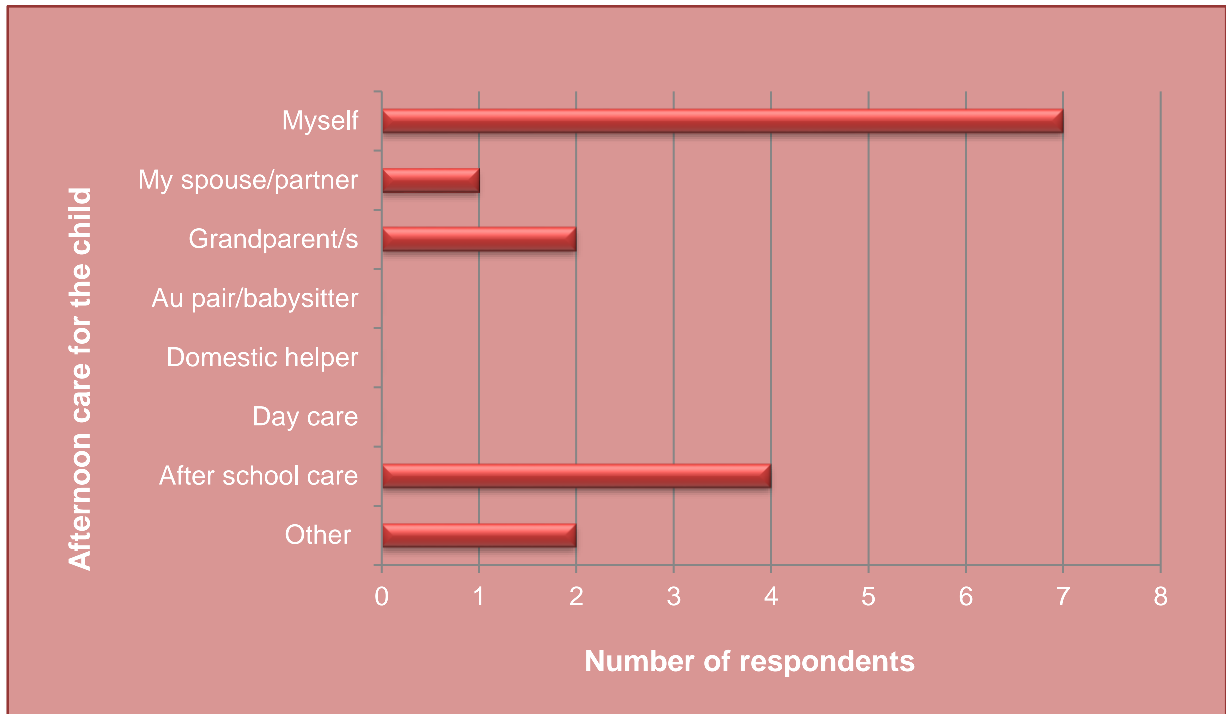

Figure 4.6: Afternoon care for the child

Of the 16 respondents (n=16), seven (43.75%) indicated that they look after their children in the afternoons, four of the respondents (25%) sent their children to after school care, two of the respondents (12.5%) had grandparents who looked after the children, one respondent (6.25%) had a spouse/partner looking after the child, another respondent (6.25%) indicated the child stayed at a boarding facility, and the other one respondent (6.25%) had the child wait at the gate of the school.

b. Findings

The results show that the child is mostly looked after in the afternoons by one parent. Owing to the fact that the majority of the caregivers who completed this questionnaire are females, it is a possibility that the children are being looked after primarily by their mothers.

c. Discussion

Elliott (2008) states that families differ in their structure, functioning support systems and duties or roles of each family member, depending on their unique needs, their particular preference, circumstance and context. Thus, a form of support for the family may be in providing assistance with regular care for the child (Ohan, Seward, Stallman, Bayliss & Sanders, 2015). A possible reason for the prevalence of mothers being those who provide care for the child is stated in Edlund and Rahman (2005): primary caregivers, whether mother or father, are more often than not biologically[8] motivated to unselfishly devote resources for the well-being of their children. If one parent looks after the child in the afternoons, once again, it implies that most probably the income of the other parent is sufficient to support the family, possibly indicating supportive socio-economic systems.

4.2.8 Income bracket (ZAR per year as of 2017)

a. Results

Figure 4.7 shows the results for the income bracket of the respondents.

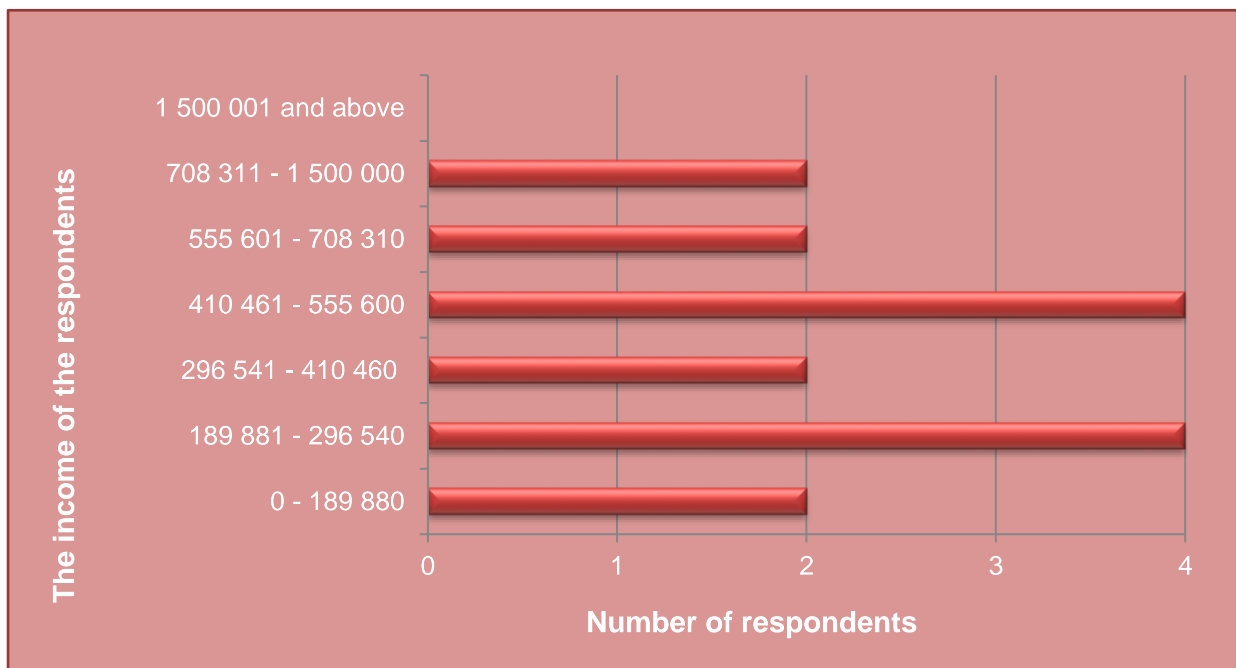

Figure 4.7: The yearlyincome of the respondents

[8] Biological motivated altruism is when an individual behaves altruistically for the benefit of another (Edlund & Rahman, 2005).

The average income of the respondents (n=16) was between R135050 – R228 799 per year.

b. Findings

The lowest monthly income was approximately R15800/month, and the highest monthly income was approximately R125 00/month. The average monthly salary for each of the salary brackets are displayed in Table 4.1.

Table 4.1: Average monthly salary per income bracket

Salary bracket (ZAR), before taxes are deducted	Average monthly salary, based on upper limit
0 - 189 880	0 – 15823
189 881 - 296 540	24711
296 541 – 410 460	34205
410 461 – 555 600	46 300
555 601 – 708 310	59 026
708 311 – 1 500 000	125000
>1 500 000	> 125 000

c. Discussion

According to Gustafsson (2011), the average monthly income for an individual who has completed Grade 12 and possibly attained a two-year diploma is between R8000 and R14000 and this monthly amount usually increases after the attainment of a degree. Resource characteristics as a factor in Bronfenbrenner's PPCT model states that sufficient available finances influences the attainment and access to mental healthcare services (Swart & Pettipher, 2016) The training facility at the University of Pretoria offered its psychological services during 2015 and 2016 at a once off fee of R750 for the entire assessment and therapeutic process. In cases where the caregivers are unable to afford these fees, the training facility also offer pro bono services. The minimum monthly income suggests that financial constraints may perhaps be a possibility when caregivers attempt to follow through with some of the recommendations made in the educational psychology reports.

The amount indicated is that of the respondents who completed the electronic questionnaire. Therefore, it should be considered that there may be a possibility of more than one source of income in each household; that is, income from the mother and the father in most cases (STATS SA, 2016). The electronic questionnaire was only completed by one parent per household; therefore it remains unclear if the amount indicated is of that particular respondent or a combined income.

4.2.9 Number of family members supported by this income

a. Results

Figure 4.8 illustrates the results for the number of family members supported by the income attained.

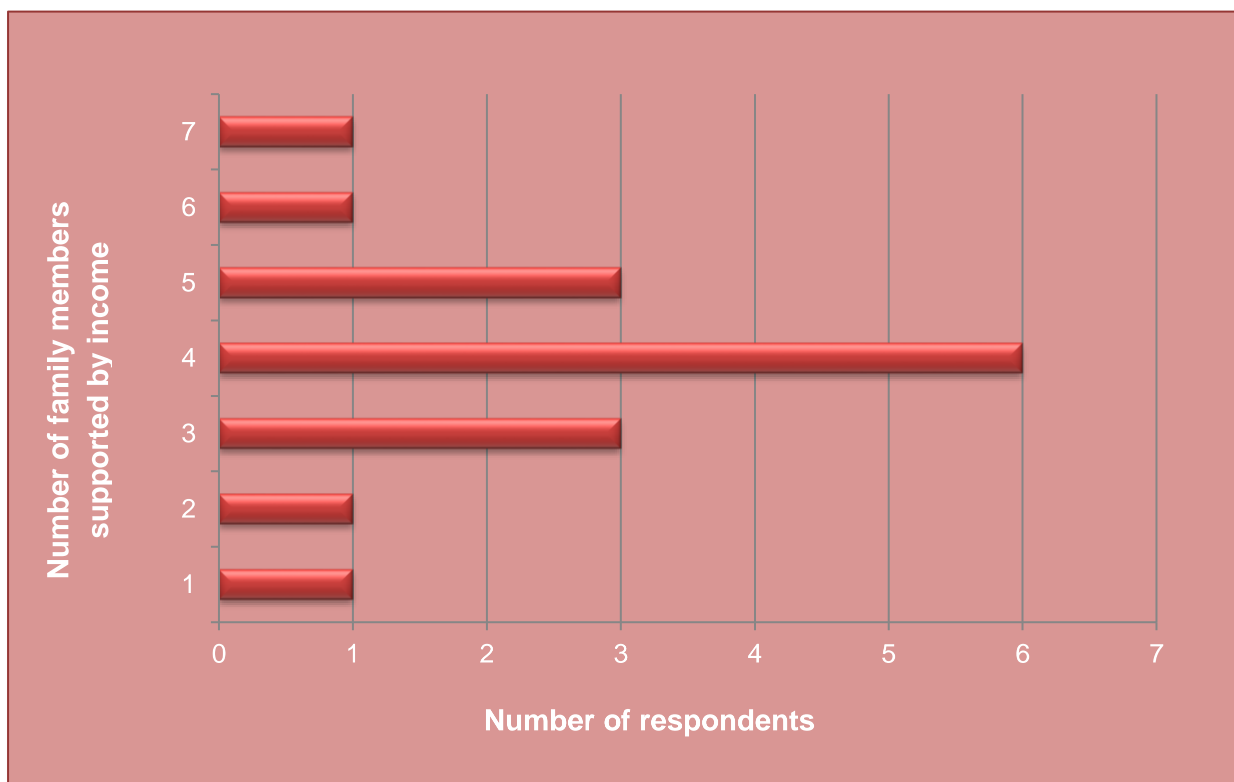

Figure 4.8: Family members supported by income

Of the 16 respondents, six respondents (37.5%) supported four family members, three respondents (18.75%) supported five family members, and three respondents (18.75%) supported three members. One respondent (6.25%) each supported one, two, six, and seven family members respectively.

b. Findings

The data above reveals that most of the respondents support four family members.

c. Discussion

Parents' motivation is strongly affected by socio-economic and environmental factors (Burleson &Thoron, 2014; Maslow, 1943; also see the Health Belief Model in 2.4.3). Supporting multiple family members with one income may place strain on the breadwinner and influence the amount of time available outside of the work place (Bronfenbrenner, 1994; Swart & Pettipher, 2016), financial resources to follow through with the suggested recommendations as discussed in Bronfenbrenner's PPCT model (Bronfenbrenner, 1994; Swart & Pettipher, 2016); and may cause interpersonal conflict affecting self-efficacy which is elucidated within the Health Belief Model (Abraham & Sheehan, 2015; Rosenstock, 1974).

4.2.10 Medical aid scheme at the time of assessment

a. Results

Figure 4.9 show the results for access to medical aid funds during the time of assessment.

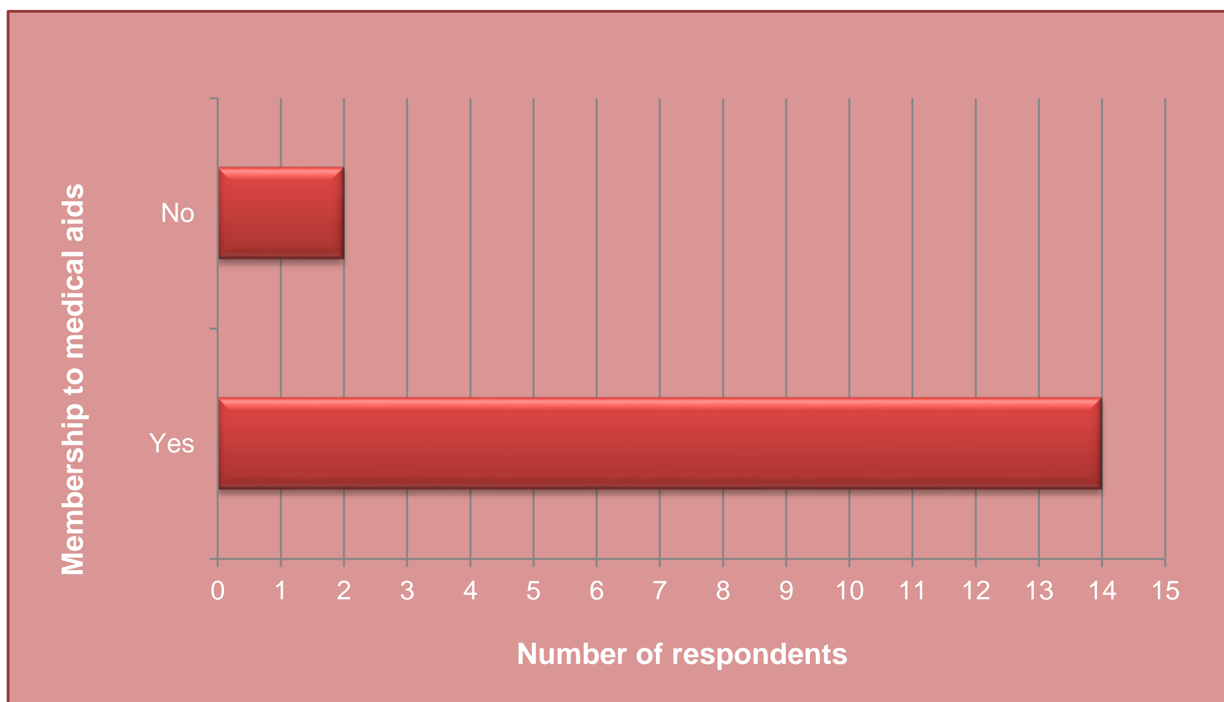

Figure 4.9: Membership to medical aids

Of the 16 respondents, 14 respondents (87.5%) belonged to a medical aid scheme.

b. Findings

The majority of the respondents (n=14) indicated that they do in fact rely on medical aid funds to access health care services. However, the data does not intimate whether the funds were sufficient in order to cover for the possible referrals suggested in the recommendations.

c. Discussion

Peyper (2016) highlights the importance of individuals choosing a medical aid scheme which best suits their needs whilst taking into consideration their current health status, marital status and dependents' needs, as this seriously affects the scheme chosen as well as health coverage or benefits. According to Van Eeden (2009) there are very limited studies in South Africa which reveal the prevalence of medical aid usage for mental healthcare services, indicating that only 14.3% of the South Africa population belonged to a medical aid scheme during the period in which this study was conducted. The General Household survey conducted later in 2016 states that 23.5% of all South African households have a minimum of one member belonging to a medical aid, with Gauteng producing the highest number of individuals at 27.7% belonging to a medical aid, and even higher in the city of Tshwane at 33.0% of households covered by a medical aid (STATS SA, 2016). According to the PPCT-model of Bronfenbrenner (1994) (see also Swart & Pettipher, 2016), access to the health system, for example through medical aid funds, will support following through with recommendations.

Summary:

The profile of an average respondent for this study appeared to be a 42 year old English speaking female, with a medical aid, who is married and living within a household of four or five members. Furthermore, the respondent may earn between 15800 and 125000 South African Rands per month supporting the entire household. The respondent is mainly responsible for afternoon care of the children.

SECTION B

4.2.11 Working hours per day

a. Results

Figure 4.10 shows the results for the number of working hours per day.

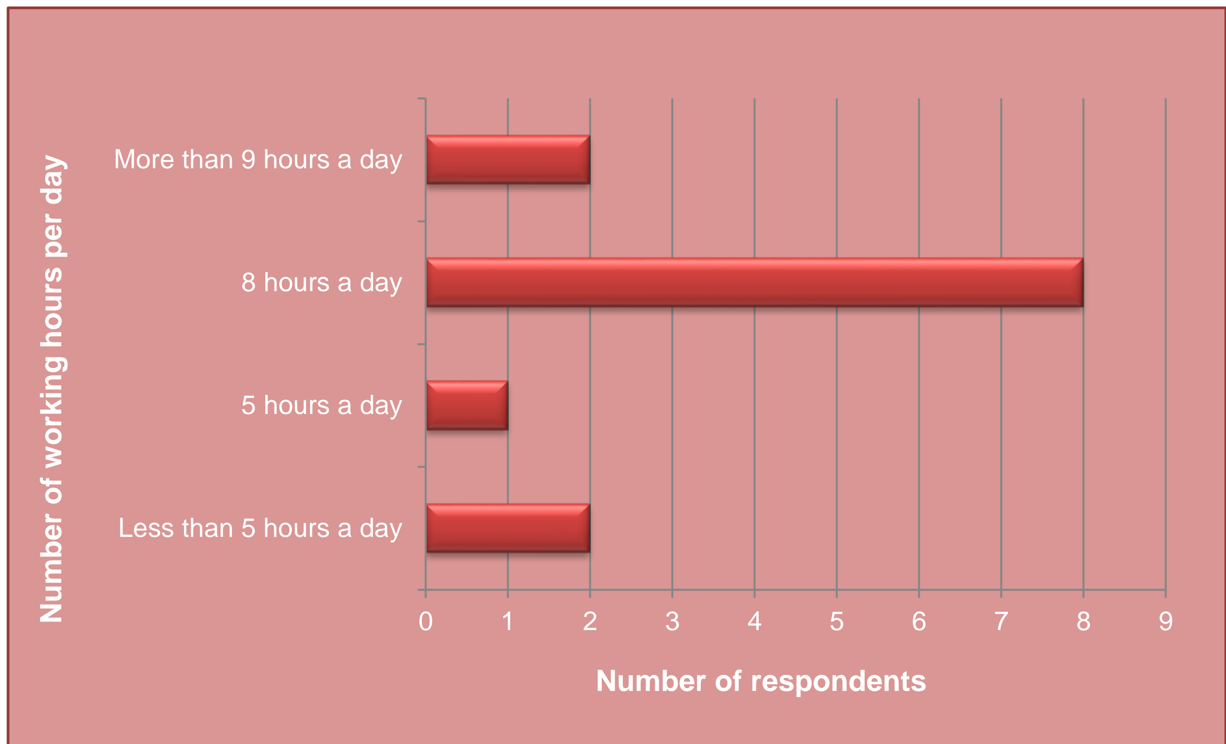

Figure 4.10: Number of working hours per day

Two of the 13[9] respondents (15.4%) worked more than 9 hours a day, eight of the 13 respondents (61.5%) worked 8 hours a day, one respondent (7.7%) worked 5 hours a day, and two respondents (15.4%) worked less than 5 hours a day.

b. Findings

11 out of the 13 respondents work more than 5 hours a day. Based on the results in Figure 4.2, reporting that 14 out of the 16 respondents are female, it is safe to assume that most mothers in this study worked for more than 5 hours every day.

[9] Three respondents did not complete the e-questionnaire, leaving only 13 respondents remaining.

c. Discussion

A study conducted in the United States of America in 2011 revealed that amid the 34.3 million family units with children, approximately 87% included one working parent and a further 59% of these units had both parents employed (Heinrich, 2014). Working parents bring forth positive attributes to the family household such as higher income, encouraging good work ethic and a sense of responsibility in their children; dynamic and fruitful family routines; and an elevated sense of self-esteem especially amongst working mothers (Heinrich, 2014).

Working mothers whose children face barriers in their development, learning and functioning face challenges (Warefield, 2001) and often lack the support for child care and supervision, which culminate in having to do both with much difficulty and fewer positive outcomes (Heinrich, 2014). In the case where their children have extra needs and require higher levels of support due to a disability, these parents are often required to compromise in one of their roles daily, such as resigning from work or conversely having less time to support their child's needs as this requires higher financial aid which means more demanding working hours (Shah & Shah, 2016; Warfield, 2001).The results of this study reflect Bronfenbrenner's PPCT model, as less time is available for following through on recommendations due to working hours which may cause barriers within/limiting the proximal processes between the respondents and their children, thus hindering effective interactions within their microsystems (Bronfenbrenner, 1994; Swart & Pettipher, 2016; Tudge et al., 2009).

4.2.12 The manner in which information about the University of Pretoria training facility was obtained

a. Results

Figure 4.11 depicts the results indicating where the respondents heard of the training facility at the University of Pretoria.

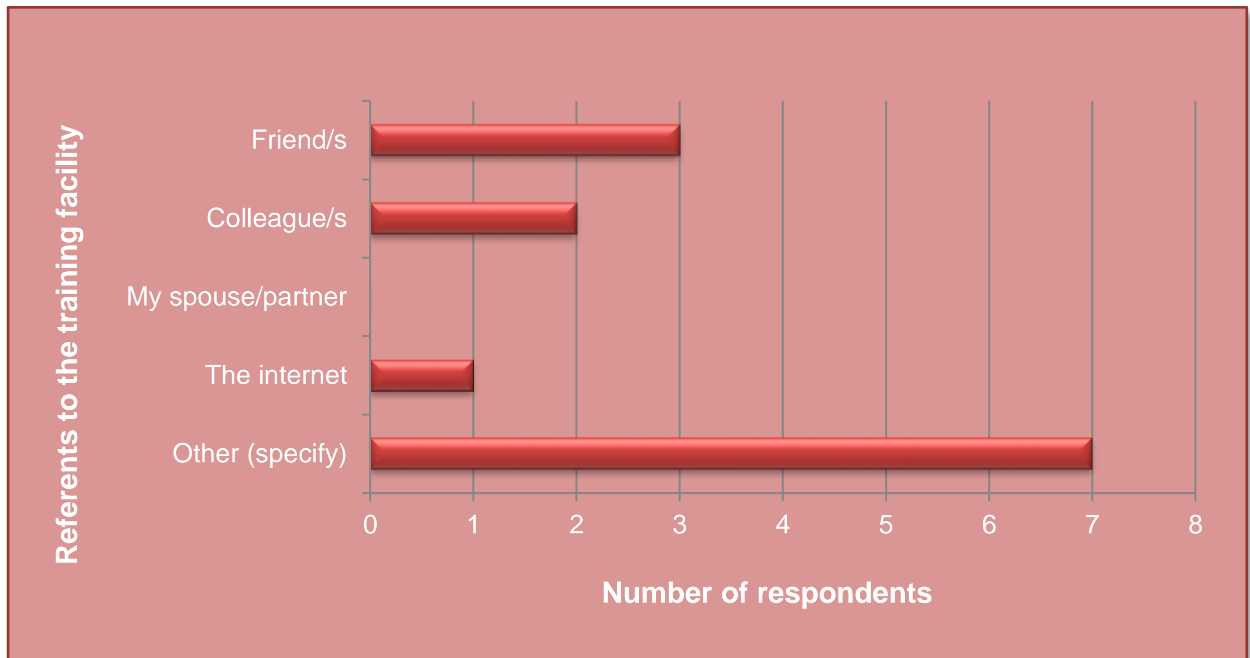

Figure 4.11: Referents to the training facility

From the above graph it is clear that three of the respondents (23.08%) were referred by their friends and two of the respondents (15.38%) were referred by colleagues. The following people or organisations each referred one respondent to (7.69%) the training facility: the internet, an educational psychologist, another psychologist, the school, family, the respondent self, teacher, and school counsellor. The latter list was compiled from responses that the respondents gave in the 'other' category.

b. Findings

Five of the referrals came from people with whom the respondent (parent) associated closely on a daily basis, namely friends and colleagues. One referral (7.7%) came from the internet. The option "other" was chosen by seven of the 13 respondents (53.85%). Five of these seven respondents stated that they were recommended to the training facility by the school's various staff members or by other health care professionals.

c. Discussion

The micro and mesosystems in which the respondents are involved, can clearly be seen from the referents, namely friends, colleagues and the internet. Similarly, the micro and mesosystems in which the clients are involved can be seen from the responses to the ‘other’ choice, such as the school, the teacher and the school counsellor. The policy and guidelines on child and adolescent mental health as stipulated by the Department of Health in South Africa (2015) states that children are in constant interaction with their environment and individuals included in these environments are their teachers. Children spend the longest period of their entire formal educational journey in school as opposed to any other educational institution (Fazel, Hoagwood, Stephan & Ford, 2014). The Department of Health (2015) adds that education, support and guidance of these teachers in mental health are essential as they are the initial individuals to assist children seeking mental health services. According to Williams, Horvath, Wei, Van Dorn and Jonson-Reid (2007), teachers are the primary source of referring children to mental healthcare providers; however, the referral process is heavily dependent upon their own perceptions of the self, their mental health status, their level of understanding of mental health and the context of the child (Cloutier, Cappelli, Glennie & Charron, 2010; Williams et al., 2007). This process of referral may result in under referral or even late referral as teachers often do not receive adequate training in identifying these barriers experienced by their learners and therefore delay early intervention or even contribute to the worsening of the challenge (Dvorsky, Girio-Herrera & Owens, 2014). The reciprocal interactions of the individuals and systems within Bronfenbrenner’s bio-ecological theory could either be supportive or detrimental to a learner (Swart & Pettipher, 2016).

4.2.13 Attendance of the feedback session following the child's assessment

a. Results

Figure 4.12 illustrates the results for attending the feedback session.

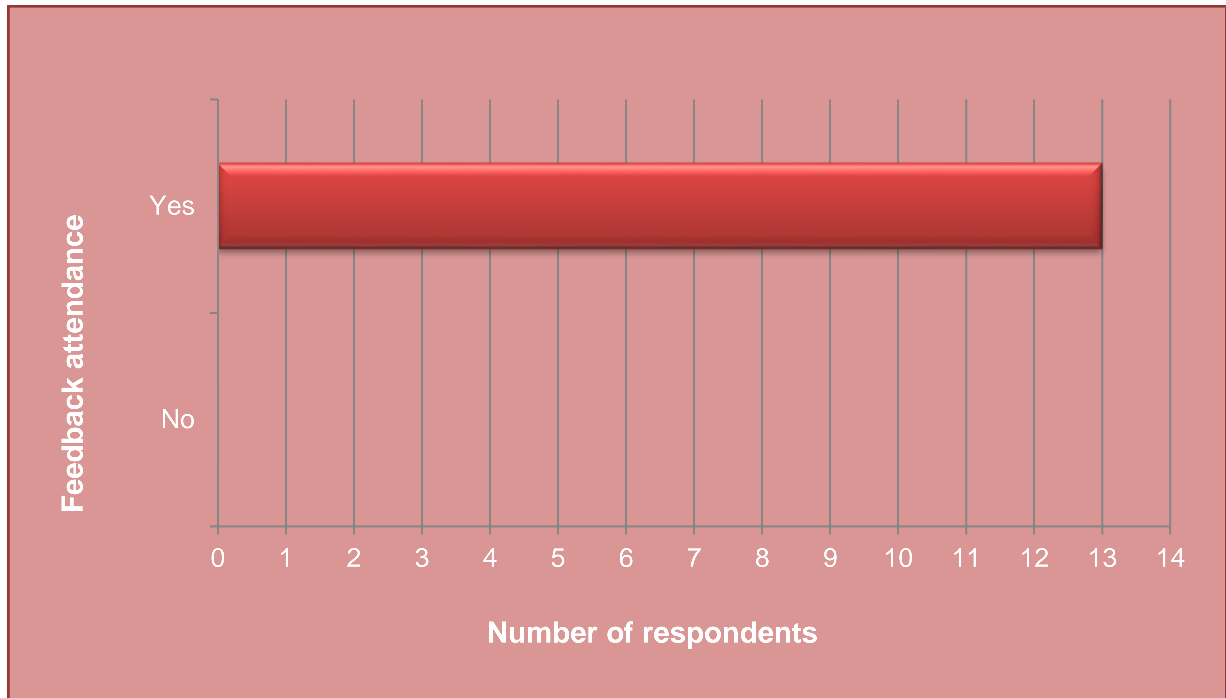

Figure 4.12: Feedback attendance

13 of the 13 respondents (100%) attended the feedback session.

b. Findings

All the respondents attended the feedback session. It is a policy of the training facility that no reports are sent to clients without a feedback session; therefore the 100% attendance of feedback may be misleading compared with private practices.

c. Discussion

Although the results appear to be positive, 100% attendance does not imply that both parents of every client attended the feedback. Often either the mother or the father attends the feedback. Compliance to recommendations may be compromised if both parents had not attended the feedback session where the recommendations were explained. The electronic questionnaire was designed to be completed ideally by each

caregiver, that is the mother and the father separately, however this was not the final outcome.

4.2.14 Were the recommendations helpful?

a. Results

Figure 4.13 shows the results (yes/no) for the helpfulness of the suggested recommendations.

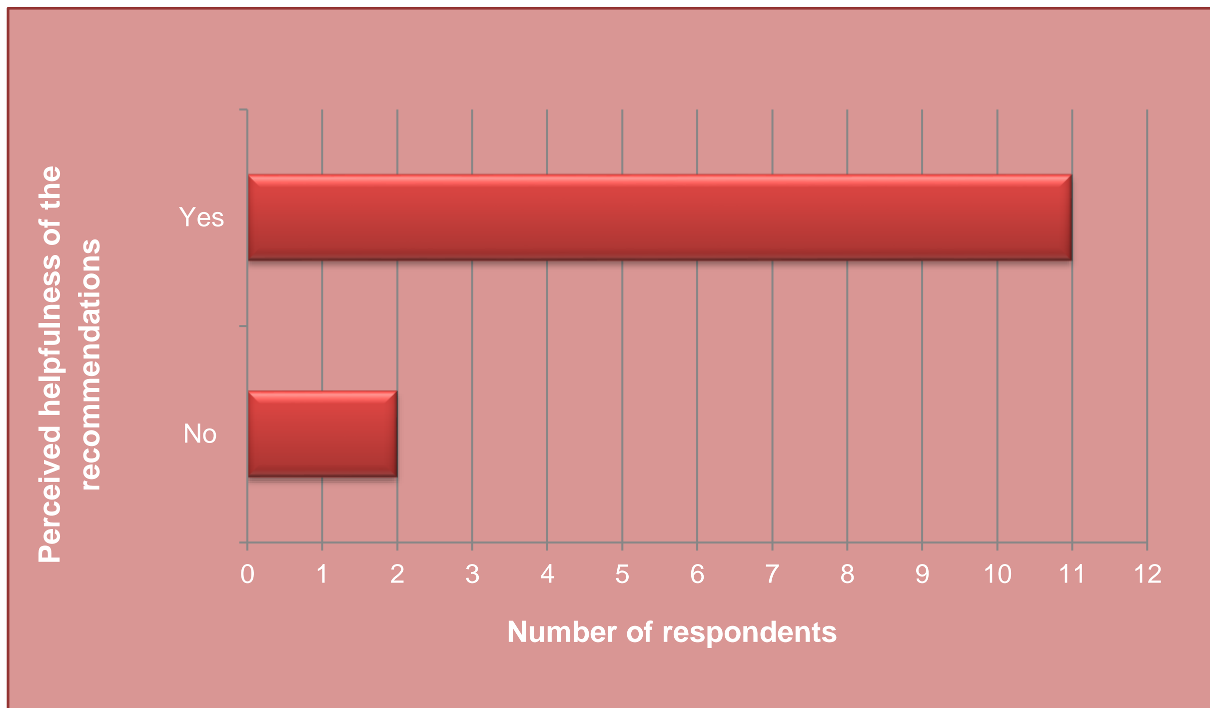

Figure 4.13: Perceived helpfulness of the recommendations

According to the data, 11 of the 13 respondents (84.62%) reported that the recommendations were helpful. Only 2 of the 13 respondents (15.38%) reported that the recommendations were not helpful.

b. and c. Findings and discussion

Recommendations included, but were not limited to, the following:

- Recommendations for the child, including one or more than one of the following:
    - Play-therapy at the training facility;
    - Psychotherapy at the training facility; and/or

    - Learning support for reading, spelling, writing and/or mathematics at the training facility.
- ❖ Recommendations to the parents, mostly constituting
    - Psycho education regarding sibling rivalry, ADHD, discipline, routine, homework, relationships, independence, autism, learning challenges, and language enrichment of children.
- ❖ Recommendations to the school, often including one or more than one of the following:
    - Psycho education to teachers regarding ADHD, discipline, comments, praise;
    - Concessions; and/or
    - School placement.
- ❖ Referrals to one or more than one of the following:
    - Speech therapist;
    - Occupational therapist;
    - Paediatrician;
    - (Paediatric) neurologist;
    - (Paediatric) psychiatrist; and/or
    - Dietician.

Recommendations for every client are uniquely compiled for the specific client, and usually include role players from all the microsystems who are involved in proximal processes with the child. Kindly refer to the conclusion in 4.4.

4.2.15 Level at which the recommendations were found to be helpful

a. Results

Figure 4.14 contains the results for the level of helpfulness of the suggested recommendations.

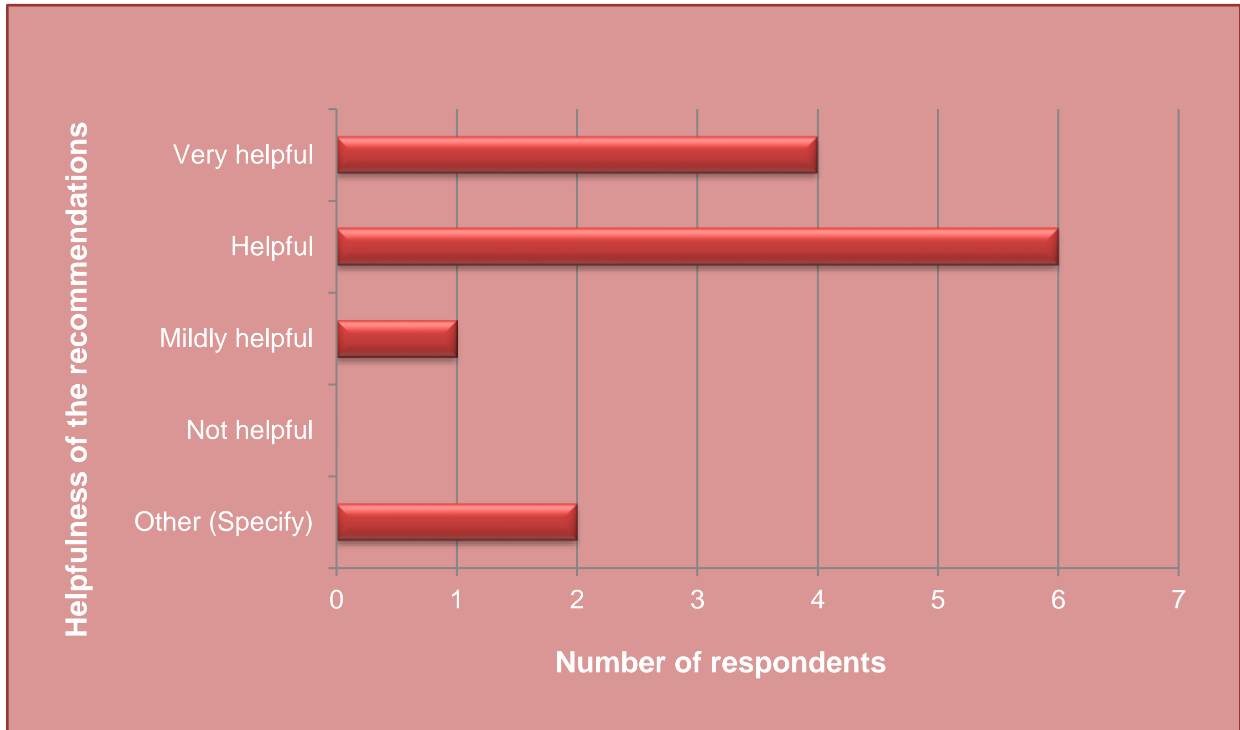

Figure 4.14: Helpfulness of the recommendations

Four of the 13 respondents (30.77%) were of the opinion that the recommendations were very helpful. Six of the 13 respondents (46.15%) were of the opinion that the recommendations were helpful. One of the 13 respondents (7.69%) was of the opinion that the recommendations were mildly helpful. Two of the 13 respondents (15.38%) wrote comments regarding approved concessions and availability of the report.

b. Findings

None of the respondents (0%) were of the opinion that the recommendations were not helpful. It may thus be concluded that all respondents were of the opinion that the recommendations were helpful to some degree.

c. Discussion

Although two respondents indicated in Figure 4.13 that the recommendations were not helpful, none of the respondents in Figure 4.14 indicated the recommendations to be not helpful. It might be that the other-category gave opportunity for them to voice their concerns.

4.2.16 Did you follow through with the recommendations?

a. Results

Figure 4.15 shows the results for the respondents' follow-through of the suggested recommendations.

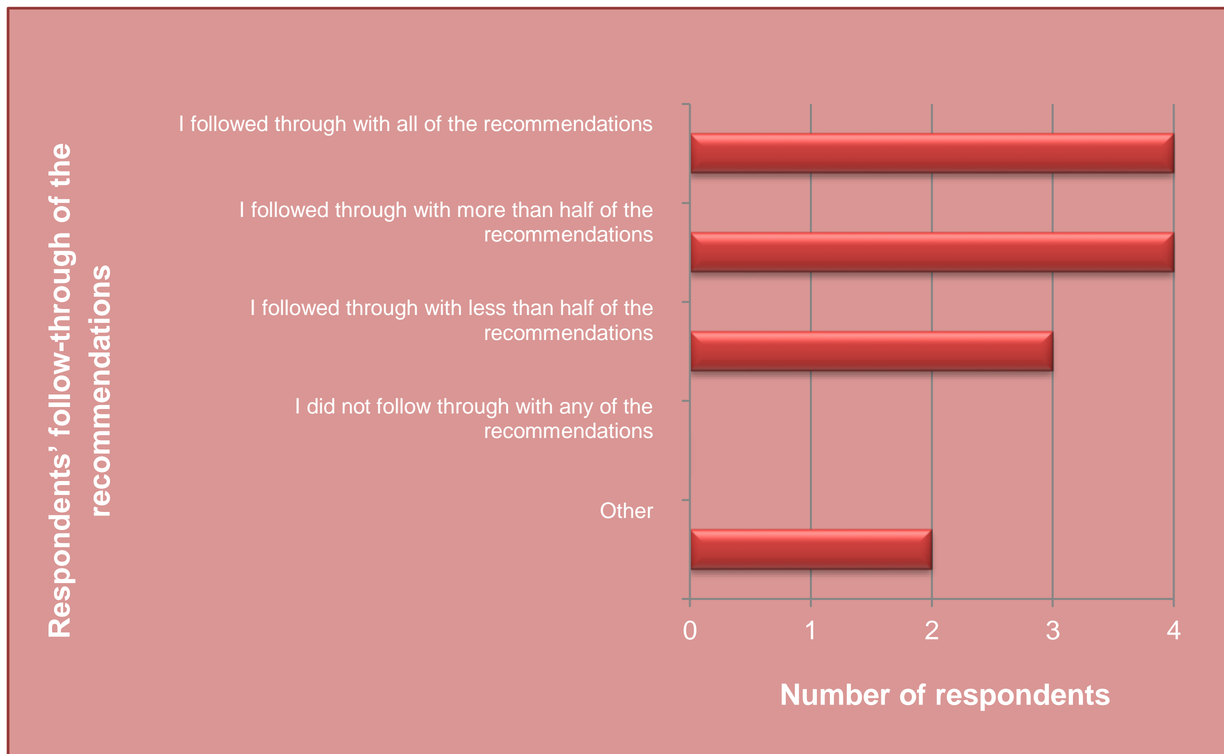

Figure 4.15: Respondents' follow-through of the recommendations

Four of 13 of the respondents (30.77%) followed through with all the recommendations. Four of 13 of the respondents (30.77%) followed through with more than half of the recommendations. Three of the 13 respondents followed through with less than half of the recommendations, while none of the respondents (0%) did not follow through with any of the recommendations. In the 'Other' category one

respondent (7.69%) said that the “amount of schoolwork does not permit for much other stuff” and one respondent (7.69%) said “still waiting[10]”.

b. Findings

11 of the 13 respondents (84.62%) followed through with some of the recommendations, more than half of the recommendations or all of the recommendations.

c. Discussion

The percentage of parents following through with recommendations in this study exceeds percentages of compliance which was reported in the literature study. From the point of view of an institution which provides the training facility for university/Masters students, it is especially good to have such high levels of compliance. Factors in the training of the students most probably contribute to the high levels of compliance, as students are trained to be aware of proximal processes between people, to be sensitive to the contexts clients come from, including other cultures and languages. In addition, students are supervised by experienced educational psychologists. When the model as suggested at the end of Chapter Two is applied to compliance at the training facility, one would be able to surmise many of the supportive factors in parental compliance (see 4.3Summary and 4.4 Conclusion).

[10]One caregiver indicated the inability to gain access to the report. This was later clarified with the researcher as the caregiver had misplaced the report, but after making contact with the researcher, the caregiver proceeded to follow-up and collected an additional report from the training facility.

4.2.17 Reasons for following through with most of the recommendations

a. Results

Figure 4.16 show the results for the possible reasons behind the respondents' following through with the recommendations.

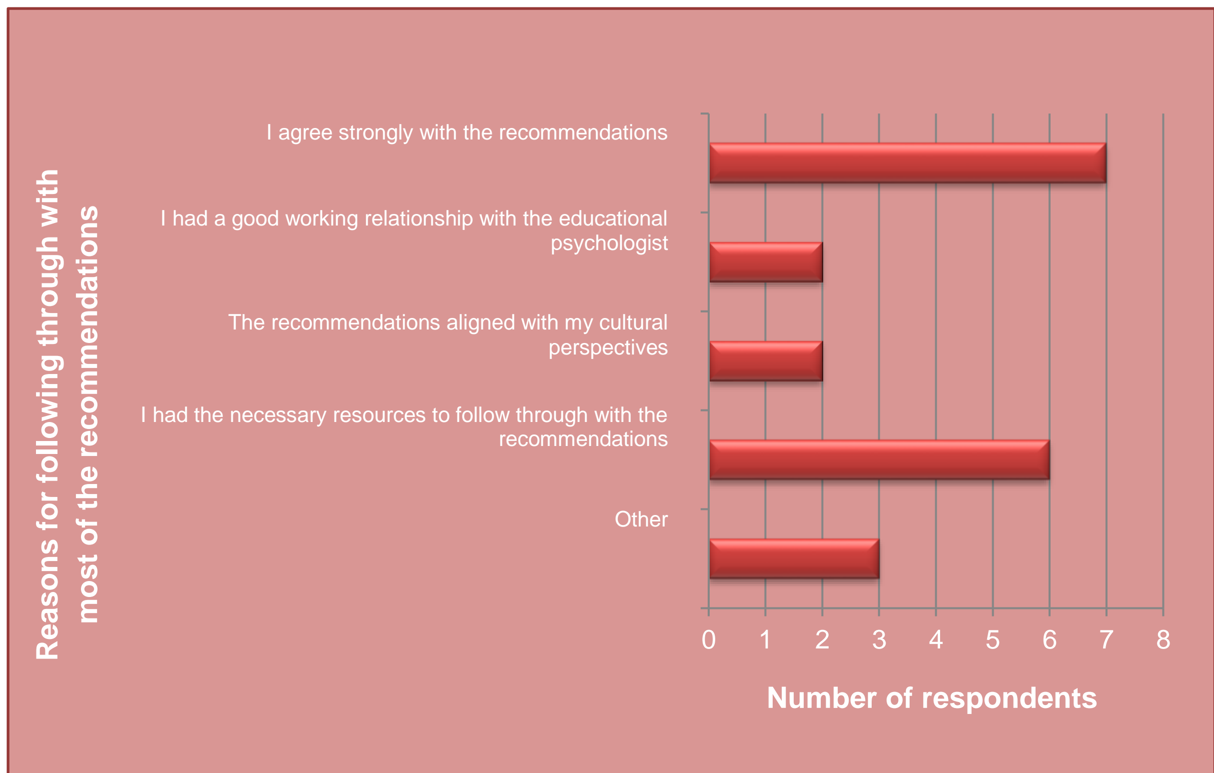

Figure 4.16: Reasons for following through with most of the recommendations

For this question, respondents could indicate more than one reason why they followed through with recommendations. Seven of the 13 respondents (53.85%) agreed very strongly with the recommendations. Six of the respondents (46.15%) had the necessary resources to follow through with the recommendations. Two of the respondents (15.38%) were of the opinion that they followed through with the recommendations as they had a good working relationship with the educational psychologist. Two of the respondents (15.38%) were of the opinion that they followed through with the recommendations as the recommendations aligned with their cultural perspectives. Three (23.01%) of the respondents chose the "Other" option, but did not explain why they chose this option.

b. Findings

Agreement with the recommendations was why more than half (53.85%) of the respondents complied with the recommendations. Having the resources to comply with the recommendations was the reason for the second highest (46.15%) selection by the respondents. Having a working relationship with the educational psychologist and having the recommendations aligned with cultural perspectives combined (30.77%) was not as strong a reason for compliance as agreement with recommendations or availability of resources separately.

c. Discussion

Agreement with recommendations entails parents understanding and agreeing with the process of assessment as well as agreeing with the results of the assessments and the recommendations based on these results (Nsamenang & Hirsch, 2015; Venzin, 2017).The data obtained reveals that more than half of the respondents agreed strongly with the suggested recommendations. This data may be linked to the aspects discussed by the Australian Department of Health which suggest that a collaborative and strong therapeutic relationship obtained by prioritising the client's needs, interests and values may influence the respondents' opinion of the recommendations positively (Venzin, 2017). Agreeing with recommendations also implies that the nature of the contact, communication and mindful collaboration between the educational psychologist and the respondents were of a high quality, as explained by the therapeutic alliance theory (refer to 2.4.4).

Almost half of the respondents acknowledged the important role that the availability of resources played in following recommendations which correspond with resource characteristics within Bronfenbrenner's PPCT model stating that the availability and accessibility of resources and the respondents' ability to interact effectively with these resources influence the outcome of the therapeutic process (Baylis et al., 2011; Swart & Pettipher, 2016).

4.2.18 Reasons for not following through with the suggested recommendations

a. Results

Figure 4.17 shows the results for the possible reasons for the respondents not following through with the suggested recommendations.

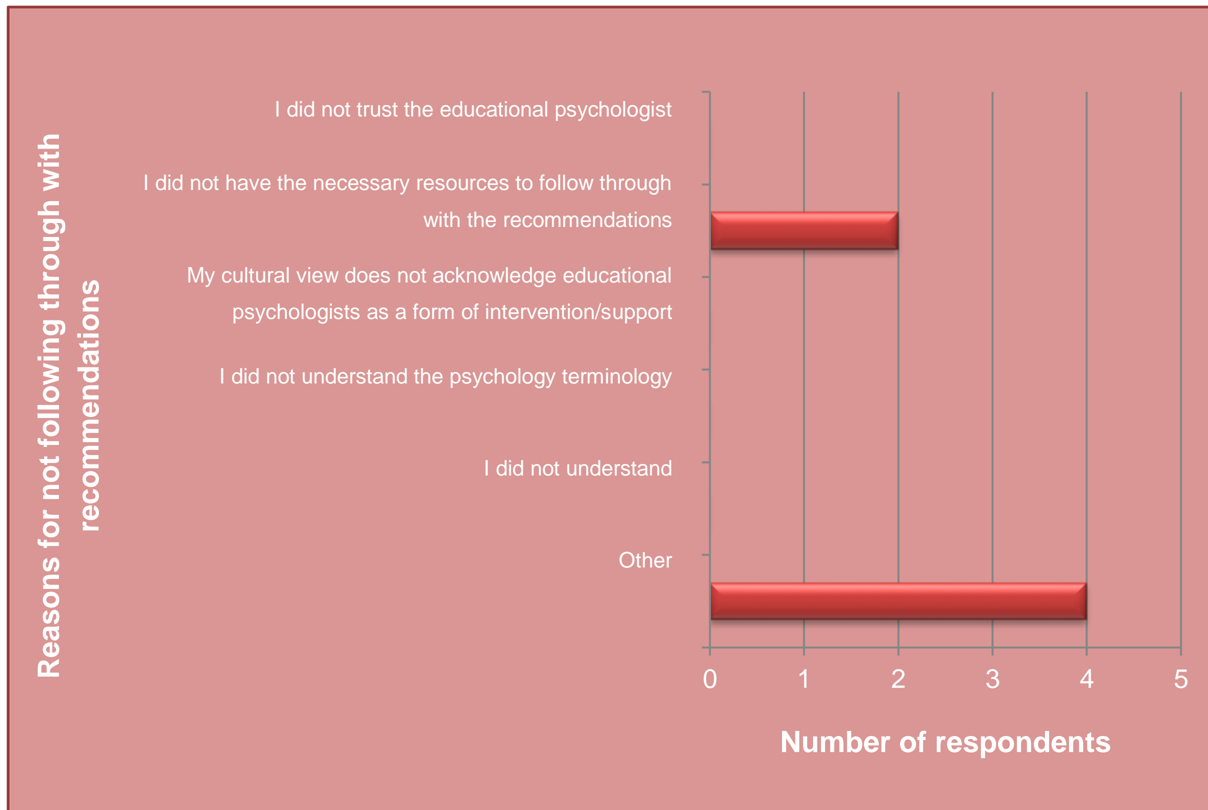

Figure 4.17: Reasons for not following through with recommendations

Only 6 respondents (46.15%) selected a reason/s for not following through with recommendations. More than one reason could be selected. Two of the respondents indicated that lack of resources was a reason why recommendations were not followed. A remark by another respondent agreed that finances were challenging: “changing to a cheaper medication that does not give the best results”. Time as a resource was also mentioned: “Our lives are always rushed and busy, so [we] tend to take shortcuts without thinking or cut out something completely and there is not time”. One respondent said that some recommendations were “physically and timeously impossible”. Another respondent mentioned “Progress is slow due to doing one type of therapy at a time”. Finally, one respondent did not follow through with the recommendations as he/she was of the opinion that “Some recommendations have not necessarily been needed as of yet”.

b. Findings

Reasons for not following recommendations were mainly related to lack of time and a lack of financial resources. Not trusting the educational psychologist and not understanding the feedback and recommendations were not reasons why recommendations were not carried out.

c. Discussion

Understanding a client in the context of the systems involved, promotes understanding for the client. The economic system as exosystem, as mentioned by Bronfenbrenner (1994), plays a role in non-adherence to recommendations, as well as the apparent misalignment of the health system and the individual system, as the health system did not provide the required resources for support. However, motivation as understood by the HBM suggests that had parents understood the benefits of the recommendations, they would have been motivated to carry them out (see 2.4.3).

From the results of the data it appears that the respondents trusted the educational psychologist and understood the feedback and recommendations, thus implying that the therapeutic alliance, according to the Therapeutic Alliance Theory, between the educational psychologist and the respondents was adequate in terms of contact, mindful collaboration and communication (see 2.4.4). It is especially note-worthy that all of the respondents felt they understood the feedback and recommendations and that language and psychology terminology did not interfere with their understanding.

4.2.19 Challenges faced when attempting to follow through with the recommendations

a. Results

Figure 4.18 contains the results for the challenges that were faced when attempting to follow-through with the suggested recommendations.

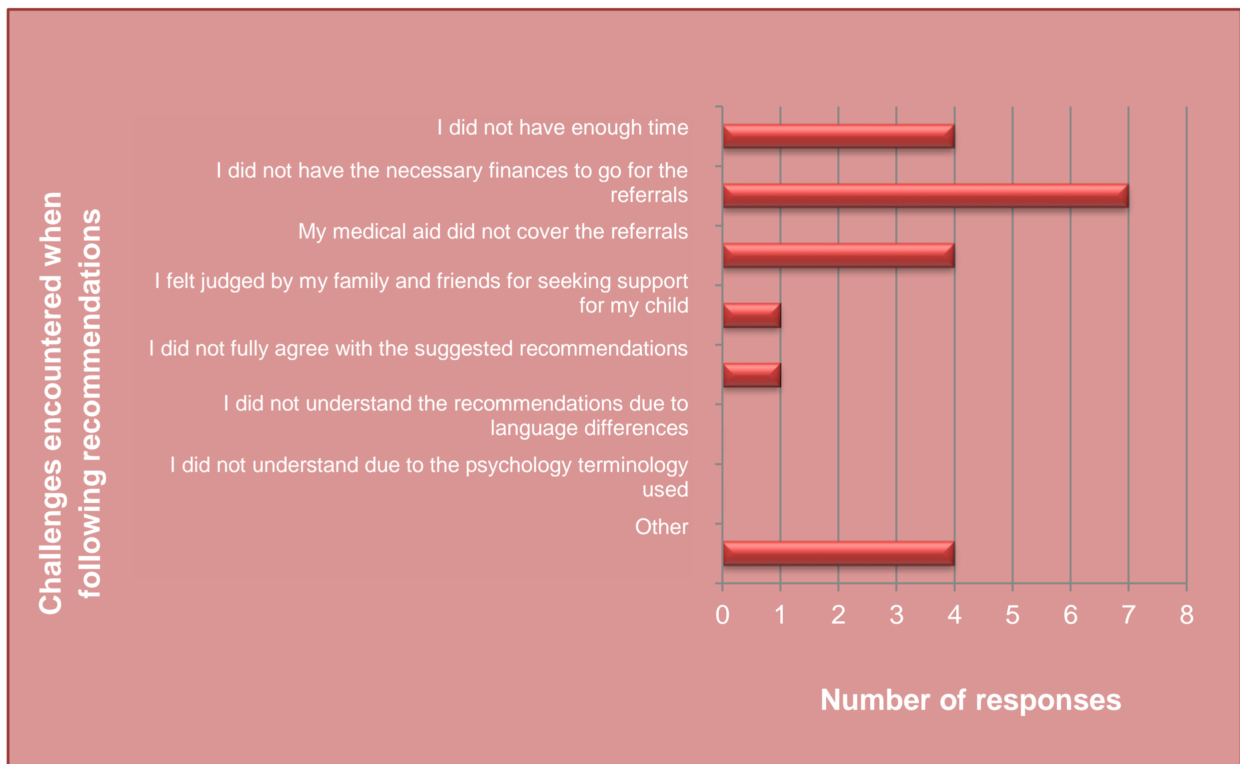

Figure 4.18: Challenges encountered when following recommendations

The respondents could select more than one response. Seven respondents indicated that personal finances were a challenge in following recommendations. Related to personal finances, four respondents indicated that their medical aid did not cover the recommendations. Four respondents indicated that they did not have enough time to carry out the recommendations. One respondent felt judged by family and friends for seeking support for his/her child and one respondent did not agree fully with the recommendations. Four respondents indicated the “Other” option, of whom two elucidated: one respondent was of the opinion that some recommendations “simply did not help”, whilst one respondent mentioned that the Department of Education was a challenge in following through with recommendations.

b. Findings

The two options not selected by respondents is relevant to the training facility: none of the respondents were of the opinion that language differences were a challenge in understanding recommendations, and none of the respondents believed that psychological terminology was a challenge in following through with recommendations.

c. Discussion

From the results, it appears as if possible challenges in following recommendations within the proximal processes, HBM and the therapeutic alliance theory are within the capacity of the educational psychologist to control, as no reasons for non-compliance, such as not understanding, could be located in either of these models, although one respondent did not fully agree with the recommendations (see 2.4.3 and 2.4.4). However, challenges outside the control of the educational psychologist located in the systems theory, such as finances (economic system), medical aid (health system) and judgement by family and friends (family and social system) proved to be challenges in following recommendations (Bronfenbrenner, 1994; Swart & Pettipher, 2016).

The one challenge mentioned which is located in the individual system and the HBM, and which the educational psychologist cannot fully control, is the concept time. Four of the 13 respondents (30.77%) indicated that time was a challenge in following recommendations. The responsibility of the educational psychologist remains to make recommendations that are possible and practical for the specific clients to carry out. In addition, when clients understand the necessity of the recommendations, follow through of recommendations is easier (see the HBM in 2.4.3).

4.2.20 To what level did the recommendations assist you in providing support for your child at home?

a. Results

Figure 4.19 contains the results for the level of supportiveness of the suggested recommendations.

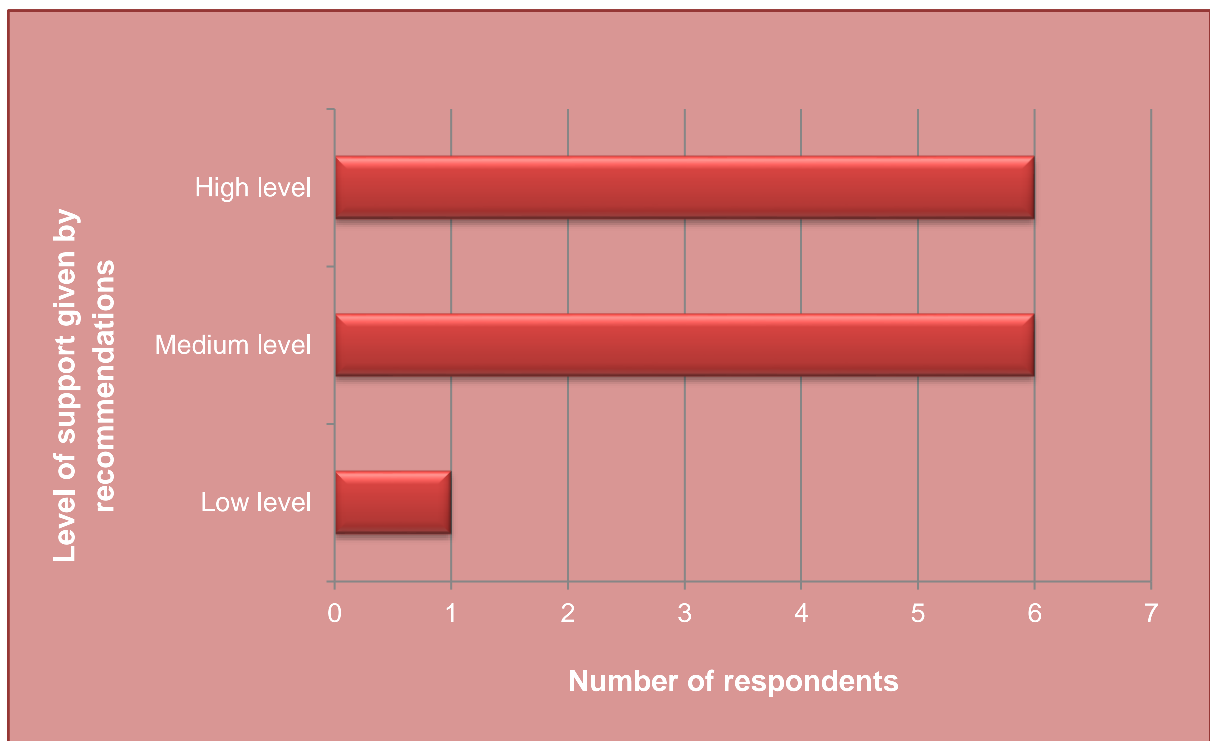

Figure 4.19: Level of support given by recommendations

Six of the 13 respondents (46.15%) were of the opinion that the recommendations provided a high level of support. Additionally, six of the 13 respondents (46.15%) were of the opinion that the recommendations provided a medium level of support. One of the 13 respondents (7.69%) was of the opinion that the recommendations provided a low level of support.

b. Findings

All the responses show that at least some level of support was experienced. Twelve of the 13 respondents (92.31%) were of the opinion that the recommendations provided a high and medium level of support, with equal responses for a medium and a high level of supportiveness.

c. Discussion

Following through with recommendations are facilitated by recommendations being supportive. In a previous section (section 4.3.16), one respondent was of the opinion that some recommendations did not help. Such recommendations will probably not be carried out. From an educational psychologist's perspective, possible reasons for recommendations not having the desired supportive effect have to be found. One possible reason is that the recommendation was not appropriate (Venzin, 2017). Another possible reason could be that the respondent did not carry out the recommendation correctly, or for long enough to have the desired effect (Theron et al., 2015; Tola et al., 2016).

4.2.21 How well do you feel your child is supported at home for his or her specific needs?

a. Results

Figure 4.20 shows the results for the level of support available for the child at home.

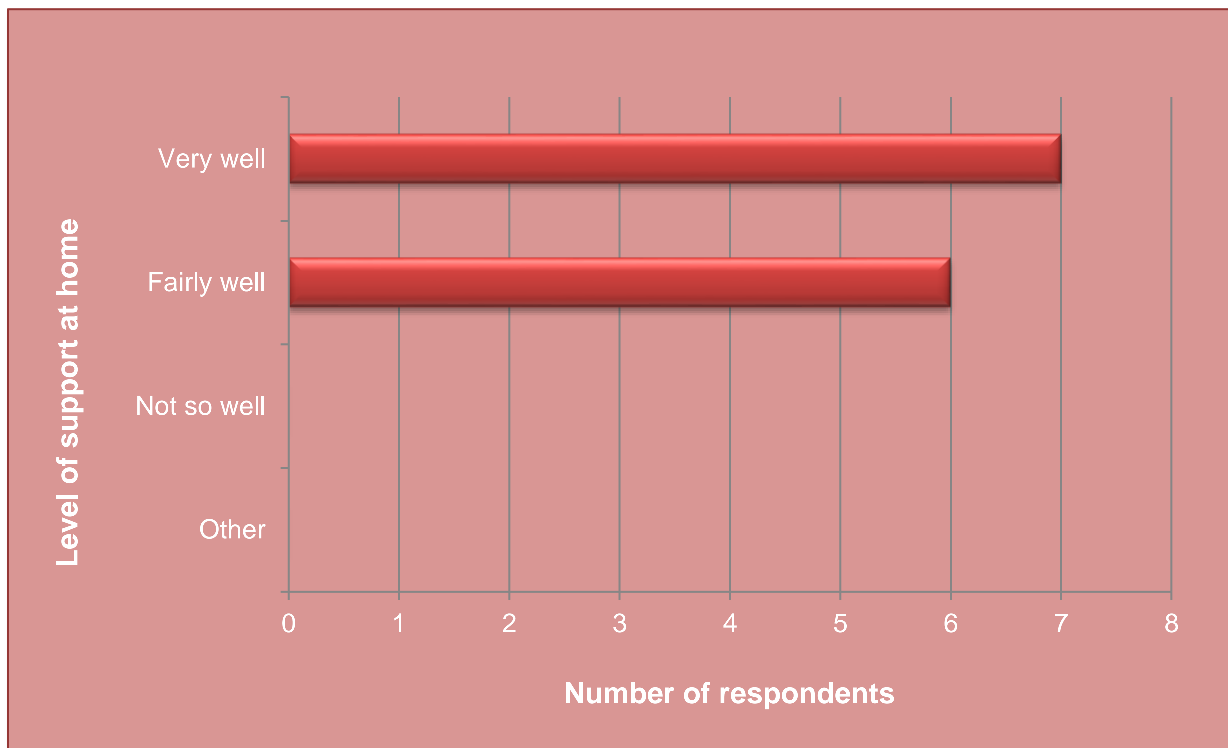

Figure 4.20: Level of support at home

Seven of the 13 respondents (53.85%) were of the opinion that their children were very well supported at home for his or her specific needs. Six of the 13 respondents (46.15%) were of the opinion that their children were fairly well supported at home for his or her specific needs.

b. Findings

All 13 of the caregivers responded that they felt their children are supported at home ranging from fairly well to very well.

c. Discussion

The question in the e-questionnaire "How well do you feel your child is supported at home for his or her specific needs?" could have referred not only to the recommendations, but also to what caregivers feel they already have in place to support their children, such as a grandparent providing supervision, or support and encouragement from the family. As such, the question does not only refer to the supportive effect of recommendations.

4.2.22 Respondents' ranking of helpfulness with recommendations

a. Results

Table 4.2 contains the results for the ranking of the least to the most helpful people or organisations with recommendations.

Table 4.2: Ranking from least to most helpful

	1		2		3		4	
	least helpful		less helpful		more helpful		most helpful	
	#*	%	#	%	#	%	#	%
Educational psychologist	0	0.00	4	30.77	5	38.46	4	30.77
Familial support	1	7.69	1	7.69	2	15.38	9	69.23
School	1	7.69	6	46.15	6	46.15	0	0.00
Medical aid funds	11	84.62	2	15.38	0	0.00	0	0.00

* Number of selections by the respondents

Four of the 13 respondents (30.77%) found the educational psychologist the most helpful. Five of the 13 respondents (38.46%) found the educational psychologist more helpful. Four of the 13 respondents (30.77%) found the educational psychologist less helpful. All the respondents rated the educational psychologist to be helpful in following through with the recommendations.

Nine of the 13 respondents (69.23%) found the family the most helpful. Two of the 13 respondents (15.38%) found the family more helpful. One of the 13 respondents (7.69%) found the family less helpful and one respondent (7.69%) found the family the least helpful.

Six of the 13 respondents (46.15%) found the school more helpful and less helpful. One of the 13 respondents (7.69%) found the school the least helpful.

Two of the 13 respondents (15.38%) found the medical aid funds less helpful and 11 of the 13 respondents (84.62%) found the medical aid funds the least helpful. None of the respondents rated the medical aid funds to be more or most helpful.

b. Findings

Per category of helpfulness, the medical aid funds were regarded as the least helpful (11 respondents), schools as less (6 respondents) and more (6 respondents) helpful,

and family as the most helpful (9 respondents). However, when all the categories which indicate some form of helpfulness are added (less, more and most helpful categories), educational psychologists are ranked at the top (with 13 of the 13 respondents agreeing), followed by family and school (both families and schools have 12 of the 13 respondents agreeing) and lastly the medical aid funds with only 2 of the 13 respondents agreeing that they were less helpful.

c. Discussion

The important role that the educational psychologist and the school and family systems play in supporting parents to follow recommendations cannot be overlooked. The absence of support by the medical aid funds as part of the health and economic systems is equally difficult to overlook. The three theories selected to form the theoretical bases of the study (Bronfenbrenner's bio-ecological model, HBM and AIM, and therapeutic alliance theory) is supported by the results of the study.

4.3 SUMMARY

The following section summarises the process and results illustrated in the above figures from 4.3.1 to 4.3.21, and Table 4.1 and Table 4.2. Figure 4.21 below illustrates the process which occurs after the assessment and feedback is given to the child's parents or caregivers.

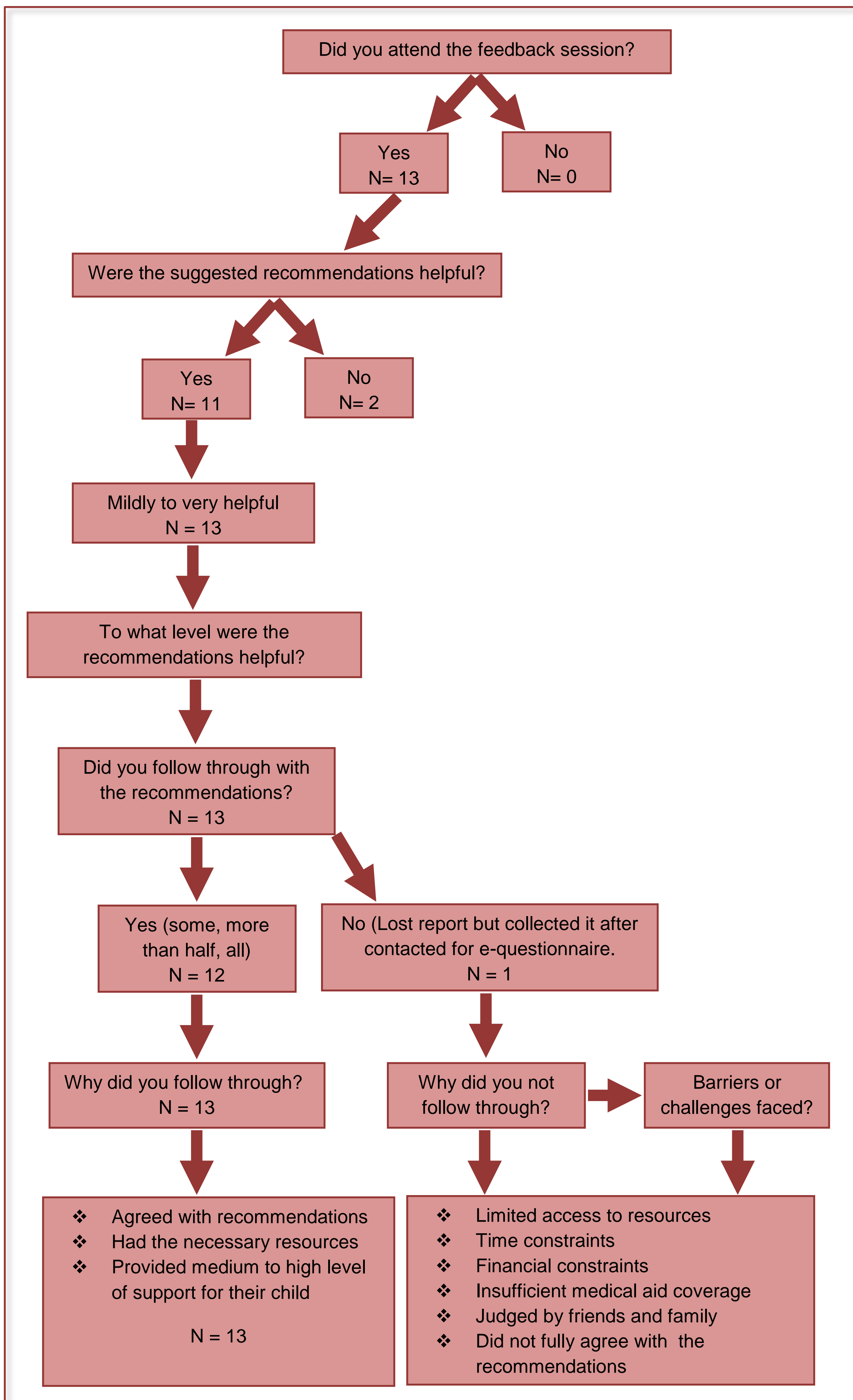

Figure 4.21: Flow chart of the assessment and feedback process summarising the results

Results from the electronic questionnaire revealed that all the caregivers attended the feedback session following the assessment process with their children.

The majority (84.62%) of the respondents followed through with some of the recommendations, more than half of the recommendations or all of the recommendations. The high percentage of respondents who found the recommendations helpful, stands in contrast to the results mentioned elsewhere in this study, namely that research conducted in the United States of America has found that 50% of parents do not follow through with the recommendations made in their children's psychological reports (Geffken, Keeley, Kellison, Rodrigue & Storch, 2006). It is relevant that the feedback session conducted by the psychologist is conducted in a well-planned and sensitive manner (Bailey et al., 2008), with compassion and in a manner that guides the parents or caregivers from a place of uncertainty to one of clarity regarding the results of their children's assessments (Bray & Kehle, 2011; Tharinger et al., 2008a). Bray and Kehle (2011) claim that even the best written psychological reports are unsuccessful if the information within it is not conveyed in an understandable, considerate and optimistic manner (Bailey et al., 2008) to the parents so that every finding and recommendation is accurately comprehended. Parents should leave the feedback session with a sense of hopefulness, be well-informed of the situation and not only have more clearly defined goals, but an understandable direction towards the steps that need to be taken in order to properly support their child/ren in order to obtain the best possible outcomes (Mead, 2013). The suggestions made by these authors clearly echo the tenets of the therapeutic alliance theory, which include mindful collaboration, communication and contact. Furthermore, by understanding the HBM, the educational psychologist can also understand the factors and processes which support favourable decision making. By incorporating those factors in the feedback session, the educational psychologist can influence adherence to recommendations.

The establishment of a strong therapeutic alliance between the educational psychologist and the caregivers occurs if the educational psychologist possesses the above-mentioned professional qualities (Bailey et al., 2008; Bray & Kehle, 2011) and engages effectively with the caregiver as discussed in Figure 2.5 in Chapter 2. Once this is achieved, the caregivers will probably find the recommendations to be helpful

as was the case in this study, as 84.62% of the respondents agreed that they did in fact find the suggested recommendations to be helpful in varying degrees.

There were no caregivers who responded that they did not find the suggested recommendations helpful at all. In Table 4.2, all the responses show that at least some level of support was experienced, with 46.15% of respondents indicating a medium level of supportiveness and 46.15% indicating a high level of supportiveness. Consequently, this suggests that the feedback session after assessment was successful for a number of reasons. Employing a collaborative nature during the feedback session is a key factor in ensuring that the parents feel included, their concerns are heard and their queries are clarified (Cloutier et al., 2010); this in turn sets the tone for a successful potential therapeutic process with the child, and encourages the parent to engage with the suggested recommendations (Bailey et al., 2008; Tharinger et al., 2008a). Mash and Barkley (2007) and Salofske, Reynolds and Schwean (2013) state that discussing parental concerns, aims and expectations, their views and beliefs concerning the child's challenges, and past experiences with other mental health professionals before and after the assessment may construct feelings of being congruent with the psychologist and thus ensuring that parents or caregivers have a pre-established optimistic outlook of the intervention plan, referrals and suggested recommendations.

Furthermore, 11 of the 13 caregivers indicated that the suggested recommendations were helpful on various levels. One of the caregivers expressed the opinion that although the recommendations were helpful, he/she felt that the challenges the child faces in itself did not change. This data concurs with Bronfenbrenner's PPCT model, which stated that the clients' and caregivers' context must be taken into account by the educational psychologist when considering various recommendations (Barnwell, 2016; Swart &Pettipher, 2016). This is depicted in Figure 2.5 as the model illustrates the process involved in encouraging adherence to the suggested recommendations. However, it is not always possible for the educational psychologist to make recommendations which suit all the caregivers' needs and conditions (Theron et al., 2015; Tola et al., 2016), thus indicating a possible area of growth in improving the overall therapeutic process.

In addition, the results show that eight of the caregivers followed through with more than half to all of the suggested recommendations, and a further three followed through with at least some and not all of the recommendations. This denotes that not a single caregiver opted not to follow through at all with the suggested recommendations, thus suggesting that the educational psychologist was at least able to motivate the parents to do something about the challenges faced by the child. Once again it can be seen that conducting a well-structured feedback session with the parents help them to feel encouraged and hopeful which prompts them to follow through with the suggested recommendations.

Caregivers were afforded the opportunity to choose more than one option in illustrating their various reasons for finding the recommendations to be helpful. The highest numbers of responses were present in that the parents agreed strongly with the recommendations suggested by the educational psychologist and that they were able to access the necessary resources to follow through with these recommendations.

33.33% of the caregivers responded that the necessary resources were not available or accessible in order to follow through with the recommendations, whilst 66.67 % responded that they did not have sufficient time, that financial constraints were a reality, and that the recommendations were not yet necessary to be followed through. Furthermore, results indicate that out of the 13 caregivers, only 11 responded to this question thus “n” in this case is equal to 11. The majority of the responses indicate that financial constraints were a major hindrance to follow through with the suggested recommendations. Time constraints and insufficient medical aid funds were the second largest percentage at posing challenges to the parents, and stigma or judgement from family and friends was reported by approximately 5% of the parents.

4.4 CONCLUSION

From the data obtained from the caregivers through the electronic questionnaire, it may be deduced that there are various challenges experienced by the caregivers when attempting to follow through with the suggested recommendations made in the educational psychologists’ reports, namely shortage of financial resources, lack of time and lack of medical aid funds. In addition, there are also components which were clear that influenced the caregivers positively in attempting to follow through with the

recommendations made, such as the strong therapeutic alliance between the parents and the educational psychologist which leads to the parents agreeing with the recommendations made and attempting to follow through with them.

In Chapter Five I summarise the study, provide answers to the research questions, discuss the possible recommendations and limitations, as well as explore contributions of this study.

CHAPTER FIVE

RESEARCH CONCLUSION AND RECOMMENDATONS

5.1 INTRODUCTION

This chapter will contain a summary of the chapters in this dissertation. Additionally, the research questions will be answered, followed by the contributions of this study, as well as its limitations. Finally, I make recommendations for future research, including the possibility to establish a training model for healthcare professionals.

5.2 SUMMARY

Chapter One explained the background, context and rationale of the study before the purpose of the study and the research questions were presented. Driven by the research questions, in addition, Chapter One oriented the reader regarding the research epistemology and methodology which grounded the study, followed by the sampling strategies implemented, data collection methods employed and the process of data analysis. The chapter concluded with ethical guidelines which became a beacon for research.

In **Chapter Two,** based on the research questions, the following was sourced: firstly, Bronfenbrenner's bio-ecological systems theory (Bronfenbrenner, 1994) was applied as this encompassed the caregiver's context of day-to-day living, everyday challenges, available resources, and transactional interactions (Swart &Pettipher, 2016; Smith, 2011). Emphasis was placed especially on the reciprocal interactions taking place between each member that is interpersonal, within each member who is intrapersonal to this context and then their interactions with the environment (Krishnan, 2010).

Bordin's therapeutic alliance theory (Johnson, Ketring, Rohacs & Brewer, 2006) and Maslow's hierarchy of needs theory pertaining to motivational drive within the caregivers (Maslow, 1943) together with Bronfenbrenner's bio-ecological systems theory, brought about the concept of parental motivation and its impact on adherence /non-adherence to the suggested recommendations in the educational psychologists'

reports. This motivation for adherence/non-adherence is further elucidated and supported by the Health Belief (Abraham & Sheehan, 2015; Rosenstock, 1974) and AIM (Mayer, 2007) models respectively. From the literature study, it was apparent that adherence and, conversely, non-adherence to the recommendations made by healthcare and mental healthcare professionals exists globally (Medical Protection Workbook, 2015; Theron et al., 2005; Tola et al., 2016), however, limited research exists in South Africa when considering mental health fields of work.

Based on the nature of the research question, **Chapter Three** contained an explanation of the primary research question motivating the study investigating parental responses to recommendations made in educational psychology reports. A discussion of the advantages as well as the challenges which may be faced in employing the positivistic paradigm, explanation of the implications of employing the survey research design, and the measures utilised in sampling the respondents was discussed. The set-up and deployment of the electronic questionnaire through the Qualtrics platform in order to collect data, and the process of data analysis was discussed in-depth in order to answer the secondary research questions.

Chapter Four included the findings of this study which indicated the various overlapping components which influenced the caregivers' decisions in attempting to follow through with most of the recommendations made by the educational psychologist in the feedback report. The findings also included the barriers caregivers experienced when attempting to follow through with the suggested recommendations.

Figure 5.1 represents the research process.

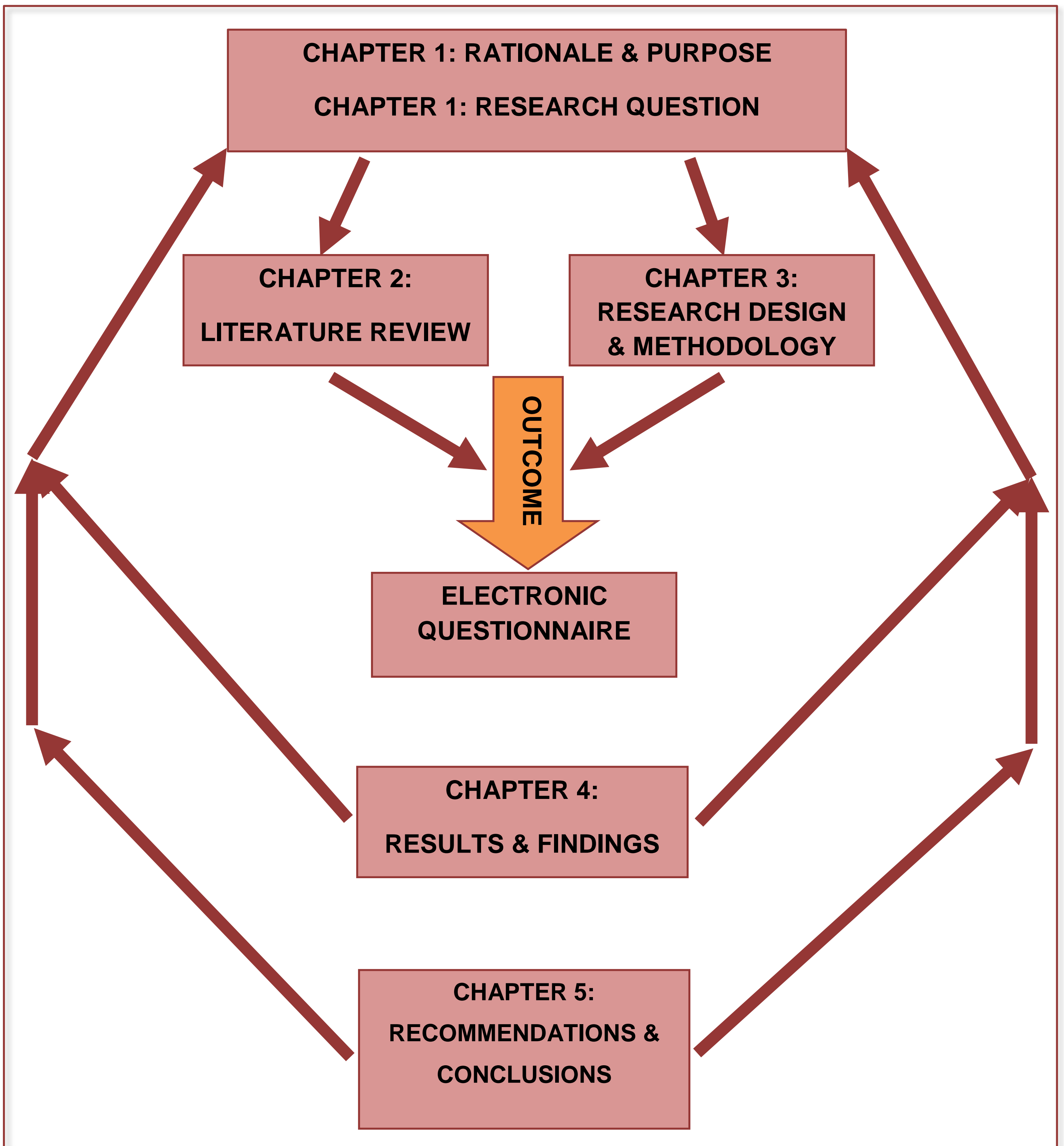

Figure 5.1: Visual representation of the research process

5.3 DISCUSSION

I will first discuss the secondary research questions before attempting to answer the primary research question.

Secondary research questions

1. What are the general responses made by parents in South Africa to recommendations made by psychologists?

Little evidence of general responses made by parents in South Africa to recommendations made by psychologists could be found. No research particularly pertaining to educational psychologists in South Africa could be found, confirming the rationale for the study. Responses to mental healthcare are often limited due to lack of mental healthcare awareness, lack of access to facilities, stigmatism, lack of support as well as a lack of formal education (Theron et al., 2015; Tola et al., 2016). Non-adherence as response to recommendations are also affected by factors such as the distance an individual must travel in order to receive health care, the stigma in the community, alteration of living conditions, marital status and socio-economic status (Tola et al., 2016). Barnwell (2016), a South African psychologist, stated that non-adherence as a response is also the mental healthcare system's fault, which remains unable to meet the clients' needs.

2. What are the outcomes of the actions taken by the parents of children in primary schools to the recommendations made in educational psychology reports?

Improved overall wellbeing and development of the child is achieved through parents following through with the suggested recommendations (Green & Walker, 2007). Parents usually follow through with the suggested recommendations or at least attempt to follow through with some of these recommendations as they are willing to do what is required for the well-being of their children (Edlund & Rahman, 2005).

The outcome of the electronic questionnaire indicates that parents found the educational psychologists as well as the schools to be helpful in supporting their children. The schools' involvement may be experienced as supportive to the parents as they were involved in the early identification of their children's challenges and

provided many of the parents with the contact details for the training facility at the University of Pretoria.

Another outcome is that the respondents in the survey estimated the recommendations to support their children fairly well and well.

3. What are possible modifications or adjustments educational psychologists can make in their feedback and recommendations in order to increase the possibility that parents decide to make favourable decisions?

It is the ethical responsibility of the educational psychologist to provide feedback to the parents (Tapsak, 2011). The educational psychologist should take care to create an environment that ensures that parents feel comfortable to share their concerns (Bailey et al., 2008), remain structured to relay the assessment results effectively (Tharinger et al., 2008b), ensure that valuable clarifications are given to the parents queries (Bray & Kehle, 2011), conduct the entire feedback session in a compassionate manner (Bailey et al., 2008), and compile the feedback report in a language that is comprehensible to the parents (Mead, 2013).

Furthermore, educational psychologists should take care to understand the specific needs of the parents in order to structure their recommendations in the best possible way to enable the parents to calm their children and provide support in order to face and overcome their challenges effectively (Mead, 2013; Swart &Pettipher, 2016). Careful consideration of the parents' context regarding available time, available resources both financially and emotionally, as well as available support from other family members will enable the educational psychologists to adjust their approaches and intervention plans to best suit the parents' and their children's needs (Cloutier et al., 2010).

Through implementing the above-mentioned professional qualities, an effective and constructive therapeutic alliance is built between the educational psychologist and the parents which directly impacts the positive therapeutic outcomes experienced by the child (Abraham & Sheehan, 2015; Rosenstock, 1974).

Based on the literature study and the theoretical framework presented in Chapter Two, Figure 2.5, a summary of guidelines for educational psychologists was developed in

order to improve the therapeutic and feedback process, and increase the likelihood that parents would follow through with the suggested recommendations in the reports (see 5.5 Contribution).

Primary research question

What are parents' responses to the recommendations made in educational psychology reports for their primary school children at a training centre in Pretoria?

Drawing from the answers to the secondary research questions, the primary research question is answered as follows:

The results obtained from the electronic questionnaire indicated that most caregivers responded favourably to the recommendations that were suggested by the educational psychologists. Caregivers indicated that financial and time constraints posed a challenge; they also indicated that the medical aid funds were insufficient to cover the costs involved in following through with the recommendations.

In this study, the electronic questionnaire revealed the respondents' agreement with the suggested recommendations, access to the necessary resources, as well as providing an adequate level of support for their children as the main reasons for adherence. Barriers to following through with the suggested recommendations such as limited access to resources, financial and time constraints, insufficient medical aid funds, stigma and difference of opinion to the educational psychologist were experienced by the respondents. Bronfenbrenner's PPCT model addresses these findings by taking a closer look at the socio-economic context of the caregivers (Krishnan, 2010), as well as the sensitive interrelatedness of the various influencing factors, interactions and interrelationships among the child, parent/s and their environment (Swart & Pettipher, 2016) which could influence adherence to recommendations.

Ohan, Seward, Stallman, Bayliss and Sanders (2015) classify barriers into two main categories namely, "structural" and "attitudinal barriers", with Reardon et al. (2017) adding that individuals' own understanding and familiarity with mental health challenges and subsequent search for assistance, as well as family situations are both key categories in understanding and identifying barriers. Structural barriers may be better understood with reference to Cloutier et al. (2010), who indicate possible

barriers that could be experienced by the parents when attempting to follow through with the suggested recommendations. These barriers include, but are not limited to, lack of sufficient feedback from the healthcare professional, limited access to mental healthcare services but also a lack of information concerning available mental health services. Therefore, these barriers in short are a lack of availability of the above mentioned resources, ease of access and the families' socio-economic status (Wood, Littleton & Sheehy, 2006) which relate to financial constraints experienced due to expenses incurred (Ohan et al., 2015).

Parents may find it costly to travel to the mental healthcare sites (Ohan et al., 2015) especially if they are travelling from rural to urban areas in order to seek assistance (Reardon et al., 2017). Families often rely on the available funds of their particular medical insurance schemes to cover mental health treatment which could also influence their ability to utilise the services provided (Mash & Barkley, 2007; Reardon et al., 2017). A study conducted in the United States of America concluded that being Caucasian, having a superior medical aid scheme, residing in an urbanised area, and having a child with a higher severity of a mental health condition played a role in the likeliness of the parents seeking mental health services on behalf of their children (Reardon et al., 2017).

Additionally, Wood, Littleton and Sheehy (2006) state that barriers such as the reality of not being able to be a present caregiver for the child, and the families views or belief systems regarding mental health may act as a barrier to accessing and adhering to the recommendations made by mental healthcare professionals. These barriers are classified as "attitudinal" barriers as they encompass the parents' awareness of and views about mental health challenges as well as mental health services (Ohan et al., 2015, Tapsak, 2011). Stigma, lack of mental health resources and access thereof for parents, teachers and children, as well as preconceived ideas about the mental health field and professionals, and a lack of confidentiality are the major barriers individuals experience (Ohan et al., 2015; Reardon et al., 2017). Whilst parental engagement with the suggested recommendations is of importance in ensuring that their child reaches their set goals, a multiple support system approach towards these recommendations is emphasised which involves the parents, teachers, other family members and healthcare professionals (Ohan et al., 2015). This multiple support approach ensures continuous communication between the various role players, thus

strengthening the working relationship between each and this in turn solidifies the parental engagement which leads to the improvement in the child's well-being (Ohan et al., 2015).

Often, parents believe that the mental health challenges that their children face will pass or that it is only temporary and may be managed on their own. Parents also find it challenging to accept medicinal intervention and have an ominous fear of pessimistic societal stigma not only from their family and friends but also the fear that the child's teachers may begin marginalising and labelling their child after the assessment and therapeutic processes (Mash & Barkley, 2007; Ohan et al., 2015, Reardon et al., 2017). Williams and Polaha (2014) suggest that parents may feel embarrassed or ashamed should their friends, family and the child's teacher find out that guidance was sought from mental health professionals.

When applying the integrated model of theories in Chapter Two, the following becomes clear:

Results from the study corresponding with Bronfenbrenner's bio-ecological model:

- ❖ Age of the caregivers, socio-economic status and their marital status suggest that financial availability and access to medical aid funds are a strong possibility (Nsamenang & Hirsch, 2015) which support following through with recommendations.
- ❖ Environmental factors such as support from family members and extended family members, the educational psychologist, stigma, and available time influences the likelihood of compliance to the suggested recommendations (Elliott, 2008; Swart & Pettipher, 2016).

Results from the study corresponding with Therapeutic Alliance Theory:

- ❖ The absence of jargon or academic language facilitated the relationship between the parents and the educational psychologist, thus probably contributing to adherence.
- ❖ Contact, mindful collaboration and communication between the educational psychologist and the caregivers further enhance the therapeutic alliance encouraging compliance of the suggested recommendations (Baylis et al., 2011; Venzin, 2017).

Results from the study corresponding with the HBM and AIM models:

- ❖ Parents' motivation is strongly affected by socio-economic and environmental factors which may cause interpersonal conflict affecting self-efficacy and subsequently compliance (Abraham & Sheehan, 2015; Maslow, 1943; Rosenstock, 1974). However, motivation as understood by the HBM suggests that many factors may motivate, influence and persuade parents to follow through with the suggested recommendations, or conversely not to follow through. This means that should parents feel that the benefits of following through outweigh the challenges they may face whilst following through, they will end up adhering to the suggested recommendations.
- ❖ Parents understanding the benefits of the recommendations ensures that they are motivated to carry them out (Green & Walker, 2007; Ryan & Deci, 2000).

5.4 RECOMMENDATIONS

As stated in Chapter Three (Section 3.2.1), this study was conducted in a manner that quantitative data could be collected through the use of the electronic questionnaire (McMillan & Schumacher, 2001) which ensures that the research process remains objective (Antwi & Hamza, 2015; Taylor & Medina, 2013) whilst exploring human behaviours in order to measure and predict this in future (Cohen, 2007; Maree, 2010; Salkind, 2010). These results were then expected to be predictive of the behaviours of the population (Bacon-Shoane, 2015; Creswell, 2014). However, as this study is a mini-dissertation, with 13 participants in total, it is not possible to make wider predictions of this nature to larger populations.

Therefore, in order to be able to make such future predictions and generalise findings, I recommend that corresponding research be conducted and completed with a much larger sample of participants of various socio-cultural groupings. This type of research could include a qualitative component, thus making it a mixed methods study and additional qualitative data could be collected from the parents. The researcher could conduct focus group discussions with both parents, instead of acquiring the responses from just the child's mother as in this study. Additionally, it could be a possibility that more detailed information may be obtained regarding the specific reasons that influence parents to follow through with recommendations and conversely the reasons

why they do not follow through with the suggested recommendations made in the educational psychologists' reports. More detailed information should include the specificity of who looks after the child in the afternoons, the exact income of the family and the breakdown of expenses, and the specific medical aid scheme that was being used by the family at that time. This in turn will aid the researcher in better understanding the reasoning and motivation behind the parents following through with, or not following through with the suggested recommendations.

An additional recommendation would be to conduct research into the applicability of the proposed model (Refer to Chapter Two) to understand and improve feedback and compliance to recommendations in South Africa. The model may be used by educational psychologists, and other health care workers, when interacting with clients. Training institutions could make use of the model in preparing students for the world of work.

5.5 CONTRIBUTION

The main contribution of the study lies not only in the high percentage of recommendations at the training facility being adhered to, thus confirming a good training model, but in the potential the integrated model of adherence has for training psychologists and other health care workers and understanding the intricate dynamics of compliance. By understanding the reciprocal interactions amongst the systems, as well as the interpersonal and intrapersonal interactions according to Bronfenbrenner, combined with the specifics of therapeutic alliance theory which codetermine interpersonal communication, together with the motivation as understood through the HBM and AIM models, any psychologist, medical professional and health care worker can optimise feedback to clients to increase adherence to recommendations and thus overall well-being.

5.6 LIMITATIONS OF THE STUDY

The main limitation in this study was that only 13 parents participated and completed the electronic questionnaire, whereas the initial plan was for approximately 30 to 40 respondents to participate in the study. A sample group this small is likely to have an effect on the generalisability of the study, therefore the results that were generated and analysed should be examined cautiously. The sample population does not

represent all the population groups. The study was conducted with parents whose children were involved in the assessment process in the training facility at the University of Pretoria, however, as a result, the outcomes cannot be generalised to all the parents who have been involved in the preceding years. Therefore, it is proposed that the conclusions and possible recommendations form the foundation for prospective research on this topic. Moreover, mainly mothers participated in this study, whereas the perspectives of fathers might have added another dimension to the results.

Although parents indicated that English is the language mostly spoken at home, English is not necessarily their home language. Therefore, the language of the electronic questionnaire could have been a possible barrier regarding the parents' comprehension and thus influencing the quality of their responses.

A methodological limitation of the study was the use of a survey design. The response rate for such a design is usually low, requiring a large initial sample. The initial sample in this study was too small to allow any form of generalisation through the use of a survey design, even though the response rate for this particular study had been quite high, namely 43.24%, in comparison to the generally expected response rate of 33% (Nulty, 2015). This indicates that more than half of the parents who were contacted and verbally agreed to complete the electronic questionnaire did not respond. Those who did not respond, made it impossible to determine whether or not the suggested recommendations were adhered to or not adhered to, in other words the high rate of compliance in the study might be contributed to the fact that the respondents who followed the recommendations participated more readily in the survey than other parents who did not follow through with the recommendations.

Additionally, it was not possible to infer whether responding favourably to the survey invitation corresponds with the respondents following through with the suggested recommendations. Other undiscovered influential factors may still influence parental responses to the suggested recommendations as the sample size of 13 respondents is too small. Therefore, this confirms that the study should be replicated to other larger populations in order to confirm generalisability.

5.7 CONCLUSION

In conclusion, I would like to restate that the ideal to run a smooth and supportive assessment feedback process is not always a reality and that families in South Africa are facing constant challenges and barriers in attempting to follow through with the recommendations suggested by educational psychologists. Seeking professional mental health services continues to pose stigmatisation and marginalisation as a general rule.

The results of this study produced substantiation of the importance of seeking mental healthcare services, the importance of the therapeutic alliance between the caregivers and the educational psychologist as well as the importance of presenting all forms of intervention frameworks to the needs and context of the client and their families.

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APPENDIX A: PILOT ELECTRONIC QUESTIONNAIRE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Education

26 June 2017

To whom it may concern

PILOT ELECTRONIC QUESTIONNAIRE

I am currently a master's student in Educational Psychology at the University of Pretoria with Dr Anna-Barbara du Plessis (083 655 2009 or abeduplessis@yahoo.com) as my supervisor. I have recently been awarded my ethical clearance certificate and wish to commence with my data collection phase. However, as part of my research, I would like to pilot my electronic questionnaire before distributing it to the participants. For this purpose I kindly request your time, knowledge and expertise.

The purpose of the research is to investigate parental responses to recommendations made by educational psychologist students at the training facility for educational psychologists here at Groenkloof campus, UP. The rationale is that if I can understand why parents respond in certain ways to recommendations, I can make suggestions to add to or change the feedback interview so that parental responses become more favourable. More favourable parental responses will contribute to more children being supported to deal with challenges, contributing to better mental well-being in the long term.

The electronic questionnaire is attached to this e-mail. Kindly read through it. Please feel free to make any changes or additions you feel are necessary (e.g. question content, question format and answer format) to the questionnaire through comments or track changes on the document and return it to kipas26@gmail.com by Friday, 30 June 2017.

I look forward to your response!

Kind regards

Kipa Shrestha

Electronic questionnaire: Parental responses to recommendations

Background/demographic information

Age: [ ]

Gender: [Male] [Female]

Marital status: [Single] [Married] [Divorced] [Widowed]

[Other (please specify) ....]

Language mostly spoken at home: [Afrikaans] [English] [Ndebele] [Northern Sotho] [Sotho] [Swazi] [Tsonga] [Tswana] [Venda] [Xhosa] [Zulu]

Income bracket (ZAR per year as of 2017): [0 – 189 880] [189 881 – 296 540] [296 541 – 410 460] [410 461 – 555 600] [555 601 – 706 310] [708 311 – 1 500 000] [1 500 001 and above]

Medical-aid: (at the time of assessment) [ ]

Number of child-ren supported by this income: [ ]

1.	Which one of the following best describes your working hours? a. 8 hours a day b. 5 hours a day c. More than 9 hours a day d. Less than 5 hours a day
2.	Did you find the recommendations to be useful? a. Yes b. No
3.	To what level were the recommendations helpful for you? a. Very helpful b. Helpful c. Mildly helpful d. Not helpful e. Other (please specify) ....
4.	If you answered YES (question 2), why did you follow through with most of the recommendations? You may indicate more than one option. a. I agreed strongly with the recommendations. b. I had a good working relationship with the educational psychologist. c. The recommendations aligned with my cultural perspectives. d. I had the necessary resources to follow through with the recommendations. e. Other (please specify) ....

5.	If you answered NO (question 2), why did you not follow through with the suggested recommendations? You may indicate more than one option. a. I did not trust the educational psychologist. b. I did not have the necessary resources to follow through with the recommendations. c. My cultural view does not acknowledge educational psychologists as a form of intervention/support. d. Other (please specify) …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… ……………………………………………………………………
6.	Which of these challenges did you face when attempting to follow through with the recommendations? You may indicate more than one option. a. I did not have enough time. b. I did not have the necessary finances to go for referrals. c. My medical aid scheme did not cover the referrals. d. I felt judged by my family and friends for seeking support for my child. e. I did not fully agree with the suggested recommendations. f. I did not understand the recommendations due to language differences. g. Other (please specify) …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… …………………………………………………………………… ……………………………………………………………………

7.	To what level did the recommendations assist you in providing support for your child at home? a. High level b. Medium level c. Low level
8.	Who looks after your child in the afternoons? (after school and after extra-curricular activities) a. Myself b. My spouse c. Grandparent/s d. Au pair/baby sitter e. Domestic helper f. Day care g. After school care h. Other (please specify) ....
9.	How well do you feel that your child is supported at home for his/her specific needs? a. Very well b. Fairly well c. Not so well d. Other (please specify) ....

10.	Which people in this process made following the recommendations easier? Rank from most helpful to least. (E.g. a, d, c, b.). a. The educational psychologist b. Familial support c. School d. Medical aid funds ....

Open questions:

1. Were there any barriers and/or challenges you experienced which the questionnaire did not sufficiently cover?

   ....
   ....
   ....
   ....
   ....

2. Is there anything you would like to add and elaborate on in terms of the questionnaire?

   ....
   ....
   ....
   ....
   ....

Thank you for your time and input! I greatly appreciate your contribution!

APPENDIX B: FINAL ELECTRONIC QUESTIONNAIRE

Electronic-Questionnaire: Parental responses to recommendations

This survey is currently LOCKED to prevent invalidation of collected responses! Please unlock your survey to make changes.

Background/Demographic Information   Block Options

1. Age:

2. Gender:
- Male
- Female

3. Marital status:
- Single
- Married
- Divorced
- Widowed
- Other (Please specify)

4. Language mostly spoken at home:
- Afrikaans
- English
- isiNdebele
- Sesotho sa Leboa (Sepedi)
- Sesotho
- siSwati
- Xitsonga
- Setswana
- Tshivenda
- isiXhosa
- isiZulu
- Other (Please specify)

APPENDIX C: AN EXAMPLE OF RAW DATA

Default Report

Electronic-Questionnaire: Parental responses to recommendations
January 12th 2018, 12:47 pm MST

1. - Age:

Age:
47
48
36
48
38
47
40
55
37
35
35
33
48
40
45
45

APPENDIX D: CONSENT FOR PARTICIPATION IN A RESEARCH STUDY

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Education

CONSENT FOR PARTICIPATION IN A RESEARCH STUDY

Dear Participant

Background and invitation

You are invited to take part in this research study aimed at investigating responses of parents to recommendations made in educational psychology reports.

My name is Kipa Shrestha and I will conduct research as a Masters student in Educational Psychology at the University of Pretoria. The study will be supervised by Dr Anna-Barbara du Plessis, also from the Department of Educational Psychology at the University of Pretoria. By taking part in the study, you will probably help us to improve our feedback sessions to parents and perhaps even that more children receive support.

Afterwards, I am expected to publish an article based on the findings from my study.

Expectations from participants

You will be asked to complete an electronic questionnaire which should take no longer than 15 minutes of your time. The questions are focused on the aspects of your daily life and routine and your experience of the psychological assessment process at the training facility on Groenkloof Campus. Your completion of the electronic questionnaire will be regarded as informed consent to participate. No one will link your answers to you. The link to the electronic questionnaire will be e-mailed to you via the server itself.

Rights of the participant

- Participation is voluntary.
- No one will know who you are.
- You may refuse to participate.
- You may withdraw from the study at any time, without repercussions, and without giving reasons.
- The study will not deceive you.
- The study will not expose you to any physical harm.
- If you want emotional support, you are kindly referred to a psychologist (Moira Brown, 082 870 666 5).
- All the data obtained during this research study will be kept strictly confidential and will only be available to the researcher and her supervisor.
- All the data collected will be locked away and secured at the department.
- All electronic files will also remain password protected.

Questions and Information

Please feel free to ask any questions if you require any clarification.

Dr. Anna-Barbara du Plessis: abeduplessis@yahoo.com

Ms. Kipa Shrestha: 0796904080/ kipas26@gmail.com

Thank you in advance!

I truly appreciate your consideration to take part in my study.

Ms Kipa Shrestha
Researcher

Dr. Anna-Barbara du Plessis
Supervisor

APPENDIX E: TELEPHONE SCRIPT

<u>Telephone script</u>

Good morning, afternoon, evening Mr/Mrs ....

How are you?...

Y do not know me. I am calling from the training facility at the University of Pretoria, Groenkloof. May I have two minutes of your time, please?

I am Kipa Shrestha. I am currently a master's student at the dept. of Educational Psychology and calling you with regards to my research project.

I would like to send you an e-mail regarding research I am doing about parental responses to recommendations made in the Ed Psych reports. May I please have your e-mail address to send you a very short and completely anonymous and confidential electronic questionnaire?

The e-mail will give you all the details regarding participation or not..

- Ask for email
- Do you perhaps have a spouse or life partner who was also involved in the assessment to whose e-mail address I can send this short and completely anonymous and confidential electronic questionnaire?

(Copy address, read back to person to verify)

Please feel free also to whatsapp/ sms the addresses to me on 0796904080 (this number)

You will receive the official email soon.

Thank you very much for your time.

Goodbye!

APPENDIX F: EXAMPLE OF THE RESEARCHERS REFLECTIVE JOURNAL

REFLECTIVE JOURNAL

14 April 2017

Drawing up the e-questionnaire

1. Section for background/biographical information, gender, race, income bracket
   - Understand the context.
   - Understand the challenges they face on a daily basis or on a regular basis if not daily.
   - What are their qualifications or highest level of education?
2. Have they (parents and client) had previous experiences with educational psychologists? How was this? When? Why?
3. How were the recommendations made? How were these communicated by the educational psychologist? how did these make the parent feel?
4. Was there a follow through on the suggested recommendations? Why? Why not?

Meeting with Supervisor 24 April

1. Make sections very distinct
   - Biographical/background
   - Include how many people are supported by the income; are there financial constraints
   - Was there access to medical aid? Was there a support system like this in place that assisted parents to follow through with the recommendations?
   - Add language mostly spoken at home; to see if there were any language barriers to following through with recommendations
2. Working hours of parents per day should be added – is time a possible barrier to following recommendations
3. Were recommendations useful? Why? Why not?
4. Consider adding rating scales to some of the multiple-choice options

Execution of e-questionnaire June 2017

1. Most parents that were contacted were willing to assist
2. No comments or phone calls received for any reason such as not understanding the questions or any other related inquiries