

The Application of Stigma-Induced Identity Threat to Individuals With Hearing Loss

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Conventional wisdom within audiologic rehabilitation suggests that hearing loss stigma and the stigma associated with hearing aids act as a barrier to persons with hearing loss entering rehabilitative services. Regrettably, this knowledge has led to few investigations attempting to better understand this phenomenon. In recent years, researchers in the social sciences have made great strides to conceptualize *stigma* from the perspective of people who are the target of prejudicial attitudes. In our view, most of these concepts proposed are applicable to the social stigma associated with hearing loss. In the present article we attempt to position hearing loss stigma within a model of stigma-induced identity threat. Based on this new information, we explore how intervention services could be modified to better serve individuals who show signs that their personal identity is diminished due to the fact that they have a hearing loss.

BACKGROUND

In North America, hearing loss stigma is a powerful social and psychological force. Stigma acts to delay the help-seeking behaviours of adults who develop

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hearing loss in a variety of ways. Hearing loss stigma has been associated with reduced self-esteem (Héту, 1996); decreased levels of confidence, friendliness, and intelligence (Doggett, Stein, & Gans, 1998; Héту, 1996); constraints on social participation (Héту, Riverin, Lalande, Getty, & St-Cyr, 1988); denial and/or minimization of the hearing problem (Héту, Riverin, Getty, Lalande, & St-Cyr, 1990); concealment of hearing-related problems (Hallberg & Barrenas, 1995; Hallberg & Jansson, 1996; Héту, Getty, & Waridel, 1994); and a reluctance to use hearing aids due to unfavourable cosmetics (Blood, 1997). The origins of contemporary perspectives on hearing loss stigma date back to Raymond Héту's ground-breaking article "The Stigma Attached to Hearing Impairment" (Héту, 1996). In this article, Héту described how hearing loss stigma acts as a threat to one's social identity, and that reactions to stigma might be explained using *shame* as a foundational base. Héту's (1996) treatise on the stigma associated with hearing loss has become one of the most influential documents on this topic in the domain of audiologic rehabilitation.

Evidence suggests that "The Stigma Attached to Hearing Impairment" (Héту, 1996) was published during a time of strong growth in the quantity of stigma focused research. A keyword search for *stigma* in the database PsycInfo for the period 1860-1986 reveals just 585 articles. However, in the 10 years prior to the Héту article (1986-1996) 1,133 articles are uncovered, while for the 10 years following Héту's article (1996-2006) the number of hits increases to 3,716. An additional 1,673 articles are flagged by adding the years 2006-2009. As a research topic, stigma is booming.

In the Social Sciences it is generally accepted that stigmatization occurs in social settings in which two groups exist: the outsiders and the insiders (Link & Phelan, 2001, 2006; Oyserman & Swim, 2001). The outsiders are a dominant group that possess and exercise power over the insiders. The insiders are subordinate to the outsiders because they possess an attribute that is distinct from the outsiders. Stigma research might take a number of different perspectives; however, the literature has two main trends. There is research that examines the *insiders* (i.e., the person being stigmatized). Research of this kind typically focuses on the psychological traits of insiders as opposed to aspects of the sociological scene. Conversely, there is research that investigates the outsiders and the macro-social level contributors to stigmatization. This research tends to focus on the impact of social inequities linked to behaviours of the stigmatizers. For this paper, we will limit our discussion to the individual, and more specifically to the person being stigmatized.

Over the past decade, great strides have been made to conceptualize stigma from the perspective of the individual who possesses a stigmatizing attribute. A number of "stigma-induced identity threat models" have been proposed that summarize the perception of, and responses to stigma (Crocker, Major, & Steele, 1998; Major & O'Brien, 2005; Steele, Spencer, & Aronson, 2002). According to

this conceptualization, the intensity of perceived stigmatization is determined by the relevant stereotype, characteristics of the individual, and of situational cues. According to Major and O'Brien (2005) identity threat models dominate the current stigma research landscape.

Identity threat models are founded on the assumption that the impact of stigmatization is determined by the motives of the person who possesses the stigmatized attribute, by their understanding of the particular social scene, and by their understanding of what other people think of them (Lazarus & Folkman, 1984). Although not explicitly incorporated into his model of stigma, to his credit Héту (1996) addressed the issue of social identity and (albeit briefly) described how elements inherent to the situation influence one's perception of stigmatization. Although an introduction to this model will likely lead to insights into how to optimally address stigma within the realm of audiologic rehabilitation, the primary intent of this article is to extend our understanding of hearing loss stigma by way of introducing a contemporary stigma identity threat model. We will limit our discussion of stigma to the perspective of people who acquire a permanent hearing loss in adulthood. Overall, the goals of this paper are to (a) offer a brief summary of hearing loss stigma, (b) present a specific stigma identity threat model and incorporate ideas about hearing loss stigma into this general conceptualization of stigma, and (c) reflect on the appropriateness of this model for the domain of rehabilitative audiology.

HEARING LOSS STIGMA

In ancient Greece, the word *stigma* represented the cuts and burns inflicted on people thought to be traitors, criminals, or slaves (Goffman, 1963). Over time, the definition of stigma evolved to focus on how these marks or attributes designate the bearer of a spoiled identity, or someone who is valued less in society (Goffman, 1963). In *Stigma: Notes on the Management of a Spoiled Identity*, Goffman (1963) proposed that stigmatization takes place when a person possesses an attribute (e.g., abominations of the body, of the character, or of race/religion) that is other than what is anticipated, and therefore undesirable, leading this person to be devalued as a human being. For the purpose of this paper, stigma refers to the possession of, or belief that one possesses an attribute or characteristic that conveys a social identity that is devalued in a particular social context (Crocker et al., 1998).

Goffman (1963) reported that people with hearing loss often experience archetypal elements of stigmatization. Hearing difficulties (the devalued attribute) is often generalized to other aspects of a person's social identity. Specifically, the reduced capacity to hear is often misunderstood as an intellectual challenge or deficiency in personality/character (Goffman, 1963). One key dimension of stigma that is particularly relevant to the discussion of stigma associated with hearing loss is the capacity for the stigmatized person to conceal the stigmatizing trait

from others (Jones, Farina, Hastorf, Miller, & Scott, 1984). Many individuals who have a concealable stigma attempt to “pass as normal,” in effect keeping the devalued attribute a secret (Goffman, 1963). In the case of a progressive hearing loss however, over time the stigmatized attribute becomes more apparent to communication partners. Therefore, the inherent risks associated with concealing hearing loss gradually become greater, as do the penalties of being caught in this deception.

A second key dimension of stigma that is particularly relevant to the discussion of hearing loss is the extent to which a person’s hearing difficulties become disruptive in social settings. Disruptiveness is a subjective measure of the extent to which a stigmatizing condition interferes with the normal course of a social interaction. Dovidio, Major, and Crocker (2000) reported that people who have stigmatizing conditions make poor partners for social interactions. One particularly distressing aspect of stigmas is that the individual is aware that the quality of his or her social identity is being devalued, yet the person is uncertain as to whether this evaluation is based on their stigmatizing attribute (Goffman, 1963). This uncertainty surrounding the reasoning for mistreatment imparts a constant stress on the individual (Miller & Major, 2000). Goffman (1963) also proposed that it is particularly psychologically difficult for people who “bought into” prejudicial attitudes about a stigmatized group early in life to subsequently become a member of that stigmatized group later in life. Individuals who acquire hearing loss in adulthood might experience difficulties of this kind.

MODEL OF STIGMA-INDUCED IDENTITY THREAT

According to the model of stigma-induced identity threat proposed by Major and O’Brien (2005), stigmatization can threaten one’s social identity. These authors suggested that experiencing a potentially stigmatizing event (and the coping responses that follow) is fundamentally similar to experiencing a stressful situation. A block diagram depicting the conceptualization of stigma as proposed by Major and O’Brien (2005) is shown in Figure 1. The core element of this model is box D, appraisals of identity threat. When confronted with a potentially stigmatizing situation, the person who possesses the stigmatized attribute appraises (consciously or at a pre-conscious level) the threat to his or her social identity. This is an “on the spot” assessment of the meaning and significance of this mistreatment (i.e., stigma). If the demands of the situation tax or exceed available personal resources, the event is deemed threatening, thereby creating need for a response. The appraised identity threat is based on three construals: the collective representation present (box A), situational cues inherent to this event (box B), and personal characteristics of the person who possesses the stigmatizing attribute (box C). The person responds to a threatening event with non-volitional responses (box E), and with volitional responses (box F). The outcomes (box G) of coping responses likely feed back to the construals level of the

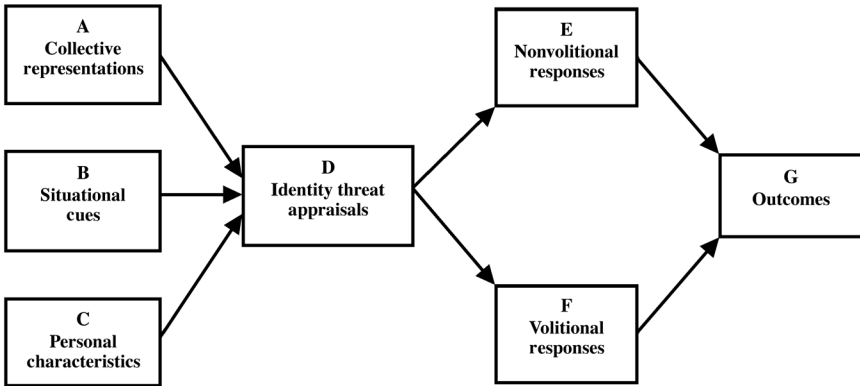


Figure 1. Model of stigma-induced identity threat. From “The Social Psychology of Stigma,” by B. Major and L.T. O’Brien, 2005, *Annual Review of Psychology*, 56, pp. 393-421.

model (i.e., to the collective representations, situational cues, and personal characteristics) and the appraised identity threat levels (note: although these feedback loops exist, they are not displayed in the visual representation of Figure 1).

Note that the design of this specific stigma-induced identity threat model is general enough to consider a wide range of stigmatizing traits and individual characteristics. We consider this to be a strength of the model. For example, concerning hearing loss, it is likely that characteristics such as the age of onset of hearing loss, the degree and type of hearing loss, and the mode of communication used will have an influence on the magnitude and the type of identity threat a person with hearing loss will experience (these factors are grouped under the personal characteristics component of the stigma model proposed by Major & O’Brien, 2005).

COLLECTIVE REPRESENTATIONS

Collective representations are the shared (societal) understandings and beliefs about stigmatizing conditions (Crocker, 1999). As a first approximation, this term can be thought of as being synonymous with the term stereotype. Evidence suggests that currently, in Western societies, to have a hearing loss is to be perceived by others as unacceptably different (Erler & Garstecki, 2002). Although most collective representations about hearing loss in North America are negative, in some communities such as the Deaf community hearing loss is not devalued.

From a general perspective, even toward the end of the twentieth century, there remained a lack of understanding of the manifestations of hearing difficulties (Garstecki, 1990). Hearing loss is often being mistaken for senility (Oyer & Oyer, 1985). Communication partners often perceive hearing loss to be annoy-

ing because of the disruptive influence that it has on the natural flow of social interactions (Jones et al., 1984). To make matters worse, commonly employed approaches to rehabilitation (i.e., hearing aids and hearing assistance technologies) act as symbols of stigma that perpetuate stereotypes (Goffman, 1963). The “hearing aid effect” (i.e., negative perceptions of hearing aid users) has been described by numerous authors (e.g., Blood, Blood, & Danhauer, 1977; Doggett et al., 1998; Kochkin, 2007). Low hearing aid utilization rates by people with an acquired hearing loss suggest that many adults “buy into” prevalent collective representations and choose to attempt to conceal their hearing difficulties rather than risk being perceived as old, weak, or disruptive (Kochkin, 2007).

Recent evidence suggests that some people might be more resilient to the negative effects of stereotyping than others. Link and Phelan (2001) suggested that the extent that one buys into a collective representation (in part) determines resilience to threatening situations. For example, based on our understanding of stigma-induced identity threat models, a person with an acquired hearing loss who buys into the belief that people with hearing loss have intellectual deficiencies, would likely experience elevated levels of stress during occasions when he or she is stigmatized based on intellect. Elevated levels of stress would in turn prompt expenditures of cognitive, psychological, and emotional resources to cope with this threat, perhaps making the person more vulnerable to subsequent stigma threats. By contrast, it is also reasonable to suggest that a person who does not buy into the link between hearing difficulties and intelligence will maintain proportionately lower levels of stress during the same event; would preserve cognitive, psychological, and emotional resources; and may build up resilience to stigmatization. Identity threat appraisals have obvious implications for audiologic rehabilitation. This will be described in more detail in the clinical implications section.

SITUATIONAL CUES

Situational cues are matters related to the physical and social environment inherent in a potentially stigmatizing event. Situational cues are influenced by the meanings assigned to situations or events by the key players (Crocker & Quinn, 2000). Related to audiologic rehabilitation, the relevance of *physical* situational cues is found in Hallberg and colleague’s examination of coping with situations of handicap (Hallberg & Carlsson, 1993; Hallberg & Barrenas, 1995). In these studies, background noise (i.e., a physical cue) was appraised in some instances to be problematic (and stigma inducing), while relatively manageable in other instances. In one study, Hallberg and Barrenas (1995) reported that the background noise found on the shop floor to be a manageable situational cue, because co-workers were in the habit of speaking loudly to one another. This situational cue resulted in few communication breakdowns, presumably little stress, and little risk of stigmatization. By contrast, in a second study (Hallberg & Carlsson,

1993), participants expressed that the noise typically found in meetings (e.g., shuffling papers) caused elevated levels of stress. This background noise caused communication breakdowns, fear of the need to disclose hearing loss, and potentially an increased risk of stigmatization. These two examples demonstrate how one *physical situational cue* (i.e., background noise) can result in two distinctly different levels of stress.

An example of the impact of *social situational cues* is found in Héту's (1996) examination of adult male workers with hearing loss. While workers often concealed or denied hearing loss at work, the same men admitted (albeit reluctantly) difficulty hearing at home. Disclosure of hearing loss varied across different scenarios. This finding was corroborated in a study that examined disclosure/nondisclosure of epilepsy. Troster (1997) reported that willingness to disclose epilepsy was dependent upon a subjective evaluation of (a) the perceived risk of unwittingly being detected or identified as a person who has epilepsy, and (b) the anticipated consequences of disclosure. Again, willingness to disclose this stigmatized attribute varied across different scenarios.

The salient point is that the level of stress induced by situations of stigma is determined in part by aspects of the physical and social environment, and by meanings assigned to interactions by communication partners. Cues inherent to the situation play a key role in identity threat appraisals. For example, a person without paid employment may experience an elevated level of stress due to stigmatization during a job interview, compared to the stress induced by stigmatization while purchasing a carton of milk at their local corner store.

PERSONAL CHARACTERISTICS

Within the context of the model, personal characteristics are attributes or aspects of a person that influence how one appraises a situation of stigma-induced identity threat. This might be any characteristic that distinguishes one person from another. Thus, this category is comprised of (but not limited to): age, gender, personality, ethnic and/or cultural identity, presence or absence of other stigmatizing traits, religious beliefs and practices, marital status, significant life events, and so forth.

A growing body of evidence in the social sciences suggests that personal differences impact how we appraise situations of stigma (Crocker et al., 1998; Major & O'Brien, 2005; Steele et al., 2002). Similar findings have been reported in rehabilitative audiology. For example, women with hearing loss are less likely than men to allow stigma to act as an obstacle to social involvement (e.g., Erdman & Demorest, 1998; Garstecki & Erler, 1999). Relative to men (and to younger women), the stigma associated with hearing aids tends to become less important to *women* as they age (Erler & Garstecki, 2002; Gilhome Herbst, Meredith, & Stephens, 1990). Younger adults are more likely than older adults to reject hearing aids because of stigma (Kochkin, 1993). Differences in help-seeking behav-

ious have been reported based also on personality type. In this case, Cox, Alexander, and Gray (2005) found that compared to the typical adult, individuals who actively seek to purchase hearing aids tended to have a greater internal locus of control. It has also been suggested that a positive attitude is associated with greater hearing aid use (Goldstein & Stephens, 1981; Hickson, Hamilton, & Orange, 1986).

A complete analysis of the personal characteristics that influence behavioural responses to stigma is beyond the scope of the current discussion. Nonetheless, the examples of individual differences presented above suggest that personal characteristics may affect the appraisal of identity threat and the subsequent coping responses arising from a stigmatizing situation.

IDENTITY THREAT APPRAISALS

According to the stigma-induced identity threat model proposed by Major and O'Brien (2005), identity threat appraisals are multi-factorial assessments made by a person when confronted with a stigmatizing event. The individual who possesses the stigmatized trait evaluates his or her motives in the particular social setting, their understanding of the particular social event, and their understanding of how they are perceived by the other people present to determine if he or she has the resources to cope with this threat (Lazarus & Folkman, 1984). If the situation is appraised as threatening (as described earlier), the individual will formulate (a) coping response(s). As illustrated in Figure 1, responses to appraised identity threats are modulated by collective representations, personal characteristics, and situational cues relevant to the specific social scene (Major & O'Brien, 2005).

COPING RESPONSES

For the purposes of this article, coping responses can be thought of as efforts made by an individual to regulate emotion, thought, behaviour, physiology, and the environment in response to a stigma-induced identity threat (Miller & Kaiser, 2001). The section that follows describes and provides examples of volitional and nonvolitional responses to appraised stigma threats (illustrated as boxes E and F respectively in Figure 1). Moreover, this section will describe how this conceptualization of coping is relevant to hearing loss stigmatization. It should be noted that some coping responses might be assigned to both volitional and nonvolitional categories. This apparent ambiguity is consistent with the contention that stigmatization and responses to stigmatization are highly individualized and situation specific.

VOLITIONAL RESPONSES

Volitional responses are voluntary efforts to change or adapt to stressful situations. When confronted with an appraised identity threat an individual might at-

tempt to change the course of a stressful event by problem-solving, or by regulating emotions (Miller & Kaiser, 2001). For example, one might attempt to *adapt* personal behaviours in social interactions as a means to manage a stressful event (Shih, 2004). Evidence suggests that being assertive or persistent is useful to make oneself less vulnerable to the stigmatizing behaviours of others (Hebl & Kleck, 2000; Shih, 2004). This strategy has also been reported in rehabilitative audiology. Hallberg and Barrenas (1995) reported that men with an acquired hearing loss often attempted to control their social interactions by making modifications to verbal and non-verbal communication, structuring difficult auditory situations (e.g., requesting help from their spouse) and maintaining social interactions (e.g., persistence). These volitional responses likely reduce the number of communication breakdowns, and disruptiveness of hearing loss, thereby deflating the stress of the situation.

Alternatively, if a person with hearing loss is repeatedly excluded from social interactions with a specific group of people, he or she might decide to search out new social opportunities. There is a tendency for some people who are stigmatized to be drawn into peer-group involvement (Goffman, 1963). This effect has been investigated for adults with acquired hearing loss (Gagné, Jennings, & Southall, 2009; Southall, Storck, & Hannan, 2008). In a recent study we interviewed hearing health advocates to explore their perspectives on the influence that stigma has on help-seeking behaviours. We found that adults with an acquired hearing loss may find a sense of community and social belonging in peer support groups (e.g., Hearing Loss Association of America or Canadian Hard of Hearing Association). Participants in this study also explained that involvement in these groups allowed for the development of healthy attitudes about hearing loss, and the social support received enabled many respondents to seek out audiological services without feeling stigmatized. Major and O'Brien (2005) reported that participation in peer-groups is often accompanied by benefits including educational and instrumental support, social validation, and a sense of belonging. The activities and educational campaigns engaged in by peer-groups might also lower feelings of helplessness and stress (Baker, 2002; Morrell, 2002).

A more passive volitional response to a stigmatizing event is to deliberately remove oneself physically or psychologically from the stressful situation. Numerous authors have reported avoidance strategies by individuals who are placed in stigmatizing situations (Hallberg & Carlsson, 1993; Hallberg & Barrenas, 1995; Major & Schmader, 1998; Steele, 1997). Hallberg and Barrenas (1995) observed that men with noise induced hearing loss frequently "avoided" by withdrawing, pretending to understand during interactions, or guessing during interactions. A different strategy involves individuals who are stigmatized dissociating their self-esteem from the domains in which they are being negatively stereotyped, thereby protecting their pride and self-esteem (Major & Schmader, 1998). For example, it has been found that some older adults who perceive ageist stereotypes con-

sciously disregard their own chronological age and focus on perceived physical and psychological age (Montepare, 1996). Again, the same strategy is reported in rehabilitative audiology. People with hearing loss often deny hearing difficulties and claim that communication problems are due to the environment (i.e., noise) or an ineffective communication partner (Jones, Kyle, & Wood, 1987).

NONVOLITIONAL RESPONSES

Nonvolitional responses to stress are involuntary changes in physiological and emotional functioning made by an individual to cope with stressful situations. Appraised identity threats have been associated with numerous changes in physiological functioning, including anxiety (Spencer, Steele, & Quinn, 2002), elevated blood pressure (Blascovich & Mendes, 2000), and arousal (Ben-Zeev, Fein, & Inzlicht, 2005). These studies indicate that the stress associated with stigma can cause adaptive and maladaptive changes in bodily functions. Perhaps more relevant to the present article, an appraised stigma identity threat can prompt involuntary emotional responses. Two examples will be described below. First, Feldman and Swim (1998) reported that recurring situations of stigmatization can lead some people to respond with automatic vigilance. This involuntary response involves the individual who possesses the stigmatized trait to establish a heightened sensitivity to stigmatization. A second example of an involuntary response to an appraised identity threat is preconscious avoidance. Mogg, Bradley, and Hallowell (1994) reported that some individuals are able to block out prejudicial attitudes at the preconscious level in order to cope with stigma related stress. These authors reported that avoidance of cancer-related words (i.e., a nonvolitional response to the stigma associated with cancer) was positively correlated with positive adjustment to the disease, while volitional avoidance was not. The clinical implications of volitional and nonvolitional responses to an appraised identity threat will be addressed later in this article.

OUTCOMES

Within the context of the present discussion, outcomes can be thought of as the result of volitional and nonvolitional responses to an appraised identity threat. This section will address how appraised identity threats might influence people in their everyday life. To illustrate this point, two outcomes of hearing loss stigmatization have been selected, namely: self-esteem and communication satisfaction. These topics were selected because they are often associated with hearing loss stigma, and because they illustrate a range of outcomes that might result from stigmatization (Doggett et al., 1998; Héту, 1996).

Self-Esteem

One possible outcome of repeated identity threats is change to one's self-esteem. Self-esteem might be described as confidence in your own merit as an in-

dividual. There remains little doubt that many individuals who are stigmatized experience reduced self-esteem. Link and his colleagues (Link, 1987; Link & Phelan, 2001) have proposed a process to illustrate the connections between self-stigmatization and self-esteem. According to these authors, reductions in self-esteem begin when people who are stigmatized become aware that they possess a stigmatizing mark and might continue to decline if the individual agrees with or buys into these societal attitudes. Declines in self-esteem become harmful if the individual self-discriminates or acts on these beliefs. Traditionally, it was assumed that stigmatization invariably led to reduced self-esteem. However, as alluded to earlier, contemporary research indicates that the effects of stigmatization on self-esteem are not always negative (Corrigan & Watson, 2002). In fact, one study that explored the factors leading to hearing aid abandonment in older women actually found that stigmatization might lead to higher self-esteem (Lockey, Jennings, & Shaw, 2008). In this study, one lady recognized that many of her peers had difficulty hearing, yet few chose to use hearing aids. This lady observed that using her hearing aids, albeit stigmatizing, gave her the advantage of hearing things that her peers could not hear. She noted that this relative advantage lead to higher self-esteem

Communication Satisfaction

A second possible outcome of recurring identity threats are changes to communication satisfaction. Communication satisfaction is the fulfillment derived when the need for human social contact is met. Erber (1988) identified several aspects of verbal interactions that influence communication satisfaction. These include (a) the amount of new information exchanged, (b) the level of conversation fluency (turn taking; number of communication breakdowns), and (c) the proportion of time spent on repairing breakdowns and time spent for a meta-communication. The following brief discussion provides a range of possible communication satisfaction outcomes within the context of the stigma associated with hearing loss.

The extent to which an individual buys into a given collective representation will likely influence communication satisfaction outcomes. For example, an adult who buys into the collective representation that hearing loss is a sign of frailty might decide to conceal hearing difficulties in certain social settings. A commonly used strategy to conceal hearing difficulties is to dominate the conversation. This strategy limits the likelihood of misunderstandings, the need to reveal hearing loss, and opportunities for stigmatization. Yet, this strategy might also limit turn-taking and the amount of new information being exchanged. Thus, according to the verbal interaction cues identified by Erber (1988), this strategy might result in lower communication satisfaction.

On the other hand, if a person does not buy into the above-mentioned collective representation, they might decide to disclose their hearing loss in certain so-

cial settings. Communication partners seem to respond favourably to disclosure of hearing loss. Blood (1997) reported that people who acknowledged their hearing loss were assessed favourably on personality, adjustment, and employability. Disclosure of hearing loss however might result in a reduction of communication satisfaction if disclosure is accompanied by an escalation in the number of communication breakdowns (Gagné, Stelmacovich, & Yovetich, 1991). Therefore, we recommend that disclosure of hearing loss be accompanied by specific repairs strategies selected to reduce the number of communication breakdowns.

IMPLICATIONS FOR PRACTICE

Stigma serves as a formidable obstacle to many adults with hearing loss who could benefit from hearing health care services. The primary goal of this article is to present a specific stigma identity threat model and reflect on the appropriateness of this model to the domain of rehabilitative audiology. The stigma-induced identity threat model (Major & O'Brien, 2005) helps us understand stigma and the effects of stigma from the perspective of the insiders. The implications for rehabilitative audiology are numerous and far-reaching. The goal of this section is to briefly discuss potential applications of this conceptual model to the practice of clinical audiology. It is not our intent to recommend specific intervention programs or assessments that address aspects of identity threat, rather to discuss how existing services within rehabilitative audiology might be viewed from the perspective of the identity threat model. First, we describe how this model might be used to inform clinicians about hearing loss stigmatization so that they might better serve clients. Second, we describe how this conceptual model might provide clinicians with a fresh perspective on programs that they are currently offering.

Adopting use of the stigma-induced identity threat model into clinical settings will likely provide clinicians with a better understanding of the stigmatization process, from the perspective of people who are stigmatized. We expect that this information would serve as a useful resource for clinicians. With this information clinicians might counsel clients on the situational nature of stigma threats, the role that they play in these situations, help-seeking, and most effective coping responses. A better-informed client is (in itself) a useful rehabilitative strategy. Clinicians might also incorporate general information about the stigmatization process into the services presently offered to clients. For example, even a basic introduction to the concepts held in the stigma-induced identity threat model may help clients better understand the stigmatization process and its manifestations. This knowledge may enable clients to recognize threatening situations, and employ appropriate coping strategies. Clinicians might assist clients use the ideas proposed in the model to better analyze specific situations that are identified as difficult. For example, it may be helpful for a person with hearing loss to understand (become conscious) that the reason they exhibit nonvolitional

responses (e.g., swallow breathing or sweating) in certain settings (e.g., business meeting with their boss) may be attributable to the fact that they experience a high-level of identity threat in that situation (perhaps because the person with hearing loss has opted not to disclose the hearing loss to his or her superior).

We feel that the stigma-induced identity threat model provides clinicians with a useful framework to consider rehabilitation services presently being offered to people who exhibit some level of identity threat due to their hearing loss. One current area of investigation in rehabilitative audiology is the effect that personality has on hearing aid use (Kricos, Erdman, Bratt, & Williams, 2007). According to the stigma-induced identity threat model, personality (and other psychological characteristics) play a key role in the appraisal of identity threat. This is crucial information that clinical audiologists and their clients should consider when they are planning intervention programs. It may be useful for the clinician to assess (formally or informally) the client's propensity for identity threat in different activities of daily living. Candidates who do not experience identity threat in various social settings may be better candidates for hearing aid use. On the other hand, clients who are susceptible to experiencing identity threats may be candidates for intervention programs geared toward diminishing identity threats before they are encouraged to use amplification systems in their everyday activities. Similarly, it is important for clients to be aware of all other elements of the stigma-induced identity threat model and to understand how these elements interact to influence help-seeking behaviours. A better understanding of the stigma-induced identity threat model will lead to improved rehabilitation services that address individual needs.

In our view, the stigma-induced identity threat model is a useful complement to individual programming presently being offered to clients. For example, recall that stress is the foundation on which the stigma-induced identity threat model is constructed. Stress provides rehabilitative audiologists with a solid theoretical base on which to plan rehabilitative options for specific clients. Within rehabilitative audiology, several authors have proposed treatments that focus on stress reduction (Jennings, 1993, 2005; Trychin, 1986). Many hearing health care professionals presently assess their client's coping resources to manage the challenges associated with hearing loss. The stigma-induced identity threat model provides clinical audiologists with a rationale for these programs specific to the context of stigma. We expect that this framework will assist audiologists plan a logical sequence of interventions for clients that might experience stigmatization because of hearing loss.

A pertinent illustration of how this model complements existing audiologic rehabilitation interventions can be seen by re-examining the normalization process described by Héту (1996). Recall that Héту proposed a two-step normalization process, whereby people who have hearing loss learn to overcome the detrimental impacts of stigma. In the first step, individuals who have hearing loss (and

have experienced the negative emotions associated with communication breakdowns) congregate to start the process of restoring a normal social identity. In the second step, participants return to familiar activities with people who do not have a hearing loss, where they are encouraged to utilize appropriate communication strategies to rebuild confidence in their own abilities to communicate effectively, and to restore a positive self-image.

It is relatively easy to see how the stigma-induced identity threat model complements the normalization process. In the first step individuals who have the same stigmatizable attribute (i.e., personal characteristic) work to improve communication strategies such as assertive behaviours and listening skills, learn to be empathetic to one another and to respond with understanding (i.e., volitional responses) to communication breakdowns. The group members are less likely to devalue the social identities of those present (i.e., identity threats), thus lowering perceived identity threat. Peer group involvement of this kind likely bolsters self-esteem and confidence (i.e., outcomes) of group members. In the second step, after the individual has developed confidence in the application of these strategies he or she is encouraged to test these newly acquired skills in "real-world" settings (i.e., situational cues) where they might experience people who ascribe to prejudicial attitudes (i.e., collective representations). We expect that when placed against a comprehensive framework of stigmatization (i.e., the stigma-induced identity threat model) clinicians are likely to view existing programs with a renewed sense of direction. From the perspective of audiologists, the stigma-induced identity threat model has the potential to provide insight into stigma relevant problems of help-seeking, adherence (or nonadherence) to hearing health care recommendations, and to designing effective programs of assessment and intervention.

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