

# **The Impact of Grief on the Delivery of Information: Increasing Student Effectiveness**

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Through examination of the underlying grief within 3 case scenarios audiologist's delivery of diagnostic findings and treatment recommendations is examined. Researchers have provided anecdotal reports that audiologists may be perceived as indifferent or insensitive. In this article many facets of effective information delivery are explored in an effort to help students improve clinical dialogue.

Counseling is recognized as an integral component of the clinical services an audiologist provides (American Academy of Audiology [AAA], 2004; American Speech-Language-Hearing Association [ASHA], 2006a, 2006b). Like counseling, good clinical services require empathetic listening skills, full acceptance of all participants and how they interact within the treatment process, recognition of the amount of information a family can absorb, and creation of environments that facilitate open communication. To better address the needs of audiology patients, there has been an increase in the percentage of audiology programs that require a counseling course in their curriculum from 12% of audiology masters programs in 1986 (McCarthy, Culpepper, & Lucks, 1986) to 71% when AuD programs were examined in 2005 (English & Weist, 2005).

English and Weist (2005) provided anecdotal reports from AuD students re-

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garding their own struggles with counseling such as:

I don't know how to handle the emotions patients experience because of their hearing loss.

I never know if it's OK to act like a therapist.

How do you make sure patients know what they need to know?

I can't find the words that would make sense to the hearing aid user.

Obviously, students are far less concerned with content counseling than they are with personal adjustment counseling. In fact, none of the top 27 concerns noted by AuD students relating to their interactions with patients involved what content or information to deliver during counseling (English & Weist, 2005). It is important to note that 45% of audiologists in practice who presumably had little professional preparation in counseling have been reported to feel similarly unprepared to counsel individuals with hearing loss (Martin, Barr, & Bernstein, 1992). What is unknown at this time is how this has changed due to the increased number of academic programs which require a counseling course in their curriculum.

The problem may be based on the fact that, like for so many other health professions, audiology clinical preparation is steeped in training students in *the information* they must pass on to patients, often to the near exclusion of teaching *effective* information delivery. When effective delivery is taught in the revised curricula that include counseling instruction, the learning is often not reinforced within assigned practicum rotations through effective modeling by preceptors. The result is that student audiologists frequently continue to grapple with means of delivering the knowledge they are mastering. This information must be consciously presented in a fashion that can be comprehended and utilized by patients and families as they confront the impact of hearing loss and the measures that must be taken to lessen its toll.

Given the positive impact of effective information transfer, training in this clinical skill is critical. To be effective in information transfer, students must recognize and acknowledge the emotional impact of the words being spoken, the effect of the emotional state of the patient on information absorption, and the importance of a full and demonstrated acceptance of each individual. Much of what an audiologist must do in the course of hearing loss treatment is to impart to those seeking hearing care services the requisite knowledge to become effective communicators in the varying environs of their lives. This knowledge is assimilated through the basic processes of adult learning. Self-directed adult learning is defined as a means in which individuals take the initiative to design learning experiences, diagnose needs, locate resources, and evaluate learning (Knowles, 1975). Rogers (1969) views this process as experiential learning which embodies a quality of personal involvement. It is self-initiated; pervasive (makes a difference in

the behavior, attitudes, and perhaps even the personality of the learner); and evaluated by the learner. Rogers felt that the essence of experiential learning is finding meaning for the individual. These adult-learning principles are central to the growth we hope to foster during rehabilitation activities for both our adult patients and the parents of the children we see (Brueggeman, 2005). The experiential learning we hope to foster for the patients we serve begins with the information we impart following diagnostic testing and continues within subsequent clinical visits.

Unfortunately, the information given during time allotted for patient contact is not always effectively received which can slow the adult patients' learning of the critical skills they must develop during the rehabilitation process. What is even more unfortunate is that students often do not recognize this fact, or, if they do, they do not always know what to change to be more effective. If they are not given the proper supervisory guidance to know what ways they can improve their counseling style, the status quo will continue to exist for them.

Content given to patients during clinical visits may not be correctly recalled at a later time. Reese and Hnath-Chisolm (2005) found that, on average, only 74% of information given during a hearing aid orientation was correctly recognized. Additional data from the medical community reveal that 40-80% of the content given to patients in clinical situations is forgotten (Kessels, 2003). What is more striking is that nearly half of the clinical information retained is remembered incorrectly (Anderson, Dodman, Kopelman, & Fleming, 1979). It is also clear that as the amount of information given in clinical situations increases, the correct recall of that information decreases (McGuire, 1996).

There are means to improve patient understanding and recall of important information delivered within clinical exchanges (Ley, 1989). The following case scenarios are common to audiologic practice and highlight the need for personal adjustment counseling, a process which must begin with well delivered clinical information. Effective information delivery is a clear requisite to information comprehension and subsequent recall and forms an underlying base for successful learning.

### **SCENARIO #1**

Mr. and Mrs. Roth have been referred for confirmation of their son's suspected hearing loss following a positive result on a newborn screening. Prior to the screening their lives had seemed perfect in many ways. A year ago, the time had seemed right to start a family; and during the months of Mrs. Roth's pregnancy, husband and wife had talked of many scenarios for their child, what life would be like with the addition to the family, what the child would be like, and what he or she would become once grown. Now they are sitting in an unfamiliar examination room across from an audiologist who is telling them things they do not want to hear. In the days, weeks, months, and years ahead, their present shock

will be supplanted with other deeper emotions as their severely hearing-impaired son takes his place within this new and unexpected life ahead of them.

### **SCENARIO #2**

After denying the existence of any significant hearing loss for a number of years, and finally succumbing to family pressures to get a hearing test, Mr. Bennett is not surprised to hear the audiologist report he does indeed have a hearing loss. However, he is surprised to hear that the use of hearing aids is his only option, that he needs two of them, and that they will not fully restore his hearing. He has begun to envy the apparent ease of others' communication exchanges and resents his family's lack of appreciation for the difficulties he experiences. He had hoped for better news on all fronts.

### **SCENARIO #3**

Over a year ago, Rhonda experienced a sudden idiopathic sensorineural hearing loss. Despite fairly immediate medical attention and closely following doctor's orders the loss did not improve. She is increasingly frustrated with the impact this loss has on important meetings at work and on her hearing at the many social events she attends. The ever-present tinnitus she has had since the onset of her deficit seems to exacerbate the anger she experiences at the loss of the way things were.

## **WHAT DO THESE SCENARIOS HAVE IN COMMON?**

The parents in the first scenario, as well as the patients in the subsequent scenarios, like so many of our patients, are experiencing grief. Grief over a loss of what was expected – the birth of a normally hearing child, a retirement in which clear communication would come easily with grandchildren, the lack of normal hearing abilities that we all take for granted – is impacting in ways one would not have foreseen. The grief experienced is further fueled by the unknown future that these new turns of events have created for the family, for the individual, and for life. What do these scenarios have in common? The people described in these scenarios are not ready to hear the clinician's words.

The first scenario depicts parents who are receiving the news of their child's hearing loss for the first time. The grief parents are experiencing at this time can adversely influence the parent-child bond, both in terms of their connection with the child and how they communicate with the child (Leigh & Anthony, 1999). After receiving the news that their child failed a newborn hearing screening test, the most common emotional reactions parents have are fear, shock, and confusion (Yoshinaga-Itano & Abdala de Uzategui, 2001). These grief reactions are all normal responses to the instant change in the parental perception of the new fam-

ily situation.

Beazley and Moore (1995, p. 33) argue that

A parent's anger, frustration and shock originate not from their personal difficulties with psychological adjustment to news of their child's hearing impairment, but in the main, from difficulties created through the approaches and values, training and working practices of professionals.

They based this observation on the parents that they spoke to about the process of learning their child was deaf. It appears obvious that the grief reaction that an individual has is to a degree dependent upon how the bad news is delivered.

The first scenario is one that may be more familiar when we think of patient counseling as we frequently overlook the impact of grief when relaying audiologic diagnostic information to adults. Yet, surely Mr. Bennett in Scenario #2 and Rhonda in Scenario #3 are experiencing their own grief.

Grief, as we know, impacts all of us differently as we move unpredictably through its varying components of anger, depression, denial, bargaining, and so forth (Kubler-Ross, 1969). The stages of grief do not appear in any set pattern. Some people skip stages of grief altogether, others linger within a stage for longer periods than one would expect, and some revisit with surprising frequency a stage of grief they believed to have been resolved much earlier. There is evidence that the length of time spent grieving a major loss may be as long as 6 to 12 months for some individuals (Schneider, 1974). Because of their young age and relative lack of clinical experience, students may have difficulty appreciating or anticipating the impact their findings and their words can have on individuals such as those in the three scenarios we have presented – variations of which are so very common in any audiology clinic.

What we do know, but frequently forget, is that the information students have mastered and have been prepared to share, the information that patients need if their rehabilitative efforts are going to succeed, may be lost when presented at a time of crisis. This can be true for the parents of a child with newly identified hearing loss as well as for our adult patients who may not yet be ready to confront the newly evolving self-image of a person with a permanent disability or who were simply hoping for better news. For many, hearing our words, and often for the first time confronting the reality of hearing loss, indeed presents a time of crisis. Parents report that they want help in coping with the emotional impact the diagnosis of hearing loss has had on them even when they have accepted the presence of the loss. It has been found that coping with emotions is parents' second highest priority at the time of learning that their child has a hearing loss (Roush & Harrison, 2002). The impediment to progress in audiologic treatment as a result of the emotional reactions to the audiologist's reported findings is frequently great for adult patients as well. Unfortunately, students often do not fully recognize the emotional impact our words have on adults.

Researchers have confirmed frequent anecdotal evidence that audiologists may

be perceived by both parents of children with hearing loss and by adult patients as lacking compassion and proper counseling skills or as being indifferent or insensitive (Glass & Elliot, 1992; Martin, George, O'Neal, & Daly, 1987; Sjoblad, Harrison, Roush, & McWilliam, 2000). As representatives of our profession, we would all be quick to argue that these perceptions are inaccurate. We might argue that we do care, that we do want the best for those we serve. Most audiologists probably believe that they understand the many difficulties and frustrations that may arise with diminished hearing. But how do we combat the perception of indifference and insensitivity? We may start by attending to how we deliver information to our patients.

### INFORMATION DELIVERY

When preceptors teach students how to deliver information effectively to patients and their families, they stress the need to avoid professional or clinical jargon. However, when we listen to students, and sometimes even when listening to ourselves, we hear words spoken that can be found on an introduction to audiology vocabulary list. Parents of children born with hearing loss report that they want information to be given in a compassionate manner (Luterman & Kurtzer-White, 1999). Parents also report that 28% of the time the initial explanation of their child's audiogram is inadequate (Sweetow & Barrager, 1980). In Sweetow and Barrager's (1980) investigation, the parents reported problems with brevity, technical jargon, and the lack of an interpreter. Williams and Derbyshire (1982) found a similar trend in their investigation, that is, that 84% of parents were unable to understand a majority of the information that was given to them by the audiologist. To summarize, parents report that they want the information, but not specifically the jargon. Parents also report that the information should be given with "kindness, sympathy, calm, and support" and "gently and with honesty" (Luterman & Kurtzer-White, 1999, p. 15). While research is not as plentiful on information delivery with adult patients, the reported impact is frequently similar (Glass & Elliot, 1992; Martin et al., 1987).

Students may lace their speech with jargon to demonstrate to their supervisors that they have taken in some of what they have learned. If not corrected, they may later find themselves as practicing clinicians using jargon because of their familiarity with it. The use of jargon can become a speaking habit that, in fact, may confuse patients and distance them from professionals at a time when clinical dialogue should be building a collaborative rapport. With the goal of bolstering the patient's perception of the audiologist as a caring professional, there is more to effective information delivery than the avoidance of jargon. The time when information is given within the clinical process may have as much impact on the perception of sensitivity of delivery as does the style of delivery itself.

### TIMING OUR DELIVERY

As in most aspects of life, timing is everything. Neuroscientific research has demonstrated that the problem solving areas of the neo-cortex do not efficiently process new information into rational thought when a highly emotional event is occurring due to the influences from the amygdala, which is the emotional center in the brain (Cahill, Babinsky, Markowitsch, & McGaugh, 1995; Canli, Zhao, Brewer, Gabrieli, & Cahill, 2000). The encoding of emotional memories in the hippocampus is highly influenced by the amygdala as well (Richardson, Strange, & Dolan, 2004). Attention narrowing occurs when the events which unfold in clinical settings are perceived as emotional or stressful (Wessel, Van der Kooy, & Merckelbach, 2000).

When we tell a parent, “your child has a severe hearing impairment,” or an adult patient, “your hearing loss cannot be corrected through medicine or surgery,” these main messages will be retained while other peripheral information may be lost. This peripheral information given during the same appointment may include important details such as the need for medical follow-up, explanations of diagnostic results, and options for rehabilitation/habilitation. Yet it is precisely when emotions are high that we frequently find ourselves delivering details of our diagnostic findings and rehabilitative recommendations.

Many people do not need the details we are offering at this juncture and may find detailed information more useful at a later date. The dependency of information recall on the emotional state of the individual is evidenced through the phenomenon in which a person best recalls content given during stressful times at another similarly stressful time (Schramke & Bauer, 1997). This may help to explain why information given during a highly stressful clinical encounter, such as when relaying diagnostic findings, may not be accurately recalled later in a more relaxed home setting.

Sometimes it is more beneficial to a child’s parents or to an adult patient if, following the initial diagnostic statement, we simply ask, “Would you like the details on how we reached these findings and what they mean or do you simply prefer generalities at this time?” Questions such as this, or “What are your thoughts at this point?” can be an empowering means of placing the ball back into the patients’ court. Not only does this approach foster clinical collaboration between patients and their audiologist but also lays the foundation for the source of inner-guidance which will be needed in the months and years ahead. If given the chance, patients will let us know the speed at which we should proceed.

Another means to help patients and families more accurately process information given at highly stressful times is to audiotape the clinical encounter for them to listen to at a later time, assuming they are agreeable to this (Ford, Fallowfield, Hall, & Lewis, 1995; McHugh et al., 1995). This will allow the individuals to more accurately retain the details which were previously discussed during a stressful clinical encounter.

### UNCONDITIONAL ACCEPTANCE

When delivering information to patients and families we must remember our profession's code of ethics regarding acceptance of the religious, ethnic, racial, gender, and sexual orientations among our patients (AAA, 2004; ASHA, 2003). However, we easily forget that professionalism demands the same acceptance of our patients' actions and statements. When emotions are high, people can say things they might not otherwise say. It is easier to accept expressed anger, statements of dissatisfaction of services rendered, questions of our credentials, and so forth, if we recognize the emotional circumstances at the root of the remarks.

When student clinicians are well prepared and are truly doing their best, negative comments are rarely a reflection on the student but more a reflection of the emotional state of the patient or family (Clark, 2006). This is not the time to become defensive. Rather we must remind students that the goal of all clinical exchanges is to increase the patient's confidence and inner security, not the clinician's. A statement such as, "I can't imagine how difficult this may be for you," not only demonstrates our respect for and understanding of the patient's expressed feelings of the moment, but helps the patient to recognize the universality of those feelings and begins to diffuse what could otherwise become an untenable clinical situation.

Clearly this is also a time in which student clinicians, and indeed practicing audiologists, can become a bit more introspective. We must always challenge ourselves to be the best we can be, and such introspection can frequently lead to growth.

### LISTENING FOR INTENT

When we listen for the true intentions of our patients or the parents of the children we see, we must listen carefully to their concerns and feelings to better appreciate how they perceive specific problems. Patients need to know their *feelings* have been recognized even when not clearly expressed. When we are unsure of the feelings or concerns underlying a given statement, a reflection of our perception of the concern helps to facilitate a clear dialogue.

Simply stating that we appreciate one's feelings can be especially useful when patients are disclosing information that might reveal feelings of shame or guilt. Acceptance need not be equated with agreement or approval. The immediate gain when we accept our patients' statements is that it reduces their fear that we may pass judgment on what they say, which is a clear impediment to further discussion and exploration.

Listening for intent also creates a better match of our response to that of the patient. The elderly patient who portrays a negative feeling toward the use of hearing aids with a statement such as, "I always thought hearing aids were for old people," need not be reminded that many young people also wear hearing aids, or that hearing aids are less conspicuous than hearing loss. These statements do not



speak to the underlying emotions. The audiologist might do better to simply acknowledge the statement with a response such as, "It's difficult when so much changes in one's life." This acknowledgement allows for more constructive dialogue leading toward greater acceptance of the hearing loss and the actions that need be taken to improve hearing.

### **AVOIDING BARRIERS TO EMPATHY**

If our goal is to help patients feel truly listened to and understood, or at least feel that we are attempting to understand issues at hand from the patient's perspective, we must portray this more actively. Toward this end, audiologists may frequently need to confront self-generated barriers to empathy (Clark & English, 2004) and actively model and discuss clinical behaviors which will help student clinicians better display their natural empathy toward others.

One of the greatest barriers to empathy is a belief that we have heard all of this before as patients are relating what is very much a personal and individualized storied-response to hearing loss. All patients' stories are personal experiences to them and they need to be treated as individual accounts of value.

All too frequently, hand-in-hand with the belief that "I've heard all of this before," comes our erroneous generalization of our patients' experiences, as we assume that a given hearing loss largely creates similar problems for different individuals. Clinicians who have utilized any of the many available self-assessment questionnaires as part of the evaluation process are aware how such generalizations can negatively impact the formulation of meaningful recommendations.

Finally, if we are going to combat reported perceptions by patients that we are indifferent and insensitive we need to avoid clinical multitasking. When we believe we have heard all of it before and that the impact of a moderate sensorineural hearing loss for Mr. Jones is largely the same as it is for Mrs. Smith it is easy to find ourselves rifling through charts, completing identifying information at the tops of forms, or jotting a reminder note of something that entered our mind while patients are talking.

### **MOVING BEYOND INFORMATION DELIVERY**

Student audiologists, and often seasoned clinical audiologists, may feel uncomfortable in the role of patient counselor, frequently uncertain as to how far their counseling should go. In this regard we are not unlike many other health professionals who may receive minimal training in patient counseling. Nevertheless, regardless of our uncertainties, the need for counseling remains a crucial part of the management process, particularly for parents or adult patients whose reactions to what we tell them are often complex.

Sometimes audiologists and audiology students shy away from taking on the broader mantle of patient counseling as they feel such a role beyond information transfer is strictly within the domain of psychologists, psychiatrists, and mental

health workers. In reality, most who are in “helping professions” as well as many outside of this group provide supportive counseling services (Kennedy & Charles, 2001). These may include educators, attorneys, clergy, family physicians, and even audiologists. The role of these professionals is not to provide long-term therapy to explore intrapersonal conflicts that may have little basis in subjective reality and may manifest as deep depressions and anxieties, persistent guilt, confusion, or ambivalence. In contrast, audiologists work within the bounds of personal adjustment counseling that is based on a “well-patient” model and deals more exclusively with the crisis and attending problems at hand rather than all that has preceded or even all that may follow.

Some audiologists, and frequently students in audiology, have a fear that they may not relate well to patients who are in emotional crisis due to perceived barriers between themselves and the persons they are serving (Clark, 1994; Clark & English, 2004). After all, they most likely do not have a child with a handicap and have not confronted the type of life-altering diagnostic findings being presented. Students may look upon an elderly patient as one from a distant generation with life experiences so vastly different from their own that they feel a disconnect. However, the perceived gap can be bridged.

It is our human capacity to feel emotions that allows us to bridge the gap we perceive between ourselves and our patients. The emotions our patients experience are quite human. Our patients may feel a variety of emotions including disappointment and loss when they hear a life-altering diagnosis; they may feel a fear of the unknowns that lie ahead or uncertainty and confusion over the recommendations we are setting forth. We have all experienced the emotions of fear, disappointment, uncertainty, and confusion – certainly from different origins than that of our patients and perhaps to a differing degree. What our patients want most at a time of crisis are professionals who clearly express their desire to understand and relate. It is our capacity to empathize with our patients that allows us to bridge the gaps we may perceive.

### **THE UNDERLYING MESSAGE FOR SUCCESSFUL CONTENT COUNSELING**

When counseling the parents of our pediatric patients or the adults who seek our care it is information transfer that will frequently comprise the bulk of the counseling we provide. It is our effective transfer of diagnostic information and rehabilitative recommendations and direction that will facilitate the acceptance of the loss itself and the substantial learning which must occur for successful treatment. For students to be successful in content counseling they must do much more than follow the frequent admonition to avoid jargon in their presentations. We must instruct them and model for them the nuances of content counseling to ensure that the timing of their delivery is appropriate and is more closely aligned with the immediate needs of their patients. If we are to combat frequent negative

perceptions that our patients may develop toward services rendered and those who provide them, we must at all times strive to demonstrate our empathy for our patients by listening reflectively. Further, we must attempt to avoid the often unconscious behaviors that create barriers to the perception of how much we care for our patients.

By better listening to our patients as we deliver the news and information they must hear and striving to respond both effectively and empathetically, addressing their needs first – not ours, we can better help our patients to help themselves. And when we do this, we find we are transitioning ourselves beyond content counseling and moving into the important role of personal adjustment counseling – exactly where we should be as audiologists.

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