

**The Use of Humor to Facilitate Adaptation to
Hearing Loss: *A serious consideration of the
potential role of humor in aural rehabilitation.***

Part I

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Abstract

This article explores the underutilized potential of humor as a useful component of therapy for helping to facilitate adaptation to hearing loss for individuals with hearing loss and their communication partners. It is a thought piece for consideration, in part tutorial review, rather than a research article. We present, in two parts, evidence from allied health literature regarding the use of humor in addressing the biological, psychological, and social effects of a range of medical conditions resulting in adversity or loss. We then examine those findings in the context of hearing loss. Key concepts include the following:

- A sense of humor is an important personal trait supporting successful coping with hearing loss.
- Humor has great potential to help address the *biopsychosocial* effects of hearing loss.
- Humor can be an effective therapeutic tool, when used judiciously.

**Humor and Hearing Loss:
Therapeutic Perspectives and
Considerations**

The purpose of this article is to consider the potential use of humor as a viable therapeutic tool for professional use with individuals adapting to hearing loss and their families. This article explores the role of humor from two perspectives. First, it examines humor as a coping mechanism for individuals facing adversity and loss. Second, it explores humor as a potential therapeutic technique for professional use in aural rehabilitation. Although primarily written for consideration by Audiologists and Speech-Language Pathologists, the article may be useful for those in the counseling professions who work with similar populations. For individuals with hearing loss, it may help them consider the humor in many instances of miscommunication and use it as a social mechanism to cope more successfully.

Anecdotal reports abound citing the importance of having a sense of humor for overcoming loss and related adversity in medical and psychosocial areas. While the potential therapeutic role of humor is noted, little has been written or researched in this area for communication professionals, and that which does appear has not been applied to clinical practice in aural rehabilitation or other communication therapies.

Given the paucity of research as it relates to humor and hearing loss, the authors turned to the literature of the allied health professions. Studies in the medical, psychiatric, psychological, and social work professions indicate that humor is an important component for successfully coping with life's challenges and may be considered an effective therapeutic tool for helping individuals develop resiliency and cope with wide variety of physical and psychosocial challenges (Bordan & Goldin, 1999; Danermark, 1998; Fry & Salameh, 1987, 1993; Gladding, 1995; Hogan, 2001; IDA Institute, 2012; Puder, 2011; Shaughnessy & Wadsworth, 1992; Smith, Epstein, Ortiz, Christopher, & Tooley, 2017; Weaver & Wilson, 1997). Much may be

gained from reviewing observations of specific benefits of using humor found in the works of related professions and considering how such techniques might be adapted and integrated into our own professional intervention protocols. It needs to be stated from the outset that this is not a research article or tutorial, but rather a thought piece to challenge professionals to consider the use and value of humor as part of the therapeutic process.

The role of humor in facilitating adaption to hearing loss and as a therapeutic approach is examined in the framework of the biopsychosocial systems model (Bally, 2009). In Part I of this article, biologic effects (e.g., immunological) are reviewed along with psychological effects including an individual's affect (emotions), cognition (thinking), and behavior (actions). In Part II, the role of humor in coping with adversity and hearing loss is examined in sociocultural systems with respect to how it influences interpersonal relationships of individuals with significant others and society as a whole.

In considering the potential usefulness of humor for rehabilitation, this article examines the therapeutic use of humor in the limited literature of allied health professions with the following questions as a guide:

- What are the definitions and parameters of humor and its therapeutic use in the allied health literature?
- When individuals are coping successfully with adversity and loss
 - Are there biological responses to humor that can be used to foster successful adaptation?
 - What is known about the psychological effects (affective, cognitive, and behavioral) of humor that may be used to facilitate successful coping?
 - What is known about social factors and adaptation to hearing loss?
 - What is known about the function of humor for improving the psychosocial coping abilities of individuals who are experiencing hearing loss as well as for their primary communication partners?
 - Are there guidelines from health profession literature on the therapeutic use of humor that may be adapted for aural rehabilitation?

Humor and Laughter

Humor is a psychological and sociocultural phenomenon, while laughter is the most prevalent biological response to humor. Laughter is also considered a social behavior, a way to communicate (Provine, 2000). Meyer (2000) provides a review of three major theories that have emerged in humor research: the relief theory, which focuses on physiological release of tension; the incongruity theory, singling out violations of a rationally learned pattern; and the superiority theory, involving a sense of victory or triumph.

Current theories in the literature suggest that humor arises from incongruity in several ways including surprise, atypicality, and juxtaposition (Hoicka, Jutsum, & Gattis, 2008; McGee, 1979; Walton, 2003). Warren and McGraw (2016) suggest modifying incongruity theory by proposing that humor arises from a benign violation: something that threatens a person's well-being, identity, or normative belief structure but that simultaneously seems acceptable.

Within the framework that incongruity is the basis of humor, Walton (2003, p.1) provides a working definition of humor that is used by many in the health care professions and which includes the critical elements of humor: "Humor is surprise without threat or promise." This definition captures the experience as one of both surprise and benign violation. Miscommunication that occurs secondary to hearing loss captures the 'surprise' component when something happens contrary to expectation. Walton also notes that "to be surprised you must have an expectation of how the world works. When something happens contrary to that expectation, you are surprised." A particularly important point made by Walton is that relative to professional contexts, surprises that are threatening in specific contexts such as ethnic or sexually-based jokes should be excluded.

Situations that result from miscommunication have the capacity to tap into this paradigm and other shared universal experiences. Humor with profound elements of truth may be found in the situations that result from miscommunication. It is important to note that it is the circumstance and the resulting miscommunication, not the individual or the disability, that needs to be the focus of the humor. This holds true whether it relates to the client's specific situation or to examples used to direct the therapy process. The latter may serve to exemplify concepts which provide a starting point for self-discovery. This, in turn, can be a powerful resource for helping individuals understand and foster successful adaptation to their hearing losses (Dewane, 2010; Trychin, 1992).

The professional cannot easily anticipate how a specific client will react to humor, especially when it is related to issues of a personal nature. Humor should not be used too early in a relationship. Rapport must be established so that the client trusts the professional and knows the professional has the client's best interests at heart. When used, humor should be "compassionate and connecting" (Klein, 1989, p.33). The professional needs to understand what the hearing loss *means* to the person in the context of their life experiences (Pray, 1996).

Humor comes in many forms, all of which may be adopted to facilitate the use of coping mechanisms. Of potential use are jokes, cartoons, anecdotes and observations, riddles, puns, videos, and incongruities. It is important to emphasize that not everyone sees the world from the same perspective and cultural sensitivity is needed (Apte, 1987). This applies to research related to the effects of humor and to clinical

approaches using humor. For example, in one study involving humor and college students a tape of "Richard Pryor Live!" was used (Berk, Felten, Tan, Bittman, & Westengard, 2001). No criteria were offered as to what material participants found humorous, or if multiple stimuli could have been offered (i.e., what is humorous to the participant as opposed to what is assumed to be funny by the researcher.) A methodological concern is that what is seen as appropriate and humorous for one population (in this case, college students) may be viewed as less so for generally conservative populations. Humor needs to be understood within a sociocultural context (Provine, 2000). The clinical implication is that the professional needs to match the type of humor to the client's sense of humor in order for the use of humor to be successful. Taking this into account, McGhee (1979, 2011) has been an advocate of incorporating humor and laughter as a learnable tool in the promotion of health and well-being and in the training of healthcare professionals to utilize humor to help clients cope more successfully with adversity and loss.

The Potential Role of Humor in Coping with Hearing Loss

A sense of humor, in and of itself, can be an important tool in successful coping with adversity and, specifically, hearing loss. It can be a useful psychosocial component of an integrated therapeutic approach (Bordan & Goldin, 1999; Danermark, 1998; Fry & Salameh, 1987, 1993; Gladding, 1995; Puder, 2011; Shaughnessy & Wadsworth, 1992; Smith et al., 2017; Weaver & Wilson, 1997).

Socially, hearing loss impacts relationships, self-esteem, education, vocational functioning, family life, and virtually all social interactions (Baldrige, 2014a, 2014b; Clark, 2014; Harvey, 2003; Kaplan, 1996; Pray, 1996; Stafford-Mallis, 2014; Trychin, 2002, 2003; Tye-Murray, 2009). Thus, we must acknowledge and validate the negative effects of hearing loss on both individuals and those with whom they communicate. It is critical to understand the ability of humor to diffuse these effects and make the experience of hearing loss more manageable. The challenges that hearing loss presents to individuals should not be minimized or understated. Frustration, anger, embarrassment, stress, anxiety, hopelessness, guilt, isolation and other negative feelings are commonly reported responses to sustaining a loss of hearing. (Dewane, 2010, English, 2008; Kaland & Salvatore, 2002; Kricos & Lesner, 1995; Pray, 1996; Preminger 2009; Ross, 2010; Wallhagen, 2010; Wayner, 2011).

From a psychological perspective, humor may be used to defuse the emotional toll of counseling or rehabilitation, especially when emotional issues are addressed (Dewane, 2010; Glickman & Harvey, 1996; Martin, Kuiper, Olinger, & Dance, 1993). Humor may be useful in ameliorating some of the emotional effects of hearing loss of

the individual and their communication partners. Finally, humor may have a significant role in addressing and changing maladaptive behaviors as well as irrational thought processes.

Given the disabling manifestations of hearing loss, the clinical use of humor should be used judiciously so as not to exacerbate such negative responses as those enumerated above. It is reasonable to consider that a sense of humor may be a viable element in the ability to counter the negative psychological and social effects of hearing loss and communication breakdown. The professional may capitalize on this natural propensity of utilizing humor as a coping mechanism. Encouraging clients to perceive humor as a result of communication breakdowns may reduce their stress.

Professionals are interested in the inherent strengths of clients that will play a role in the successful adaptation to hearing loss. (e.g., flexibility, critical thinking ability, self-efficacy). Professionals in psychosocial fields consistently identify a sense of humor as one of the key elements in the ability of individuals to cope successfully.

From the perspective of a biopsychosocial systems model (Bally, 2009) successful adaptation to hearing loss includes addressing the biological, cognitive, affective, behavioral, and social effects of the loss and subsequent communication breakdown. Although the primary intent of humor is to solicit a positive impact in cognitive, affective and behavioral response systems, other areas may also benefit. For example, finding humor in challenging situations may be an important coping mechanism as individuals adapt to the difficulties posed by hearing loss. It has the potential to help individuals to address the stressors related to communication disorders in non-threatening and de-personalized ways. Further, the use of humor may also help facilitate the therapy process for professionals who are able to use humorous approaches effectively. There are some very positive biopsychosocial applications of humor to the counseling process that have been cited and studied in the professional literature of the counseling professions, which will be discussed below.

Biological/Physiological Benefits of Humor and Laughter

"The best clinicians understand that there is an intrinsic physiological intervention brought about by positive emotions such as mirthful laughter, optimism and hope."

—Lee Berk, DrPH, Assoc Res Prof, Loma Linda School of Medicine (2009)

There has been significant speculation in recent years about the physiological benefits of humor and laughter. Research on the link between laughter and the immune system focusing on stress hormones, including epinephrine, norepinephrine, and cortisol, has yielded conflicting results.

Psychological Benefits of Humor and Laughter

An early study by Levi (1965) supported the theory that laughter can modulate stress, but later research did not find evidence to this effect (Berk, Tan, Nehlsen-Cannarella, & Fry, 1988; Berk, Tan, Napier, & Eby, 1989; Pelletier & Herzing, 1989). Studies using salivary levels as a biologic outcome measure reported positive changes in immune function (Dillon, Minchoff, & Baker, 1985; Lefcourt, Davidson-Katz, & Kueneman, 1990), while others questioned the clinical significance of this measure (Mouton, Fillion, Tawadros, & Tessier, 1989; Stone, Cox, Valdimarsdottir, & Neale, 1987). Current thinking now relies on natural killer (NK) cell cytotoxicity as an indicator of immune system function. The work of Berk et al. (2001), based on five separate studies, provides preliminary evidence that exposure to a humorous stimulus, and the resulting laughter, can increase natural killer cell activity and immunoglobulins at least for a short period of time. Berk et al also found that exposure to humor may be useful as an adjunct to health intervention programs.

In a review of the literature on the effects of humor on cardio-respiratory function, Bennett (2006a, 2007a) reports that laughter results in immediate increases in heart and respiratory rate as well as oxygen consumption, followed by muscle relaxation and reduced blood pressure. Miller et al. (2006) used cinematic viewing to examine the role of laughter on endothelial function in the heart and found that laughter evoked significant brachial vasodilation in 75% of their participants, yielding similar effects to those reported with exercise or statin use (Rywik et al., 1999; Vogel, Corretti, & Plotnick, 1996). In all, evidence to support a relationship between humor and positive physiological outcomes is limited but emerging.

Perhaps the most direct answer to our question regarding whether there are biological responses to humor that can be used to foster successful adaptation comes from research on anxiety and stress. Huyck and Duchon (1986) state that humor serves to release tension safely and can therefore help promote a sense of well-being. Kuhlman discusses the uses of humor in stressful milieus such as group therapy (Fry & Salameh, 1993). He notes that “humor brings both short-term and long-term benefits to the stress-laden milieu. The short term benefits issue from the stress management properties of humor” (p.34). He describes the benefit of the autonomic arousal pattern associated with laughter. Stuber et al. (2009) evaluated benefits of comedy for children undergoing painful medical procedures and showed that when humorous videos were used, pain and anxiety levels decreased. Lefcourt’s work on the effects of humor on emotional response to stress has shown that “the ability to sense and appreciate humor can buffer the mood disturbances that happen in response to negative life events” (Lefcourt 1990, 1998 as summarized in Puder, 2011).

Strong support for the benefits of humor in adapting to loss and adversity is found in the psychosocial literature on therapeutic interventions. Numerous studies provide evidence of the positive influence that humor may bring to enhance the ability of an individual to cope with the psychological and interpersonal difficulties they experience. The use of humor as an integral part of therapy protocols has been discussed in the literature of the psychological and social counseling professions (Bordan & Goldin, 1999; Danermark, 1998; Fry & Salameh, 1987, 1993; Gladding, 1995; Shaughnessy & Wadsworth, 1992; Weaver & Wilson, 1997).

From a psychological perspective, the literature reveals that humor has strong relationships to the affective, behavioral, and cognitive systems, and that components of each of these psychological subsystems influences each other. For example, for any adversity an individual can be taught to problem solve (cognitive) related to ways of coping with that adversity. This helps the individual develop viable coping strategies (behavioral) which, in turn, provide empowerment through increased control and feelings of success (affective), lessen anxiety, and develop more positive attitudes. Likewise, trial behavioral changes may result in modified thinking (cognitive).

Cognitively, humor can facilitate coping by providing context and establishing the universality of experience, developing greater recognition of self, and developing clearer perspectives. Cognitive perspective can also facilitate coping by recognizing and eliminating irrational beliefs, engaging in cognitive restructuring, and actively addressing sensitive topic areas. Affectively, humor has shown a strong tendency to alter emotions positively resulting in feelings of empowerment, control, optimism, and support. Finally, behaviorally, humor has been shown to address such behaviors as advancing towards change readiness, and more effective use of coping strategies. These cognitive, affective, and behavioral effects will be discussed in greater detail in the context of hearing loss in the next sections of this article.

Affective Factors and Adaptation to Hearing Loss.

Promotes a sense of well-being. Studies show that people who laugh and see humor in situations report a sense of well-being after they laugh (Bennett, 2006a, 2007b). Bennett (2007b) further notes that the use of humor may be a useful part of a cognitive-behavioral intervention. Martin, Puhnik-Doris, Gray, and Weir (2003) report that after the use of humor in a session which addresses emotional issues or focuses on challenging behavioral changes clients, describe a sense of relaxation and well-being.

Provides momentary relief from overriding emotions. Sultanoff (1992) posits that it is not possible to feel depressed, anxious, or angry while responding to humor. When experiencing humor, the negative feelings dissolve. Those feelings may return, but during the time the feeling subsides, the client has respite that introduces the hope that negative feelings may be reduced or eliminated. The professional may judiciously insert humor into therapy to uplift the mood of the session, but must be extremely careful not to invalidate the client's feelings.

Relieves tension as entry point in groups or the therapy environment. Discussions of a highly personal nature such as those related to the social effects of hearing loss may cause tension, emotional pain, embarrassment, anxiety or stress. To counter these effects, humor has long been recognized as a means to relieve tension and break down barriers in stressful situations (Lefcourt, 1998; Mauger, 2001; Mayo Clinic, undated; Sultanoff, 1992; Trychin, 1985).

Facilitates a greater sense of control. When communication strategies are used successfully, individuals manage or control situations better for improved communication, and describe a sense of well-being. This, in turn, can reinforce the use of strategies. If a strategy is used multiple times and in a variety of contexts, it becomes a routine part of their approach when difficult communication situations arise.

An anecdote about an individual who continually responds with "Huh?" or "What?" provides a basis for discussion. The client may be asked how she would respond to the repeated use of these overused single-word questions, which provide little feedback to the speaker. In many instances, a sense of self-recognition may ensue and can be followed by an exploration of alternative strategies (confirmation, rephrasing etc.) that may be used.

Cognitive Factors and Adaptation to Hearing Loss

Universality of experience. Humor is usually based on shared or universal experience of individuals and their foibles and frailties. A humorous misunderstanding is illustrated in the following example:

Dick: "I got a new hearing aid. It really helps."

Ted: "That's great. What kind is it?"

Dick: "A quarter past four."

The image of the interchange is amusing, but the underlying misunderstanding is a common experience for people with hearing loss. Carried to an extreme, it becomes humorous. The joke also provides a working context for the concept addressed. The underlying principle of aided listening and/or the use of communication (confirmation) strategies may be addressed subsequent to the disarming humor.

Shared anecdotes related to hearing loss in one-on-one

therapy and group therapy may also be of use to the professional. In individual therapy, anecdotes provided by the client may demonstrate an understanding of a given concept. This comprehension may be an indicator of how the client will put the strategy to use. In group situations, members will relate more strongly to the anecdotes of peers than those told by the professional.

Facilitates recognition of self. A cartoon shows a man entering the front door of his home struggling to carry an air conditioner. Just out of his sight, his wife asks, "Honey, did you remember the *hair conditioner* I asked you to pick up?" Most individuals with hearing loss have experienced misunderstandings of a similar nature, even if not to such an extreme. It is likely that most clients will be able to relate to and share personal anecdotes involving such misunderstandings. The professional should emphasize that humor may be found in the absurdity of the misunderstanding and not in the person or their disability. When presented with a humorous cartoon or anecdote such as that described above, an individual may arrive at an understanding ("aha!" moment) relating the humor to their personal experience or frame of reference. A person who is in denial may make the connection and come to a realization or recognition of a personal truth e.g., recognition of potential consequences of hearing loss, ineffective communication behaviors, or need for a hearing aid. That, in turn, may open discussion of relevant communication issues and further allow exploration and problem-solving. Trychin (2003) describes a time-tested therapeutic approach using humorous "right way-wrong way" client participation skits to achieve the same purpose.

Provides perspective.

"Grant me the laughter to see with perspective, to face the future with hope, and to celebrate today...without taking myself too seriously"

—Dr. Stuart Robertshaw

In *Anxiety and Exaggerations* (2012), Knaus emphasizes that catastrophizing creates stress and anxiety and needs to be minimized so it does not impede therapy. Issues may take on more importance than necessary; their effects may not be nearly as problematic as perceived. Some indicators may include "always or never" thinking and obsessing over why things cannot change rather than what might help them to change.

The previous "Dick & Ted" exchange also exaggerates a possible result of a misunderstanding. The message is that such misunderstandings do happen and they need to be put in perspective. This sample exchange provides a basis for discerning the difference between laughing at the person and laughing at the circumstances. The visual image of Dick and Ted's interaction provides humor, directing our amusement at

the situation rather than at the person(s) responsible for the miscommunication. In group therapy, sharing of humorous anecdotes related to hearing loss may also help to find the humor in the situations, and put the incidents into perspective.

Helps dispel irrational beliefs of individual and of society.

Often, in therapy situations or counseling, irrational beliefs hinder adaptation to hearing loss. Common examples include “No, I don’t have a hearing loss. People just don’t speak as clearly as they used to,” and “My husband never....” The professional can capitalize on the inherent dangers of such skewed beliefs or *always-or-never thinking*. By taking such assumptions and generalizations to the extreme, it may help individuals to recognize the error in their assumptions. For example, the client says “He *always* talks to me from another room, so I can’t understand.” The professional responds “So, your husband *only* talks to you when you are not in the same room?” This emphasizes the fallacy of “always-or-never” thinking.

Helps facilitate cognitive restructuring. When clients have preconceived notions or ideas that may be counterproductive, cognitive restructuring may be extremely useful. Cognitive restructuring is a clinical approach that focuses on guiding a client to take a different perspective on a communication situation or concept (Ellis & Grieger, 1977; Hope, Burns, Hyes, Herbert, & Warner, 2010; Huppert, 2009; English, 2012; Taylor et al., 1997; Wallhagen, 2010). For example, many clients with hearing loss blame their lack of understanding on their [expressed perception] that “everybody mumbles.” This irrational belief may be addressed using cognitive restructuring. Mauger (2001) notes that “humor can often be used to re-interpret or re-frame distressing events. As laughter distances the individual from the stressor, a feeling of perspective and safety is created” (p.3).

Cognitive restructuring helps the client think differently about his hearing loss, how others perceive it, and what he can do about it. It may help clients realize that there are a multitude of options which can help improve communication. This requires a significant adjustment to the client’s thinking. Another benefit of restructuring is helping the client realize that he is not alone; other people have had considerable success in coping with hearing loss and they can, too.

On the other end of the spectrum, many individuals with hearing loss hold the view that their respective hearing losses are the sole cause of communication failure, when the fact is that other factors (e.g., noise, fatigue, speaker behaviors, accents) are likely to contribute to communication breakdowns. The professional may challenge this notion by putting forth an exaggerated humorous scenario.

It is generally accepted (Babeu, Kricos, & Lesner, 2004; Ellis & Grieger, 1977) that the cognitive (thinking, perspective, anticipating, planning) precedes behavioral (action). The affective (attitudes, feelings) may either drive the cognitive and/or the behavioral. When the outcomes of either thought or behavior are not ideal, clients must be taught to consider other cognitive or behavioral options.

Informational counseling may advance clients toward change readiness. There is a large body of work by Norcross, Procheska, and DiClemente and others (cited in Norcross, Krebs, & Prochaska, 2011) regarding *change readiness* or the steps one works through before making significant behavioral changes (pre-contemplation, contemplation, preparation, action, maintenance). Jeppesen (2015) applies this theoretical base to hearing loss. In the case of hearing loss, coping effectively requires making significant behavioral changes. If that person is not ready to accept the existence of hearing loss and the need to make such changes to address the problems related to hearing loss, efforts such as recommending hearing aids are unlikely to be fruitful. It is reasonable to believe that the manner in which professionals introduce the benefits of such efforts may stimulate movement toward readiness to make changes. The use of humor may provide a unique and non-threatening entrée into preparatory counseling and information sharing while in the pre-contemplation and contemplation stages of change readiness. For example, it is helpful if the client can see the humor in misunderstandings and acknowledge the usefulness of wearing hearing aids even if they are visible.

Introduces the possibility of “taking action” for coping with hearing loss. Often times, especially with gradually progressing hearing loss, individuals are unaware of the extent of their hearing difficulties. Frequently, they have received encouragement or pressure to address their hearing loss from significant others in their lives who have observed communication difficulties or been frustrated by them. Some may respond with resentment or denial, which are common responses to accepting disability or the effects of aging. When first encountering professionals, some individuals may not be fully accepting of the fact that they have hearing loss, or that they need to act on it. They may be resistant to doing so, or are simply not ready at that moment in time.

It stands to reason that a more sensitive clinical approach during rehabilitation may result in greater acceptance of hearing loss and readiness to take action. Anecdotal and cartoon-based humor are generally less threatening because they do not focus directly on the client. A skilled professional is able to assist the client in generalizing humorous incidents in the context of their own behaviors and strategies. The use of humor may provide a starting point for discussions about how hearing can impact the communication process. The combination of strategies and humor may provide a unique

way to both facilitate a greater degree of readiness to accept a hearing loss, and introduce the possibility of taking action to cope with hearing loss.

Behavioral Factors and Adaptation to Hearing Loss

Behavioral changes or adaptation to more successfully cope with hearing loss are more likely to occur after making cognitive and affective changes in terms of readiness. These changes include, but are not limited to, the active use of amplification devices and assistive technology, communications strategies, and the elimination of maladaptive strategies. Another critical component of rehabilitation is facilitating behavioral changes with frequent communication partners, which may also lead to more effective communication.

Humor may increase attending behavior (behavioral/cognitive). The use of humor increases attentive behavior. Because of the complexity of humor, the brain focuses more on the words and concepts of what is being said. This provides a basis for ongoing attentive communication (Sultanoff, 1992).

Humor may foster the active use of communication strategies. Humorous anecdotes or stories may be used by professionals to introduce the critical therapy objectives of aural rehabilitation as well as to provide examples of both successful and unsuccessful strategy use. In a selected cartoon, a man interprets his doctor's report to elicit a behavioral response from his wife:

Panel 1: Doctor to Bill: "You have a significant hearing loss in your right ear."

Panel 2: Wife to Bill: "What did the doctor say?"

Bill to Wife: "He said that you should talk into my right ear."

A relevant cartoon or anecdote provides the professional with a perfect segue to introduce anticipatory, maintenance, and repair communication strategies. These may include the analysis of communication breakdowns as well as open a discussion about communication having a shared responsibility. A humorous anecdote based on misunderstanding might provide an example of how using "confirmation" can be a critical and effective strategy that may prevent communication breakdown. To this end, Moseley and Bally (1996) and Tye-Murray (2009), provide hierarchies that offer clients a menu of options for strategy use.

Humor may help to foster expansion of strategy options. The success or failure of behaviors and strategies or strategy use may drive clients to identify additional behavioral options. Humorous anecdotes or stories may be used by professionals to introduce the critical therapy areas of aural rehabilitation as well as to provide examples of strategy use. For example, asking clients how others deal with their hearing loss may be another segue using a humorous approach.

The most common response is that others yell at them. Follow-up questions for the professional include, "How do you feel about that?" and "How do others observing this behavior react?" Inevitably, the humorous aspect of these behaviors usually can be elicited with laughter or rolling of eyes, with the goal of finding humor in the situation rather than the person with hearing loss. Then the professional can ask, "How effective is that?"

Addressing the problem of maladaptive strategy use with humor. Individuals who are experiencing hearing loss often avoid seeking professional help for many years. On average, it takes people seven years from the time they suspect they might have a hearing loss to the time they seek treatment. They often do not realize the impact of untreated hearing loss on their psychological and social functioning in everyday life; the widely cited National Council on Aging 1999 survey (Kochkin & Rogin, 2000) shows significantly higher rates of depression, anxiety, and other psychosocial disorders in individuals with hearing loss who were not wearing hearing aids. Without realizing the impact of their hearing loss individuals and their communication partners may use reactionary strategies that frequently are not effective (Kaplan, Bally, & Garretson, 1986). For example, those with hearing loss may bluff when they do not understand, may blame their failure to understand on the speaker or characteristics of the environment, may respond with repeated requests for repetition, or just plain try to hide it. Communication partners may respond to a lack of understanding of what was said by shouting or over-enunciating. The use of humor in combination with effective communication strategies can provide unique insights and a nonthreatening path towards improving communication and relationships for those with hearing loss and their communication partners.

Summary

"If you can laugh at it, you can survive it."

The purpose of Part I of this article is to introduce the potential of humor as a means of facilitating adaptation to hearing loss. While there is a substantial body of evidence provided by the psychological and social counseling professions to support its use in clinical interventions, it has yet to be explored or applied in audiology, aural rehabilitation and speech-language pathology. Physiological studies provide some important information on the effects of humor/laughter. Evidence to support the use of humor as a therapeutic tool based on physiological responses is limited but emerging.

The key ideas presented in Part I are that a sense of humor is an important personal characteristic for coping with hearing loss, has promising potential to help address the biopsychosocial effects of hearing loss, and can be an effective therapeutic tool for helping people with hearing loss and their communication partners to address the challenges of adapting

to hearing loss. In all, humor has untapped potential for successful coping, and professionals should consider incorporating it with care into clinical practice as an integral part of a counseling approach taken with individuals with hearing loss. In Part II the focus will be on social factors, as well as the biopsychosocial adaptation to hearing loss, with practical applications for both the professional and individuals with hearing loss and their significant others.

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References

- Apte, M. (1987). Ethnic humor versus "sense of humor". *American Behavioral Scientist*, 30, 27-41.
- Babeu, L., Kricos, P., & Lesner, S. (2004). Applications of the stages-of-change model in audiology. *Journal of the Academy of Rehabilitative Audiology*, 37, 41-56.
- Baldrige, D. (2014a). Career success after hearing loss: Finding and refining your path. *Hearing Loss Magazine*, 35, 12-16.
- Baldrige, D. (2014b). Workplace behavioral responses to the law. *Hearing Loss Magazine*, 35, 24-25.
- Bally, S. (2009). Group therapy and group dynamics in aural rehabilitation. In J. Montano & J. Spitzer (Eds.), *Adult audiological rehabilitation* (pp. 283-304). San Diego, CA: Plural Publishing.
- Bennett, M. & Lengacher, C. (2006a). Humor and laughter may influence health I: History and Background. *Evidence-based Complementary and Alternative Medicine*, 3, 61-63.
- Bennett, M. & Lengacher, C. (2006b). Humor and laughter may influence health II: Complementary therapies and humor in a clinical population. *Evidence-based Complementary and Alternative Medicine*, 3, 187-90.
- Bennett, M. & Lengacher, C. (2007a). Humor and laughter may influence health III: Laughter and health outcomes. *Evidence-based Complementary and Alternative Medicine*, 5, 37-40.
- Bennett, M. & Lengacher, C. (2007b). Humor and laughter may influence health IV: Humor and immune function. *Evidence-based Complementary and Alternative Medicine*, 6, 159-164.
- Berk, L., Tan, S., Nehlsen-Cannarella, S., Napier, B., Lewis, J., Lee, J., & Eby, W. (1988). Humor associated laughter decreases cortisol and increases spontaneous lymphocyte blastogenesis. *Clinical Research*, 36, 435A.
- Berk, L., Felten, D., Tan, S., Bittman, B. & Westengard, J. (2001). Modulation of neuroimmune parameters during the eustress of humor-associated mirthful laughter. *Alternative Therapies in Health and Medicine*, 7, 62-72, 74-76.
- Bordan, T. & Goldin, E. (1999). The use of humor in counseling: the laughing cure. *Journal of Counseling and Development*, 77, 405-410.
- Clark, M. (2014). Congratulations, you have an interview. What now? *Hearing Loss Magazine*, 35, 18-20.
- Danermark, B. (1998). Hearing impairment, emotions and audiological rehabilitation: a sociological perspective. *Scandinavian Audiology- Supplementum*, 49, 125-31.
- Dewane, C. (2010). Hearing loss in older adults - Its effect on mental health, *Social Work Today*, 10, 18.
- Dillon, K., Minchoff, B., Baker, K. (1985). Positive emotional states and enhancement of the immune system. *The International Journal of Psychiatry in Medicine*, 15, 13-18.
- Ellis, A., & Grieger, R. (1977). *Handbook of rational emotive therapy*. New York: Springer.
- English, K. (2008). Educating and Counseling Children and Teens with Hearing Loss. In J. Madell & C. Flexer (Eds.) *Pediatric audiology: Diagnosis, technology, and management* (pp. 89-105). New York: Thieme.
- Fry, W. & Salameh, W. (Eds.). (1993). *Advances in humor and psychotherapy*. Sarasota, FL: Professional Resource Press.
- Fry, W. & Salameh, W. (Eds.). (1987). *Handbook of Humor and Psychotherapy*. Sarasota, FL: Professional Resource Exchange.
- Gladding, S. (1995). Humor in counseling: Using a natural resource. *Journal of Humanistic Education and Development*, 34, 3-12.
- Glickman, N. & Harvey, M. (Eds.). (1996). *Culturally affirmative psychotherapy with deaf persons*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Harvey, M. (2003). *Psychotherapy with deaf and hard of hearing people: A systemic model* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum Associates.
- Hoicka, E., Jutsum, S. & Gattis, M. (2008). Humor, abstraction, and disbelief. *Cognitive Science*, 32, 985-1002.

- Hogan, A. (2001). *Hearing Rehabilitation for Deafened Adults: A psychosocial Approach*. London, England: Whurr Publishers.
- Hope, D., Burns, J., Hyes, S., Herbert, J. & Warner, M. (2010). Automatic thoughts and cognitive restructuring in cognitive behavioral group therapy for social anxiety disorder. *Cognitive Therapy Research*, 34, 1-12.
- Huppert, J. (2009). The building blocks of treatment in cognitive-behavioral therapy. *Israel Journal of Psychiatry Related Science*, 46, 245-250.
- Huyck, M. & Duchon, J. (1986). Over the miles: Coping, communicating and commiserating through age. In L. Nahemow, K. McCluskey-Fawcett, & P. McGhee (Eds.), *Humor and Aging* (pp. 139-159). Orlando FL: Academic Press.
- Ida Institute (2012). Factors to consider when providing audiologic services to people who have hearing loss and their communication partners. In Ida Institute: Redefining audiologic rehabilitation. *Seminars in Hearing*, 33, 87-96.
- Jeppesen, A. (2015, May). Empower patients to take action on their hearing. Presented in partnership with the Ida Institute. Retrieved from <http://www.audiologyonline.com>.
- Kaland, M. & Salvatore, K. (March 2002). The psychology of hearing loss *The ASHA Leader*, 7, 4-15.
- Kaplan, H. (1996). Informational and adjustment counseling. In M. Moseley & S. Bally (Eds.), *Communication therapy* (pp. 92-127). Washington, DC: Gallaudet University Press.
- Kaplan, H., Bally, S., & Garretson, C. (1986). *Speechreading: A way to improve understanding*. Washington, DC: Clerc Books.
- Klein, A. (1989). *The healing power of humor: Techniques for getting through loss, setbacks, upsets, disappointments, difficulties, trials, tribulations, and all that not-so-funny stuff*. Los Angeles, CA: Jeremy Tarcher.
- Knaus, B. (2012, November). Anxiety and exaggerations. Retrieved from www.psychologytoday.com/blog/science-and-sensibility/201211/anxiety-and-exaggerations
- Kochkin, S. & Rogin, C. (2000). Quantifying the obvious: The impact of hearing instruments on quality of life. *Hearing Review*, 7, 8-34.
- Kricos, P. & Lesner, S. (1995). *Hearing care for the older adult*. Boston, MA: Butterworth-Heinemann.
- Kuhlman, T. (1993). Humor in stressful milieus. In W. Fry & W. Salameh (Eds.), *Handbook of Humor and Psychotherapy* (pp. 19-45). Sarasota, FL: Professional Resource Exchange.
- Lefcourt, H., Davidson-Katz, K., & Kueneman, K. (1990). Humor and immune system functioning. *International Journal of Humor Research*, 3, 305-321.
- Lefcourt, H., Herbert, M., & Thomas, S. (1998). Humor and stress revisited. In W. Ruch (Ed.), *The sense of humor: Explorations of a personality characteristic* (pp. 179-202). New York: Mouton de Gruyter.
- Levi, L. (1965). The urinary output of adrenalin and noradrenalin during pleasant and unpleasant emotional states. *Psychosomatic Medicine*, 27, 403-19.
- Martin, R., Kuiper, N., Olinger, L. & Dance K. (1993). Humor, coping with stress, self-concept, and psychological well-being. *International Journal of Humor Research*, 6, 89-104.
- Martin, R., Puhnik-Doris, P., Gray, J. & Weir, K. (2003). Individual differences in uses of humor and their relation to psychological well-being: Development of the Humor Styles Questionnaire. *Journal of Research in Personality*, 37, 48-75.
- Mauger, S. (2001). The use of humour in stress management. Retrieved from <http://coachalquimia.wordpress.com/page/2/>
- Mayo Clinic (undated). Stress relief from laughter? Yes, no joke. Retrieved from <http://www.mayoclinic.com/health/stress-relief/SR00034>
- McGhee, P. (1979). *Humor: Its origin and development*. Reading, England: Freeman & Co.
- McGraw, P. (2011). The Importance of Humor Research: A serious non-serious research topic. www.psychologytoday.com/blog/the-humor-code/201109/the-importance-humor-research
- Meyer, J. (2000) Humor as a Double-Edged Sword: Four Functions of Humor in Communication. *Communication Theory*, 10, 310-331.
- Miller, M., Mangano, C., Park, Y., Goel, R., Plotnick, G. & Vogel, R. (2006). Impact of cinematic viewing on endothelial function. *Heart*, 92, 261-262.
- Moseley, M., & Bally, S. (Eds.). (1996). *Communication therapy*. Washington, DC: Gallaudet University Press.
- Mouton, C., Fillion, L., Tawadros, E., & Tessier, R. (1989). IgA is a weak stress marker. *Annals of Behavioral Medicine*, 15, 179-185.
- Norcross, J., Krebs P., & Prochaska, J. (2011). Stages of change. *Journal of Clinical Psychology*, 67, 143-154.
- Pelletier, K., & Herzog, D. (1989). Psychoneuroimmunology: Toward a mind-body model. *Advances*, 5, 27-56.
- Pray, J. (1996). Psychosocial aspects of adult aural rehabilitation. In M. Moseley & S. Bally (Eds.) *Communication therapy* (pp. 128-148). Washington, DC: Gallaudet University Press.

- Preminger, J. (2009). Audiologic rehabilitation with adults and significant others: Is it really worth it? Retrieved from <http://www.audiologyonline.com/articles/audiologic-rehabilitation-with-adults-significant-882>
- Provine, R. (2000). *Laughter: A Scientific Investigation*. New York: Viking, Penguin.
- Puder C. (2011). The healthful effects of laughter. Retrieved from <http://coachalquimia.wordpress.com/>
- Ross, M. (2010). The "stigma" of hearing loss and hearing aids. *Hearing Loss Magazine, May/June*.
- Rywik T., Blackman, M. Yataco, A., Vaitkevicius, P., Zink, R., Cotrell, E., Wright, J., Katzel, L, & Fleg, J. (1999). Enhanced endothelial vasoreactivity in endurance-trained older men. *Journal of Applied Physiology, 87*, 2136-42.
- Shaughnessy, M. & Wadsworth T. (1992). Humor in counseling and psychotherapy: a 20-year retrospective. *Psychological Reports, 70*,755-62.
- Smith, B., Epstein, E., Ortiz, J., Christopher, P. & Tooley, E. (2017). The foundations of resilience: What are the critical resources for bouncing back from stress? (pp.167-187).
- In S. Prince-Embury & D. Saklofske (Eds.) *Resilience in children, adolescents, and adults*. Springer Publishing, NY.
- Smith, M. & Segal, J. (2014, February). Laughter is the best medicine: The health benefits of humor and laughter. Retrieved from http://www.helpguide.org/life/humor_laughter_health.htm
- Stafford-Mallis, V. (2014). Hiring employees with hearing loss-what's in it for employers? *Hearing Loss Magazine 35*, 32-34.
- Stone, A., Cox, D., Valdimarsdottir, H., & Neale, J. (1987). Secretory IgA as a measure of immunocompetence. *Journal of Human Stress, 13*, 136-140.
- Stuber, M., Hilber, S., Mintzer, L., Castaneda, M., Glover, D., & Zeltzer, L. (2009) Laughter, humor and pain perception in children: a pilot study. *Evidence-based Complementary and Alternative Medicin, 6*, 271-6.
- Sultanoff, S. (1992). The impact of humor in the counseling relationship. *Laugh It Up, July/August, 1*.
- Taylor, S., Woody, S., Koch, W., McLean, P., Paterson, R., & Anderson, K. (1997). Cognitive restructuring in the treatment of social phobia. *Behavior Modification, 21*, 487-511.
- Trychin, S. (1985). *Stress management-I*. Bethesda, MD: Self Help for the Hard of Hearing Association.
- Trychin, S. (1992). Huh? A little humor goes a long way. Hearing Health, Corpus Christi, TX.
- Trychin, S. (2002). Guidelines for providing mental health services to people who are hard of hearing (Rep. No. ED466082). San Diego, CA: Rehabilitation Research and Training Center, California School of Professional Psychology- San Diego, University of California. Retrieved from <https://www.gpo.gov/fdsys/pkg/ERIC-ED466082/pdf/ERIC-ED466082.pdf>
- Trychin, S. (2003). *Communication rules: Guidelines for preventing or reducing communication problems related to hearing loss*. Erie, PA: Samuel Trychin Publishing.
- Tye-Murray, N. (2009). *Foundations of Aural Rehabilitation: Children, adults, and their family members* (3rd ed.). Clifton Park, NY: Delmar Learning.
- Vogel, R., Corretti, M., & Plotnick, G. (1996). Changes in flow-mediated brachial artery vasoactivity with lowering of desirable cholesterol levels in healthy middle-aged men. *American Journal of Cardiology, 77*, 37-40.
- Waggoner, L. (undated). Humor and hearing loss. In R. Waggoner & L. Waggoner (Eds.). *Imperative information for people with hearing loss and their partners*. Self-published.
- Wallhagen, M. (2010). The stigma of hearing loss. *Gerontologist, 50*, 66-75.
- Walton, R. (2003). What is humor? A definition of humor that works for me. Retrieved 08/03/09 from <http://www.rickwalton.com/lang/whathumo.htm>
- Warren, C., & McGraw, A. (2016). Differentiating what is humorous from what is not. *Journal of Personality and Social Psychology, 10*, 407-30.
- Wayner, D. (2011, June). Surviving the stress of hearing loss: What you can do. Paper presented at the annual meeting of the Hearing Loss Association of America, Washington, D.C.
- Weaver, S. & Wilson, N. (1997). Addiction counselors can benefit from appropriate humor in the work setting. *Journal of Employment Counseling, 9*, 108-114.

**The Use of Humor to Facilitate Adaptation to
Hearing Loss: *A serious consideration of the potential
role of humor in aural rehabilitation Part II***

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Abstract

This article explores the underutilized potential of humor as a useful component of therapy for helping to facilitate adaptation to hearing loss for individuals with hearing loss and their communication partners. Evidence from allied health literature regarding the use of humor in addressing biological, psychological and social effects of a range of medical conditions is considered in the context of hearing loss. Key concepts include the following:

- A sense of humor is an important personal trait supporting successful coping with hearing loss.
- Humor has great potential to help address the biopsychosocial effects of hearing loss.
- Humor can be an effective therapeutic tool, when used judiciously.

Part II focuses on the ways in which social factors influence adaptation to hearing loss. It also examines the potential use of humor in both the therapeutic process and for individuals and their families to ameliorate the negative social aspects of hearing loss. The article provides some preliminary guidelines, considerations, and practical applications for integrating humor into the therapeutic process.

Introduction

**The Use of Humor to Facilitate Adaptation
Hearing Loss**

This article explores the potential uses of humor as an element of the therapeutic process and the successful adaptation to the challenges of hearing loss. It investigates the biopsychosocial dynamics inherent in the use of humor both as a clinical tool and as a coping mechanism for individuals who have a hearing loss.

In considering the potential use of humor in the rehabilitation process, Part II of this article examines the literature of allied health professions with the following questions as a guide. When individuals are coping with adversity, and hearing loss in particular:

- What is known about how social factors affect adaptation to hearing loss?
- What is known about the function of humor for improving the psychosocial coping abilities of individuals who are experiencing hearing loss as well as for their primary communication partners?
- Are there guidelines from the allied health professional literature on the therapeutic use of humor that may be adapted for aural rehabilitation?

**Social Factors, Humor, and
Adaptation to Hearing Loss**

Socially, hearing loss impacts relationships, self-esteem, education, vocational functioning, family life, and virtually all social interactions (Baldrige, 2014a, 2014b; Clark, 2014; Harvey, 2003; Kaland & Salvatore, 2002; Kaplan, 1996; Kricos & Lesner, 1995; Pray, 1996; Ross, 2010; Stafford-Mallis, 2014; Trychin, 2002, 2003; Tye-Murry, 2009; Wallhagen,

2010). The social impact of hearing loss needs to be considered within the context of social system levels described below. These social system levels also provide the framework for examining the social influences of humor.

- Micro-systems representing individuals with hearing loss and their significant other(s), including family constellations;
- Meso-systems representing extended family, friends, co-workers, religious/spiritual groups, and small communities; and
- Macro-systems representing larger groups and society as a whole (e.g., corporations, large communities, towns, cities, religious/spiritual denominations, government agencies).

Prevailing attitudes and beliefs of American society regarding disability and hearing loss may play a role on every system level. There may also be an interaction between different levels of these social systems. For example, “awareness of difficulty in understanding important matters in a business meeting (macro) produces anxiety/fear (micro); conversely anxiety (micro) results in inability to focus attention and use judgment (micro) which can further increase the inability to understand what others are saying (macro) at a meeting”. (Manchaiah, V., & Stephens, D. 2013, p.6). More detailed descriptions of micro, meso, and macro systems and systems theory can found in Bally (1996) and Luhmann (2012), respectively.

One aspect of successful coping is for an individual to see the humor in miscommunications resulting from hearing loss. In such cases, humor and laughter reduce stress and tension resulting from miscommunication. While there are individual differences in the use of humor, it is most often considered to be a positive indicator for successful adaptation to adversity and loss. (Martin, Puhnik-Doris, Gray, & Weir, 2003; Pray, 1996).

In a relevant selected cartoon, a man interprets his doctor’s report to elicit a behavioral response from his wife:

Panel 1: Doctor to Steve: “You have a hearing loss in your right ear.”

Panel 2: Wife to Steve: “What did the doctor say?”

Panel 3: Steve to Wife: “He said that you should talk into my right ear.”

This type of humorous exchange provides a perfect opportunity to introduce the use of communication strategies as well as to open discussion about communication being a shared responsibility. Other cartoons and jokes may be found in multiple online venues but must be vetted first by the professional. The professional must be careful to select

humor that focuses on the miscommunications rather than the biological aspect of having a hearing loss, and the professional must emphasize that difference to the client.

Humor Facilitates Bonding

Humor is a shared phenomenon. Kuhlman (1993, p.36) provides support that humor is “a language of healthy cohesion” by explaining that “it reduces the social distance among participants and opposes tendencies toward rigidity or social structures within which participants coexist.” He notes that “humor is a vehicle for momentary emotional involvements among comrades; it underlines their mutual dependence for insuring one another’s safety and well-being under trying circumstances.” Sharing relevant types of humor in the clinical situation is a proven approach to bonding (Smith & Segal, 2014). Shared humor enhances shared values and feelings of acceptance. The client-professional relationship becomes stronger because both parties feel they can relate better. For example Sultanoff, (1992, p 1) suggests that “Humor in counseling helps build a base from which the professional can continue to respond to the client in ways that facilitate growth” By extension, humor may also help individuals bond with members of a therapy group or in other interpersonal relationships. Smith and Segal (2014, p.1) conclude that “when laughter is shared, it binds together and increases happiness and intimacy.” The humor in hearing loss related situations that result in miscommunications can be shared by members of peer-to-peer support and local self-help groups or organizations such as the SayWhatClub, the Association of Late Deafened Adults (ALDA), the Hearing Loss Association of America (HLAA), or online support groups such as Hearinglikeme.com, HearingJourney.org, or HealthfulChat.org.

Using Humor for a Non-Personalized and Non-Threatening Approach

Third party examples of humor that are not personal to clients are likely to be less threatening to them (Pray, 2006; Walton, 2003; Warren & McGraw, 2016). Humorous anecdotes or cartoons may provide the opportunity for self-recognition and, perhaps, put that recognition in a less threatening light. “Most components of humor have an element of truth to them,” therefore, the anecdote, joke, cartoon, exaggeration or other form of humor can be “a way to focus on the underlying issues and allow the client to examine its value and importance in human experience” (Boyum, 2013, p.1).

Some clients may be threatened by counseling approaches that personalize or focus on them, their disability, or their real or perceived shortcomings. Examining case studies, anecdotes, online videos, or even the underpinnings of a cartoon strip provides a ‘safe’ means of discussing interpersonal dynamics or human frailties without directing value judgments toward the

the client. A more non-threatening approach may be provided by using humor that allows the professional to direct the client's attention to underlying truths with the expectation that the client will generalize through self-assessment. Cognitive restructuring and behavioral changes may follow. These cognitive/behavioral changes may be understood from the perspective of the health belief model in which self-efficacy is one key aspect that may play a role in facilitating change (Saunders, Frederick, Silverman, Nielsen, & Laplante-Lévesque, 2016). Using humor as a therapeutic tool may be valuable for increasing the self-efficacy by increasing a client's insight regarding about communication misunderstandings, followed by learning and applying communication strategies (Smith, 2014).

Consider the following cartoon illustrating a humorous misunderstanding. A carpenter's assistant is entering the room carrying a toy kangaroo. The carpenter, whose back is to his assistant, says "Oh good! You're back with the *can of glue* I needed." This misunderstanding is an example of the human experience when hearing loss is involved. Anecdotes about humorous misunderstandings may help clients examine their own experiences and help them to see the mis-understanding as less a reflection of their own inadequacies and more as a result of the circumstances in which they find themselves.

Addressing Social Dynamics and Faulty Thinking with Humor (Cognitive/Behavioral)

Humor has the capacity to break the tension and might in turn facilitate discussion. At the same time, a key issue or concept is incorporated in these types of humor. An example is a cartoon that shows Helga talking to her husband, Hagar the Horrible:

Helga: "Why is it when we're in the same room and I ask you to do something, you can't hear me...but when you're outside you can always hear the sound of a plate being placed on the table?"

A family member who is participating in therapy is likely to identify the social dynamics of Hagar's behavior as "selective hearing." Selective hearing or listening suggests that there is a psychological or social (interpersonal) basis for such behavior. However, what may be interpreted as selective hearing may, in fact, be the result of other factors including speaker variations such as distance from the listener, accent, pitch and loudness, and noisy environment, to name a few. If family members are not aware of the impact of such factors, this might lead them to erroneously conclude that the person with hearing loss has selective hearing. A discussion of faulty thinking and a problem-solving approach may follow. Such an approach is supportive to the person with hearing loss and educates a friend or family member in a less personal way. It may be employed as a segue to working on communication strategies.

Working Model using Humor for Discussions with Communication Partners (Social/Behavioral)

A significant element of coping is to open a dialogue with communication partners and to collaboratively identify strategies and approaches that will ameliorate communication breakdowns (Ida Institute, 2012; Preminger & Lind, 2012; Scarinci, Meyer, Ekberg, & Hickson, 2013; Tye-Murray, 2015). Approaches used by the professional with a client may provide working models for that client to utilize when approaching family and friends. A person with hearing loss may adopt a humorous and non-threatening approach to open discussions of a sensitive or personal nature about the effects of hearing loss. For example, "I always thought it was funny that my mother referred to this relative as Aunt Amos...it seemed silly. Much later I got a birthday card from 'Aunt Emma' and it finally clicked that that's who she was talking about. I had not been corrected previously because family members thought it was so cute...which it was not!"

Highlight and Address Social Stigma Through Humor (Social/Cognitive)

Social stigma is a very real obstacle for individuals trying to cope with hearing loss (Atcherson, 2002; Garstecki & Erler, 1998, Pray, 1996; Ross, 2010). The lack of understanding by the person with the hearing loss may suggest to others that the individual is less able, less interested, not smart, rude, or just "different." It is not uncommon for family members, especially of older adults, to misinterpret communication difficulties as a sign of cognitive impairment.

By extension, individuals with hearing loss may self-stigmatize by doubting their own competence. An older adult with a hearing loss may begin to question his or her own mental status, not realizing that, it is a hearing loss that is responsible for the missed or misunderstood information during conversations or in social situations. The over-riding impact may be a significant loss of self-esteem or self-confidence. This sense of stigma can result in the individual avoiding challenging communication situations, resulting in withdrawal, isolation, and depression (Atcherson, 2002; Hetu, 1996; Preminger, 2009).

In addressing faulty perceptions, humor to allay stereotypes and associated stigma might involve posing questions with alternative ways of thinking. When using humorous materials to direct focus on a particular therapy objective, there is often a point of self-recognition. The key here is that there is often humor in self-recognition especially when a client realizes the error of their thinking. There is also self-recognition in humor itself. For example, this occurs when an individual looks at a cartoon and says "Yes, that's me. I've been there and I've experienced that too". This, in turn, provides an opportunity for the therapist to initiate a shift from the globalized humor to the individual's specific situation, issues, and needs.

Professionals and experienced group leaders may utilize humor as a linking technique. Members without shared experiences may be able to relate to the expressions of humor and demonstrate acceptance by laughing (Dziegielewski, Jacinto, Laudadio, & Legg-Rodriguez (2003). These important factors apply to individuals in aural rehabilitation groups and support groups for their families and friends.

Coser (1959, p.180) summarized his belief that “Humor allows the participants, in a brief span of time and with a minimum of effort, to mutually reinterpret their experiences, to entertain, reassure, and communicate; to convey their interest in one another, to pull the group together by transforming what is individual into collective experience, and to strengthen the social structure within which the group functions.” This encapsulates the ways in which a professional is able to work with individuals with hearing loss in groups to help them process humor and facilitate adaptation to hearing loss. This idea taps into the communication that transpires between a hearing health care professional and their client with hearing loss as they help them learn how to use humor to adapt to their loss.

Integrating Humor into the Rehabilitation Process: Guidelines, Considerations, and Practical Applications

“One size does not fit all.” (Frank Zappa)

The studies cited above from the literature of allied health care fields demonstrate that humor may also enhance the client-professional therapy process and be an effective therapeutic tool for helping individuals cope with wide variety of physical impairments, when used judiciously. When applied, the use of humor as a therapeutic tool needs to be integrated into client-centered treatment goals (Abrams & Chisolm, 2013). We do not always know how a person will react to humor, especially when related to issues of a potentially sensitive nature. It may be difficult to determine a priori, which clients would benefit most from this. As noted earlier, the professional needs to understand what the hearing loss *means* to the person (Pray, 1996). Humor should not be used too early in a relationship; professionals must establish a rapport so that their clients trust them and know they have their best interests at heart. It should be “compassionate and connecting” (Klein, 1989).

Guidelines and Considerations for the Use of Humor in Therapy

“Humor is risky business.” (Klein, 1989, p. 33)

As discussed previously the authors wish to re-state that it is critical that clients and their professionals share a common perspective, lest the clients perceive themselves as being

Social Considerations of Disclosure (Cognitive/Social/Behavioral)

Cognitive restructuring may facilitate social and behavioral change (Ellis & Grieger, 1977). A major issue facing many individuals is whether or not to disclose their hearing loss. A significant portion of individuals with progressive hearing loss may be in denial, attributing the hearing loss to other factors (e.g., other people mumbling, noisy environment, fatigue). In many cases, as hearing ability continues to decline, persons with hearing loss move towards acceptance of the loss. Either concurrently or sequentially, an individual may begin taking active measures to improve communication. Letting others know about a hearing loss and then pointing out what they can do to enhance communication (i.e., speak more slowly, face the person when talking) may reduce misunderstandings. However, disclosure is regarded as an issue of personal choice and is governed by a number of factors, among them readiness, work status, perceived likelihood of discrimination, acceptance, and possible repercussions, as well as self-perspective and experience (Babeu, Kricos, & Lesner, 2004; Canadian Hearing Society, undated; Clark, 2014; Smith & Kricos, 2003).

Social and self-stigma associated with hearing loss often focus on the perceived visibility and noticeability of hearing aids (Johnson et al., 2005). A cartoon depicts a Viking wearing a helmet with horns. The horns are inverted with the larger ends of the horns sticking out. One observer says to another: “There goes Thor. He’s sensitive about his new hearing aids... pretend you don’t notice!” Such a cartoon might be a good way to start a discussion about the *noticeability* of hearing aids and what people might think about a person who wears them, again using humor and examples rather than personalizing. This, in turn, may lead to self-identification of behaviors used by those with hearing loss (e.g., frequent requests for repetitions, bluffing, turning the television louder to compensate).

Breaking Down Interpersonal Barriers with Humor

At times, the professional needs to approach sensitive areas or “deflect painful truths” (Datan, 1986,) with a client. The client will need to consider and respond to the effects of hearing loss on significant others and other communication partners. Often the individual with hearing loss is either in denial or has not considered the ways in which their partners are affected. For example, communication partners may be experiencing embarrassment, frustration, and loss of intimacy (Hetu, Jones, & Getty, 1993; Lind, 2014; Pray, 1996; Trychin, 2009). Initiating these discussions requires sensitivity. Various types of humor may provide that non-threatening transition to daily communication issues.

laughed at, rather than laughed with. It is not the hearing loss that is the target of humor, but, rather, the situations, incongruities, and miscommunications that emerge as a result. This emphasizes the human condition and the common experiences we share. The humor enables us to reduce stress and get through life's challenges, put things in perspective, and try to find reasonable and successful solutions to the problems associated with hearing loss.

It is equally important to approach the use of humor with great sensitivity and use it judiciously. An understanding of the individual's sensibilities is essential. Humor should be considered, "appropriate, timely and tasteful" (Klein, 1989, p. 36). Further, humor and hearing loss need to be understood within a sociocultural context (Apte, 1987; Danermark, 1998; Glickman & Harvey, 1996; Provine, 2000). The clinical implication is that the professional needs to match the type of humor to the client's sense of humor to be successful. When humor is integrated in a sensitive, personal, and appropriate way, it may ameliorate some of the emotional impact of the hearing loss for that person and their communication partners.

The use of humor is considered a more sophisticated clinical technique that should be used carefully and with professional judgement, given that guidelines lack specificity. As clinical experience and insight expands, the professional will likely have a better understanding of the dynamics of the use of humor. The professional would then be better equipped to use humor more effectively and with greater confidence.

Guidelines for use of humor are not formally established within hearing healthcare literature. However, some guidelines are found in writings in psychology, social work, and counseling (American Counseling Association, 2018; Fry & Salameh, 1987, 1993; Klein, 1989; Nasr, 2013). Unfortunately, there is no formal research to support its use, but clearly have clinical practice application that can provide some preliminary structure:

- Clients should not be in a state of crisis or be dealing with serious psychological issues resulting from the onset or diagnosis of hearing loss (or any other major stressor).
- Professionals and clients must have developed a positive rapport and established a trusting relationship.
- Initial efforts to utilize humor in therapy should be universal rather than specific to the client's situation (situations common to all).
- The client should have demonstrated a positive response to the initial use of humor, and the professional should carefully gauge responses to these materials. If they have a negative response, stop the approach but consider re-introducing at a later time.

- Early on, the client should be given a clear understanding of why the humor is being introduced (normalizes, gives validity, demonstrates a shared experience, etc.).
- The professional needs insight into the sense of humor of the client (what the client finds funny) as well as an understanding of the cultural background and potential cultural perspectives.
- Materials should be selected with great care, focusing on situations and miscommunications rather than disabilities. They should have the potential to be generalized to a specific client's issues and be sensitive to their perspectives and current mindset.

Practical Applications

When considering the paradigm of using humor as a therapeutic tool, the authors have included a few sample exercises to illustrate the dynamics as they appear in a humorous context. There are a number of ways that a single anecdote, joke, or cartoon can be used to address issues related to hearing loss that have been discussed in Parts I and II of this article.

Important considerations concerning timing of activities

If the goal is to reduce interpersonal barriers, create bonding, and/or relieve stress, then the following group activity can be used early in the rehabilitation process. If the goal is to use humorous anecdotes, jokes, and similar material for the purpose of analysis to determine communication breakdown causes and learn strategy options, then it is recommended to wait until the basic communication strategies management training has been provided.

Group Activity #1- Humorous Miscommunication Anecdotes for Insight, Social Bonding, and Communication Strategies Training

The group leader shares an opening story. The "first date" anecdote is presented below as a practical example. <https://chearsaudiology.com/hearing-loss-and-funny-first-date-stories/>

Anecdote: The Woman's Always Right

Bob had finally gotten up the nerve to ask Dorothy to join him for dinner. He prided himself on his gentlemanly manners – always opening doors for his dates, walking on the street side of the sidewalk, pulling out the chair to seat a lady at the table. Most ladies from the senior center seemed to appreciate these courtesies. He assumed Dorothy would be no different, but that was not the case. Riding in the car, Bob tried to get a conversation going, but she did not appear the talkative type, just smiled at whatever he said. When they stepped onto the sidewalk, Dorothy quickly moved toward

the curb and took his left arm. Bob thought to himself, 'A bit independent, isn't she?' He was used to walking on the street side when escorting a lady.

When they reached their table, Bob pulled out a chair for Dorothy and she seated herself. He then took the chair to the left of her. 'I'll keep it cozy,' he thought. But as soon as he sat down, Dorothy got up and walked to the other side of the table and reseated herself to his left. He was just about to express his annoyance at her "independence" when Dorothy leaned over and said, "I hope you don't mind, but I hear much better out of my right ear. I don't want to miss anything you have to say." Needless to say, Bob realized that his assumptions about Dorothy were all wrong. From then on, Bob made sure he was always speaking into her 'right' ear.

Group Activity:

1. Begin a discussion to get reactions to the story presented. This often brings up personal stories from group members' own experiences. Ask group members to share, if they choose to, a humorous anecdote related to miscommunication from their own personal experience. Alternatively, if group members seem reluctant, they could read aloud one of the anecdotes supplied by the professional. A third option would be for the professional to read aloud the anecdotes.

2. After each anecdote, the therapist directs group members to identify and discuss the causes of communication breakdown. This may help to show that most miscommunications are caused not solely by the hearing loss, but in combination with other factors such as problems with the speaker (clarity, movement, intensity), the environment (noise, light, distance), the listener (fatigue, not paying attention), or technology (hearing aid or other technology malfunction).

3. Initiate a discussion of what can be done to prevent or resolve the miscommunication in preparation for or during the communication event. For each of the causes of the specific communication breakdown, identify multiple solutions.

4. Include role-playing. This is a good technique for bringing the anecdotes to life—it will infuse the discussion with humor. Using a prepared anecdote, have two group members act out the comic communication dynamic. Then use the interaction as a basis to demonstrate the goal of the activity (i.e., bonding, strategy options).

5. Take-home activity. Ask group members to observe and find one example of humor in miscommunication in their daily life to present to the professional or group at the next meeting.

Professional Notes:

An anecdote or story such as the one used in the above activity can ostensibly be used to provide the basis of activities that address the dynamics presented in this article. Some examples include the following:

- Shared responsibility for communication
- Cognitive restructuring
- Readiness factor
- Environmental strategies
- Group bonding

Group activity modifications:

1. The group activity could be also used for an online version, to run as a 'live group.'
2. The professional could solicit from clients, by email, humorous miscommunication experiences, with a follow-up online discussion group for those interested in participating. A similar structure could be used for the sample exercise described above. A specific time period for postings is suggested.

Group or Individual Activity #2: Humorous Miscommunication Anecdotes for Communication Strategies Training

Humorous anecdotes provide opportunities to analyze communication breakdowns, without embarrassing clients or making them uncomfortable, and introduce the primary therapy goal of using effective communication strategies. The anecdotes may provide the professional with an opportunity to open discussion of the effective use of anticipatory, maintenance, and repair communication strategies. Specific humorous anecdotes could bring the focus on more specific strategies such as using *confirmation* as a critical and effective strategy that may prevent communication breakdown from occurring. For example, a person with hearing loss may confirm by saying "Did you say that the story about Hamilton is hysterical or historical?"

Activity:

1. The following anecdotes are presented orally or in writing.
2. Each anecdote is then used as a basis for discussion and to teach communication strategies. The individual with hearing loss or group needs to:
 - Identify the source of the breakdown (i.e., sender, receiver, environment);
 - Recognize that communication has shared responsibility;
 - Consider solutions; and

- Learn possible strategies to address the miscommunication (e.g., confirmation can be a very effective strategy in this situation).

3. Include role-playing of the miscommunication anecdote.

4. The presentation of the miscommunication exchange provides a good opportunity for follow-up training for behavioral approaches to communication repair (i.e., passive, aggressive, assertive). If role-playing of behavioral approaches is done one-on-one, this will be between the client and the professional. If, however, this activity is conducted in a group, two members of the group can role-play the behavioral approaches to communication repair.

The following examples of miscommunication can be used to address communication dynamics, strategies, and behavioral approaches to repairing communication breakdown:

Anecdote 1:

A man and his wife are on vacation and walking down the beach together. Because of ongoing communication difficulties he suspects she has a hearing loss and decides to check it out. He drops behind her about 10 feet asks his wife, in a normal tone of voice, "What would you like to have for dinner?" When he doesn't get a response, he moves up to 5 feet behind her and asks the question again. Still nothing. He moves up right behind her and asks the question again. Still, he gets no response. He taps her on the shoulder, and says to her in a loud voice, "You must have a hearing loss. I've asked you three times what you'd like to have for dinner." She replies "Yes...and three times I've said "seafood!"

Anecdote 2:

Three older men are walking down the street. The first man says "It's windy today." The second man replies, "No, it's Thursday!" and the third man answers, "So am I—let's have a beer!" (card published by Andrews McMeel Publishing, LLC, Copyright 2009).

Anecdote 3:

Two older women are talking together over coffee. The first woman says to her friend, "My doctor told me that to stay young and healthy I need to exercise and eat the right foods." The second woman says "What?! I thought he said accessorize and buy nice shoes!" (card published by Tomato Cards, DCIStudios.com (undated)

Anecdote 4:

I was dining with friends and their teenage daughter. I mentioned that I was no longer eating meat, but that I still ate fish. The daughter remarked, "so you're a pescatarian." I responded, "a Presbyterian? No, I'm Jewish. And what does that have to do with eating fish?" We all had a good laugh! (this anecdote was provided by a friend with hearing loss)

Group or Individual Activity #3: Practical Cognitive and Behavioral Exercises

Exercise 1: Faulty Thinking and Unrealistic Expectations

The professional may challenge the notion that hearing loss is the sole cause of communication failure by putting forth the over-exaggerated humorous scenario of putting a group of 200 "normal hearing" people in an 8'x10' party room, and asking the client if she thinks the party-goers will all be able to understand one another.

Part 1. Initiate a discussion of Cartoon 1, which is non-threatening and has a third party referent. The party room scenario presents the idea that communication problems may impact both the speaker and the listener who share the responsibility for facilitating successful communication. However, the person with hearing loss bears the additional responsibility of guiding the speaker to modify his or her communication behaviors to achieve this end. Humor lays the groundwork for discussion and problem solving, switching to the more realistic context of daily living.

Cartoon 1



Part 2. Communication Strategies Activity. Using the group scenario from the cartoon as a prompt, begin an exploration of the strategies the person with hearing loss has used or has suggested. Discuss those that have been successful as well as those that have not worked well in a group situation with family or friends. This covers anticipatory, maintenance, environmental, and repair strategies. Further, it leads to the task of identifying other possible approaches and solutions that may achieve the desired results more efficiently and effectively.

Exercise 2: Irrational Beliefs and Realistic Expectations

Cartoon 2 provides an entre into a discussion of realistic expectations. It illustrates how communication is multisensory and involves hearing and seeing combined, in non-threatening and humorous way.

Pickles



Exercise 3: Always/Never pattern of thinking

In another sample exercise, clients may be given a series of statements about their perceptions of how they and their communication partners cope with hearing loss. The following statements reflect some common always/never patterns of thinking:

- “I’ve tried everything...”
- “My cousin tried it and it didn’t work for her....”
- “My wife always...”
- “My husband never...”

For this exercise, the professional rephrases the statements to demonstrate the problem with “always or never” thinking. Below are a few examples:

- “So, you’ve tried everything. Is there anything you have not tried?” The professional may ask specific questions here.
- “Do you think that you and your cousin have the same hearing loss and have the same needs?”
- “Your wife always does that? Can you think of a situation when she didn’t do that?”
- “Is it true that your husband never, ever did that... not even once?”

Once the professional questions the statement, the client is likely to see the error in thinking. The incongruity between what the client said and what is closer to the reality is likely to cause a smile of recognition, if not laughter. When this is the case, the professional may use this shared laughter as an element of bonding.

Exercise 4: Hearing Loss Myths and Misinformation

In this sample exercise, the client may be given the following irrational or erroneous statements, which are commonly held regarding hearing loss. The professional asks if the client agrees or disagrees, and why. This exercise can

also be presented in a True/False format. Some examples include:

- “It’s a part of aging so nothing can be done.”
- “Hearing loss is solely my problem.”
- “I ask people to speak up but they just yell at me.”
- “I ask people to slow down and a minute later they’re talking just as fast as before.”
- “Hearing aids are like eye glasses—when I put one on, my hearing should become normal.”
- “If I wear a hearing aid, I should understand everything.”
- “I tried an expensive hearing aid and I still couldn’t understand other people.”

The professional can question the client’s thinking as a basis for discussion and counseling, and can ask the client to create a statement that is more accurate. It is the irrationality of each statement that provides the humorous incongruity desired, often accompanied by a smile of recognition. When a client’s thinking is erroneous and the result is a somewhat altered perception of the cause of their communication problems, it can help facilitate cognitive restructuring.

Group or Individual Activity #4: Humorous Anecdotes to Provide Insight into Miscommunications and Strategy Use (Cognitive/Behavioral)

This activity works best in a group situation, although it could be used one-on-one. It requires two professionals (or a professional with a pre-rehearsed client) to present a humorous skit (part of the Elderhostel Program for Adults with Hearing Loss, Gallaudet University, 2002-2005).

Part I.

In a sample scenario, a woman with hearing loss is driving a car and is stopped by a policeman at dusk. The policeman is wearing Aviator mirrored sunglasses and is holding both a flashlight and his ticketing pad in his hands. He shines the

flashlight in the woman's face and says "License and registration please." She is not focusing on what he said because of the distraction of the flashlight in her eyes.

What should she do? (She should ask the policeman to please point the flashlight away from her eyes and kindly remove his sunglasses, explaining that she has a hearing loss and needs to see his face to understand him better.)

The scenario continues and she hands the policeman her driver's license and registration. The policeman examines the driver's license with his flashlight and says to her "Your license...it's expired!!!" And the woman replies "Thank you officer...I think my picture is very inspired!" The policeman responds with a scowl, thinking she's being sarcastic.

What should she do now? (Responding to his facial expression, she should ask the policeman "what's wrong?" After hearing his response, she could ask him to repeat it, and then she could confirm the information.)

In this activity, an exaggerated role-play provides a humorous basis which will segue into determining the cause of communication breakdowns and the communication strategies that could be used to repair the situation.

Part 2.

In the group or one-on-one with the professional, clients are asked to come up with one or two other scenarios from everyday life (e.g., bank, travel agent, restaurant) where common misunderstandings occur and role-play these humorous scenarios.

Selected Resources

In addition to anecdotes, jokes, and cartoons, there are many other sources of humor and resources that may be considered. The short list below is suggested for review but this is preliminary and is not an endorsement. Rather, it is a starting point from which to find material to best match the needs of a specific client.

- www.trychin.com

Dr. Sam Trychin's website offers a myriad of resources for training. His book and dvd titled "*Communication rules*" provides excellent cognitive/behavioral activities for communication strategies training often using a humorous approach. Another excellent resource is his "*Living with Hearing Loss Workbook*". The most recent addition is a book titled "*Hearing loss and emotional regulation: Building resilience*" published in 2017.

- Gael Hannon- is a writer, speaker and advocate on hearing loss issues. In addition to her weekly blog for HearingHealthMatters.org, she has also written a book titled "*The Way I Hear It: A Life with Hearing Loss*". Ms. Hannon is regularly invited to present her uniquely

humorous and insightful work.

- Gael Hannon- Laughing At Hearing Loss- February 13, 2012 blog
 - <https://hearinghealthmatters.org/betterhearingconsumer/2012/laughing-at-hearing-loss/>
- You Gotta Laugh About Hearing Loss- May 8, 2018 blog
 - <https://hearinghealthmatters.org/betterhearingconsumer/2018/you-gotta-laugh-about-hearing-loss/>
- 2016 America's Got Talent-D.J. Demurs <https://www.youtube.com/watch?v=KluCuaYtTkY>
 - D.J. Demurs performs a stand-up comedy routine about miscommunications related to hearing loss. He is an advocate for individuals with hearing loss and has stated "I want to normalize it and let people in the hard of hearing community know that they are not alone"
- <https://www.hearinglosscpr.com/>
 - Ms. Mallette website addresses "myths associated with hearing loss, offers insights to others with hearing loss like herself based on her own experience, observation, and study. She shares insights for successful, meaningful connections, and presents the lighter/humorous side of hearing loss".
 - Hearing Loss and Humor: When you're the one who doesn't get the joke. Webpage and video- December 28, 2018
 - <https://www.hearinglosscpr.com/hearing-loss-and-humor/>
- Hearing Like Me.com – website with selected articles to consider sharing with clients
 - What's So Funny? Understanding Hearing Loss- Jacqueline Drexler
 - <https://www.hearinglikeme.com/whats-so-funny-understanding-humor-with-hearing-loss/>
 - Can you repeat that? Finding humor in hearing loss- PR Hilton
 - <https://www.hearinglikeme.com/could-you-repeat-that-finding-humor-in-hearing-loss/>
- Cartoons: For a google.com search enter some of the following words: "cartoons on humor and hearing loss"; "miscommunication"; "humor and bonding". Cartoons can be found on the following websites but this is not an all inclusive list.

- cartoonstock.com
- cartoon resource.com
- poloparkhearing.com
- toonpool.com
- cartoonistgroup.com
- jokejive.com
- saywhatclub.org
- glasbergen.com
- hearinglikeme.com
- hearinglosspages.wordpress.com
- newyorker.com
- <https://www.pinterest.com>
- <http://humorresearchlab.org/> The Humor Research Lab (HuRL) is dedicated to the scientific study of humor, its antecedents, and its consequences. HuRL, directed by Dr. Peter McGraw at the University of Colorado, Boulder, looks at humor through the lens of interdisciplinary fields of emotion, judgment, and decision making, with an emphasis in social and cognitive psychology.
 - TED Talk Video- What makes things funny
- <http://www.rxlaughter.org/index.htm>
 - Rx Laughter is a 501c3 public research charity. It began for children with physical illnesses at the UCLA Jonsson Cancer Center, learning how comedy can alleviate pain and anxiety for children during a painful medical procedure and has since expanded into therapeutic and education programs that uses the power of comedy care to improve coping, communication and quality of life for those struggling with serious emotional and physical challenges. One initiative has involved using improvisational comedy techniques as a therapeutic approach.
- <http://www.aath.org>
 - Association for Applied and Therapeutic Humor Membership in this association consists of professionals who use (or want to learn to use) humor in their work to achieve a positive outcome. They have counselors and psychotherapists using humor as a treatment modality. At AATH conferences they offer courses with CME and CE credits to professionals who use or oversee humor therapy in their hospitals. Conferences offer new techniques as well as the latest neuroscience and psychological research about laughter.

- Russell Misheloff, Leader of the DC HLAA Chapter (Hearing Loss Association of America) sent out the following announcement in August 2019:
 - September's meeting will give us a chance to re-connect after the summer break & get to know new members. We'll have a rap session, where we'll introduce ourselves & share experiences: maybe a challenge we faced due to hearing loss – & how we dealt with it – OR a humorous incident. Maybe you missed information at the airport or on a tour? Or sweating in the heat caused your hearing aid to malfunction? Or thankfully you could shut off your hearing devices when the guy next to you on the plane wouldn't stop talking? Whatever the challenge or funny story, we want to hear about it! After all, the best way we learn to cope with our hearing loss is through sharing with each other...& keeping a sense of humor.

Final note to professionals in considering the use of humor in the rehabilitation process:

There are many other resources with material that can be used, but, the authors caution that the professional must follow the preliminary guidelines concerning integrating humor into the rehabilitation process and all material must be chosen carefully and used judiciously. Hickson, Worrall, & Scarinci (2007) note that in a supportive group environment participants have the opportunity to role-play the management of difficult situations in an assertive way and practice effective communication techniques. A group therapy situation in which experiences are shared is often the best starting point for incorporating humor into the rehabilitation process, because individuals with hearing loss are in the company of others who share the experience of miscommunication.

Summary

“If you can laugh at it, you can survive it.”

The purpose of this article is to introduce the potential of humor as a means of facilitating adaptation to hearing loss, both as a therapeutic tool for professionals and as a coping mechanism for clients with hearing loss. While there is a limited body of evidence provided by the psychological and social counseling professions to support the use of humor in clinical interventions, the authors find it has yet to be explored or applied in audiology, aural rehabilitation, and speech-language pathology. Both qualitative and quantitative research into the use of humor in aural rehabilitation is needed to ascertain its potential effectiveness.

Part I of this article addressed the biological and

psychological effects of hearing loss. In Part II of this article the authors identified and described social dynamics related to hearing loss at meso and macro social levels to examine their effect on adaptation, and offer an approach for how to use humor to address these dynamics in therapy with significant others and groups. Preliminary guidelines are presented for the use of humor in therapeutic milieu, which were gleaned from the allied health professions literature. Several practical applications and selected resources for materials may be found at the end of this article.

To meet the complex biopsychosocial challenges faced by individuals with hearing loss more effectively, it is critical to explore every potential rehabilitation technique and methodology. Humor has underexplored therapeutic potential as a tool for professionals in the aural rehabilitation process and is introduced in this article as a potentially viable component. Individuals with hearing loss should be encouraged to use humor to help adapt and gain greater success with communication in their daily lives. It may be an effective coping mechanism for successful adaptation on micro, meso, and macro social levels. Therefore, professionals may want to consider incorporating it with care into clinical practice as an integral part of a counseling approach taken with individuals with hearing loss.

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References

Abrams, H. & Chisolm, T. (2013). Will my patient benefit from audiological rehabilitation? The role of individual differences. *Seminars in Hearing*, 34, 128-140

Apte, M. (1987). Ethnic humor versus "sense of humor". *American Behavioral Scientist*, 30, 27-41.

American Counseling Association (2018). Interest Network for Advances in Therapeutic Humor. Retrieved from <https://www.counseling.org/aca-community/aca-connect/interest-networks>

Atcherson, S. (2002). Stigma and misconceptions of hearing loss: Implications for healthcare professionals with hearing loss. *Journal of the Association of Medical Professionals with Hearing Losses*, 1, 1-3.

Babeu, L., Kricos, P., & Lesner, S. (2004). Applications of the stages-of-change model in audiology. *Journal of the Academy of Rehabilitative Audiology*, 37, 41-56.

Baldrige, D. (2014a). Career success after hearing loss: Finding and refining your path. *Hearing Loss Magazine*, 35, 12-16.

Baldrige, D. (2014b). Workplace behavioral responses to the law. *Hearing Loss Magazine*, 35, 24-25.

Bally, S. (2009). Group therapy and group dynamics in aural rehabilitation. In J. Montano & J. Spitzer (Eds.), *Adult Audiologic Rehabilitation (1st ed.)* (pp. 283-304). San Diego, CA: Plural Publishing.

Boyum, R. (2013). Therapeutic uses of humor-counseling approach. Retrieved from <http://www.selfcounseling.com/help/Counselors/humor.html>

Canadian Hearing Society. (undated). Should I or shouldn't I disclose my hearing loss. Retrieved from <http://www.chs.ca/should-or-shouldnt-i-disclose-my-hearing-loss>

Clark, M. (2014). Congratulations, you have an interview. What now? *Hearing Loss Magazine*, 35, 18-20.

Coser, R. (1959). Some social functions of laughter: A study of humour in a hospital setting. *Human Relations*, 12, 171-82.

Danermark, B. (1998). Hearing impairment, emotions and audiological rehabilitation: a sociological perspective. *Scandinavian Audiology- Supplementum*, 49, 125-31.

Datan, N. (1986). The last minority: Humor, old age and marginal identity. In L. Nahemow, K. McCluskey-Fawcett, & P. McGhee (Eds.), *Humor and aging* (pp. 161-171). Orlando FL: Academic Press.

Dziegielewski, S., Jacinto, G., Laudadio, A., & Legg-Rodriguez, L. (2003)

Humor: An essential communication tool in therapy. *International Journal of Mental Health*, 32, 74-90.

Ellis, A., & Grieger, R. (1977). *Handbook of rational emotive therapy*. New York: Springer.

Erdman, S. (2014). The biopsychosocial approach in patient-and relationship-centered care: Implications for audiological counseling. In J. Montano & J. Spitzer (Eds.) *Adult audiological rehabilitation (2nd ed., pp 159-206)*. San Diego CA: Plural.

Fry, W. & Salameh, W. (Eds.). (1987). *Handbook of Humor and Psychotherapy*. Sarasota, FL: Professional Resource Exchange.

- Fry, W. & Salameh, W. (Eds.). (1993). *Advances in humor and psychotherapy*. Sarasota, FL: Professional Resource Press.
- FGarstecki, D. & Erler S. (1998). Hearing loss, control, and demographic factors influencing hearing aid use among older adults. *Journal of Speech, Language, and Hearing Research, 41*, 527-537.
- Glickman, N. & Harvey, M. (Eds.). (1996). *Culturally affirmative psychotherapy with deaf persons*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Harvey, M. (2003). *Psychotherapy with deaf and hard of hearing people: A systemic model* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum Associates.
- Hetu, R. (1996). The stigma attached to hearing impairment. *Scandinavian Audiology, 25*, 12-24.
- Hickson, L., Worrall, L., & Scarinci, N. (2007) A randomized controlled trial evaluating the active communication education program for older people with hearing impairment. *Ear and Hearing, 28*, 212-230.
- Huppert, J. (2009). The building blocks of treatment in cognitive-behavioral therapy. *Israel Journal of Psychiatry Related Science, 46*, 245-250.
- Ida Institute (2012). Factors to consider when providing audiologic services to people who have hearing loss and their communication partners. In Ida Institute: Redefining audiological rehabilitation. *Seminars in Hearing, 33*, 87-96.
- Jeppesen, A. (2015, May). Empower patients to take action on their hearing. Presented in partnership with the Ida Institute. Retrieved from <http://www.audiologyonline.com>.
- Johnson, C., Danhauer, J., Gavin, R., Karns, S., Reith, A., & Lopez, I. (2005). The "hearing aid effect" 2005: a rigorous test of the visibility of new hearing aid styles. *American Journal of Audiology, 14*:169-75.
- Kaland, M. & Salvatore, K. (March 2002). The psychology of hearing loss *The ASHA Leader, 7*, 4-15.
- Kaplan, H. (1996). Informational and adjustment counseling. In M. Moseley & S. Bally (Eds.), *Communication Therapy* (pp. 92-127). Washington, DC: Gallaudet University Press.
- Klein, A. (1989). *The healing power of humor: Techniques for getting through loss, setbacks, upsets, disappointments, difficulties, trials, tribulations, and all that not-so-funny stuff*. Los Angeles: Jeremy Tarcher.
- Kricos, P. & Lesner, S. (1995). *Hearing care for the older adult*. Boston, MA: Butterworth-Heinemann.
- Kuhlman, T. (1993). Humor in stressful milieus. In W. Fry & W. Salameh (Eds.), *Handbook of Humor and Psychotherapy* (pp. 19-45). Sarasota, FL: Professional Resource Exchange.
- Lind, C. (2014). Communication partnership therapy as audiologic rehabilitation. In J. Montano & J. Spitzer (Eds.) *Adult audiologic rehabilitation* (2nd ed., pp159-206). San Diego CA: Plural.
- Luhmann, N. (2012) Introduction to systems theory. United Kingdom: Polity Press.
- Manchaiah, V., & Stephens, D. (2013). Perspectives on defining 'hearing loss' and its consequences. *Hearing, Balance and Communication, 11*: 6-16.
- Martin, R., Puhnik-Doris, P., Gray, J. & Weir, K. (2003). Individual differences in uses of humor and their relation to psychological well-being: Development of the Humor Styles Questionnaire. *Journal of Research in Personality, 37*, 48-75.
- Moseley, M. & Bally, S. (Eds.). (1996). *Communication therapy: An integrated approach to aural rehabilitation with deaf and hard of hearing adolescents and adults*. Washington, DC: Gallaudet University Press.
- Nasr, S. (2013). No laughing matter: Laughter is good psychiatric medicine. *Current Psychiatry, Evidence-Based Reviews, 12*, 20-25.
- Pray, J. (1996). Psychosocial aspects of adult aural rehabilitation. In M. Moseley & S. Bally (Eds.) *Communication therapy* (pp. 128-148). Washington, DC: Gallaudet University Press.
- Preminger, J. (2011). Group audiologic rehabilitation for adults and their communication partners. *The ASHA Leader, 16*, 14-17.
- Preminger, J. & Lind, C. (2012). Assisting communication partners in the setting of treatment goals: The development of the goal-sharing for partners strategy (GPS). *Seminars in Hearing, 33*, 53-64.
- Ross, M. (2010). The "stigma" of hearing loss and hearing aids. *Hearing Loss Magazine, May/June*.
- Saunders, G., Frederick, M., Silverman, S., Nielsen, C., & Laplante-Lévesque, A. (2016). Description of adults seeking hearing help for the first time according to two health behavior change approaches: Transtheoretical model (stages of change) and health belief model *Ear and Hearing, 37*, 324-333.
- Scarinci, N., Meyer, C., Ekberg, K., & Hickson, L. (Dec 2013). Using a family-centered care approach in audiologic rehabilitation for adults with hearing-impairment. *ASHA Perspectives on Aural Rehabilitation and Its Instrumentation*.
- Shaughnessy, M. & Wadsworth T. (1992). Humor in counseling and psychotherapy: a 20-year retrospective. *Psychological Reports, 70*, 755-62.
- Smith, M. & Segal, J. (2014, February). Laughter is the best medicine: The health benefits of humor and laughter. Retrieved from http://www.helpguide.org/life/humor_laughter_health.htm

Smith, S. (2014). Self-efficacy theory in aural rehabilitation In J. Montano & J. Spitzer (Eds.) *Adult Audiologic Rehabilitation* (2nd ed., pp219-251). San Diego CA: Plural.

Stafford-Mallis, V. (2014). Hiring employees with hearing loss-what's in it for employers? *Hearing Loss Magazine* 35, 32-34.

Sultanoff, S. (1992). The impact of humor in the counseling relationship. *Laugh It Up, July/August, 1*.

Trychin, S. (2003). *Communication rules: Guidelines for preventing or reducing communication problems related to hearing loss*. Erie, PA: Samuel Trychin Publishing.

Trychin, S. (2009). Living with hearing loss program: The ABC's of stress produced by communication difficulties. Presentation at the annual meeting of the Hearing Loss Association of America, Washington, D.C.

Tye-Murray, N. (2009). *Foundations of Aural Rehabilitation: Children, adults, and their family members* (3rd ed.). Clifton Park, NY: Delmar Learning. Wallhagen, M. (2010). The stigma of hearing loss. *Gerontologist*, 50, 66-75.

Walton, R. (2003). What is humor? A definition of humor that works for me. Retrieved 08/03/09 from <http://www.rickwalton.com/lang/whathumo.htm>

Warren, C., & McGraw, A. (2016). Differentiating what is humorous from what is not. *Journal of Personality and Social Psychology*, 10, 407-30.

Wayner, D. (2011, June). Surviving the stress of hearing loss: What you can do. Paper presented at the annual meeting of the Hearing Loss Association of America, Washington, D.C.

Weaver, S. & Wilson, N. (1997). Addiction counselors can benefit from appropriate humor in the work setting. *Journal of Employment Counseling*, 9, 108-114.

Weinstein, B. (2012). *Geriatric audiology* (2nd ed.) New York: Thieme.

**Aural Rehabilitation on Behalf of Adults with
Impaired Hearing: What is it? What should it be?
What I have learned over the past 38 years.**

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Abstract

Aural rehabilitation has a lengthy history of debate as to exactly what it is and what it should involve. Adult patients with impaired hearing have questioned the worth of some aural rehabilitation services because they have had difficulty determining its true benefit. The purpose of this article is to share what I have learned from my clinical work that has assisted me in developing aural rehabilitation services that can truly benefit adults who present with impaired hearing. To that end, this paper reflects what I have learned regarding the process of aural rehabilitation on behalf of our adult patients—what works, what does not work, and perhaps what it should be. What I have written here is from the heart and from my experiences. It is not a scholarly article, but one written to share the personal insights I have gained from my career over the past 38 years.

Introduction

It has been historically observed by audiologists that our adult patients with impaired hearing have all too often not viewed aural rehabilitation services as not being as beneficial as they expected them to be. In the context of this article, I am referring to the traditional concept of aural rehabilitation that was provided as a separate service, usually provided over a one-hour period of time once a week involving lessons in speechreading and perhaps some discussions of difficult listening situations. Through the years I have learned, sometimes the hard way that those services have in too many instances not been designed to address their specific communicative difficulties and needs. Therefore, it has become clear to me that it is important that audiologists design rehabilitation services on behalf of adult patients that address the specific auditory/communicative needs of *each individual* who is seen for those services, rather than a generalized program of services.

This process of aural rehabilitation involves “patient-centered care” which encourages patients to play an active role in the therapeutic services that are provided on their behalf. It involves a power-balanced relationship with audiologists, encouraging patients to participate in determining their specific needs in relation to the services that will be provided. That is what I learned, and what I have carried forth as I have provided aural rehabilitation services on behalf of my patients.

Physicians, clinical psychologists, dentists, dermatologists, occupational therapists, speech-language pathologists, rehabilitation counselors and other health and human services providers treat the specific complaints of their patients, which in turn guide the goals and procedures of their services. Therefore, over the years it has become clear to me that we as audiologists should likewise treat the specific auditory/communicative complaints of our patients who are seen for aural rehabilitation services, as opposed to a pre-prescribed set of lessons.

Therefore, this paper addresses principles that have been developed and utilized by me on behalf of my adult patients over the past thirty-eight years. They involve processes that can be utilized in the planning and execution of aural rehabilitation services on behalf of adults of any age who exhibit varying degrees of impaired hearing, and who likewise present themselves as possessing varying degrees of difficulty in communication with specific people in specific places and under specific circumstances.

This paper, in essence, addresses the question, “What is aural rehabilitation?” Is it not what audiologists should be doing as an important part of their on-going services on behalf of older adults with impaired hearing?” Arthur Boothroyd (2007) in his scholarly treatise on adult aural rehabilitation agrees when he stated that the “ultimate goal of adult aural rehabilitation is to eliminate hearing loss induced difficulties that reduce one’s ability to engage in activities of daily living”. Furthermore, he stated that is what audiologists should be striving for in their day to day service on behalf adults who possess impaired hearing. Besides assisting adults to overcome the difficulties they may be experiencing in the activities in which they wish to engage, enhancing auditory function through the use of hearing aids, assistive listening devices and others can go a long way toward enhancing their ability to enjoy activities that require hearing and communication.

Part I. Six Principles of AR Service

For an on-going aural rehabilitation service that is provided on-site, as a separate outpatient service on behalf of adults with impaired hearing, the following principles can provide critical elements of a rehabilitation program that addresses the specific concerns of our patients.

Focus on Individual Patient Needs

First and foremost, aural rehabilitation treatment must concentrate on the expressed auditory/communicative difficulties and needs of each patient—when they occur, with whom, and within what circumstances. Every patient is different, with varying communicative frustrations and self-perceived needs. They are to be active participants in determining the process that will benefit them most in regaining, or enhancing their ability to function in their activities of daily living in spite of their hearing impairment. What I am talking about here involves “patient-centered care”. Grenness, Hickson, Laplante-Levesque and Davidson (2014) describe that process as one that encourages patients to be active participants in the services they will be receiving through the creation of a power-balanced therapeutic relationship. This approach is contrary to the more traditional delivery model of health care that is “practitioner-centered”.

After all preliminary work has been completed including audiometric evaluations, discussions of the audiometric results,

their potential impact on communication and other matters of daily living, I begin my work with my patients by giving them a questionnaire, “The WSU Communication Appraisal and Priorities Profile” (Hull, 1994) that allows them the opportunity to not only identify the situations involving communication that they find most difficult, but also identify those that they prioritize as most important to them. Further, they then determine the two or three out of those identified that they would like to resolve first, then second, and so on. This is truly “patient-centered” since patients have the opportunity to determine what *they* would like to resolve in regard to the communicative difficulties that are most important to them.

That is a lesson I learned the hard way early on as a doctoral student engaging in aural rehabilitation practicum experiences working with my adult patients who possessed impaired hearing. On the first day, I opened an Ordman and Ralli “What People Say” book and began with Lesson No. 1. That is the process of AR that I had learned about during my graduate course entitled “Aural Rehabilitation”. After about the third session with my patients, I wondered why many of them never returned! They gave excuses of a visit by one of their grandchildren, a hair appointment, needed to see the house physician, and others.

So, when one of my patients finally admitted to me out of frustration that he was there to learn to resolve the problems he was facing as a result of *his* hearing impairment rather than learning to speechread from a book of lessons, it quickly dawned on me that what I was offering them during our aural rehabilitation sessions wasn’t addressing what they needed at all! That was, to address the difficulties and concerns that those patients were experiencing in regard to their hearing/communicative difficulties! Why, then, would they desire to return for my “services”? I had neglected to ask them two important questions. Those were, “What can I do for you?” and “What do you hope to gain from my services?” Those are the same questions my physician asks her patients before she begins providing services on their behalf! Shouldn’t we do the same? Patients, then, should not only be informed of what the clinician can offer through services, but most importantly should be given the opportunity to formulate their own as per their specifically perceived needs. Patients are to be active participants in determining the rehabilitative process that will benefit them most in regaining, or enhancing their ability to function in their activities of daily living in spite of their hearing impairment.

Address both peripheral and central issues

Among older adults, both peripheral and central auditory involvement should be addressed as those symptoms manifest themselves. I talk to my patients about the role of the central auditory system as it relates to speech understanding and

speech comprehension. I stress here that as many people age, the CNS ages along with them, slowing the processing of what we hear somewhat. Speech involves a rapid set of acoustic/linguistic events that must be processed literally in milliseconds if not microseconds for comprehension of speech to occur. If our central auditory processing system slows even a small amount, it can interfere with the processing of speech that is spoken at typical rates of adult speech, even with improved hearing through the use of hearing aids that are fitted properly. In that way I am able to use a little of my PhD in neuroscience to make patients aware of reasons for the frustrations of hearing speech, but not understanding what is being said.

Consider the Environment and the Communication Partner

The listening environment is essential to consider, so we also talk about making changes in the environmental design of their homes. This would include how to change listening environments in meeting rooms, changing seating arrangement in church sanctuaries, and so on to assist patients to overcome some of their problems in understanding what others are saying, particularly in noisy or otherwise distracting listening environments.

As I tell my patients, hearing aids, no matter how well they are designed and how sophisticated they are, cannot compensate for persons who speak too rapidly or with poor articulatory skill, nor can they compensate for a poor listening environment. Therefore, I also work with significant others in patient's lives who may not speak clearly or at speeds that make processing of speech difficult for adults who demonstrate both peripheral hearing loss and central auditory decline. I work with them on speech clarity and slowing their rate of speech so that they are more easily understood by their significant other. My background in speech-language pathology and training in public speaking assists me in doing that. The speech habits of the patient's family and friends is an extremely important part of the treatment program. This is a very delicate aspect of services on behalf of adults with impaired hearing. When the spouse of your patient responds loudly and with some suppressed anger to your suggestions about the benefits of "clear speech" with, "I already speak clearly! He just can't hear!!" our approach to assisting the spouse to increase the clarity of her or his speech must be handled gently and with respect for the years of frustration attempting to communicate with their spouse who may have fairly significant difficulty hearing the phonemes of speech.

Counseling and Becoming Positively Assertive

Counseling should be considered essential to the effectiveness of all other components of treatment. Therefore, it behooves audiologists to have achieved background knowledge on the foundations of counseling and the processes and techniques of the interactive nature of

counseling during or after their formal academic preparation. Importantly, audiologists must also be aware of when the nature of the patient's problems are beyond their capability as counselors, and when and to whom to refer patients for more formal counseling.

Counseling not only involves problem-solving sessions that provide an opportunity for discussions of difficult listening situations and environments and suggestions that provide avenues of their resolution, but also the development of assertive behaviors by the patient regarding the communication environment or their communication partner. Those discussions are essential to aural rehabilitation treatment.

I thoroughly enjoy this aspect of the process of counseling on behalf of my patients. I enjoy observing the changes in behavior of my patients as they grow from adults who submit to failure as they attempt to understand those who do not speak well enough to be understood, or submissively attempt to participate in environments that prevent them from hearing and communicating, and move on to become adults who in a positively assertive manner work to make positive change in their difficult listening environments.

I love it when one of my patients finds that the speaker their organization has been looking forward to hearing at a public event refuses to use the microphone that has been provided, and after the speaker in a rather confident manner says, "I won't need to use the microphone since people seem to hear me well", and my patient raises her hand and says loudly, "PLEASE use the microphone so that we can ALL hear what you have to say!!" I love it even more when the speaker then walks back to the podium, picks up the FM microphone and says, "Can you hear me now?", and the audience in unison loudly responds, "YES!" At that point, I feel that I have achieved an important goal in what I call aural, or hearing rehabilitation!

Communication Strategies

Patients should, however, be encouraged to achieve a balance between positive assertiveness and being a negative "complainer" while working to make positive change in their communicative environments and those with whom they communicate. That is why I empathize "positive" assertiveness rather than the opposite; Patients should be instructed regarding alternative response criteria that are appropriate for specific communicative events—in other words to make change that can enhance their ability to communicate in specific environments or with specific people. One of my patients, an older man who was walked from Arkansas to Colorado in the 1920's and later owned the first John Deere farm equipment dealership in northern Colorado came to see me because he was having difficulty hearing. His goal at that time, at age 78 years was to meet a nice female who would

become his companion. He had difficulty understanding what women said to him, and he felt that perhaps I could help him in that regard. After several sessions of problem-solving and developing strategies for communication, he came to me to say that he had met a very nice woman who seemed to enjoy being with him. And, he said that he was using the communication strategies that he had learned for purposes of carrying on conversations with her. I love those outcomes!

I am definitely not a matchmaker, but if my patient and I can work on strategies that will assist in overcoming impaired hearing for purposes of communication, then perhaps I can assist male/female relationships!

Assistive Listening Devices

Assistive listening devices and other technology should be introduced into treatment sessions for educational purposes. That way I could inform them about several features of the devices. Patients often come to sessions with a newspaper or magazine add about a new and “innovative” listening device, or simply have questions about something they have read. I have found that setting aside some time during the first part of sessions to talk about such things and answer questions is a positive component of AR services. Further, I bring FM and infrared listening systems along with Pocket Talkers and other listening devices to our sessions for patients to “give them a try”. In that way they can evaluate them in a relaxed “non-sales” environment as many times as they would like to use them. After detailed instruction, I also allow them to take them home to use watching television, at the dinner table, at church, and other situations. They truly appreciate that opportunity, and feel that it is an added benefit for coming to my AR services.

Part II. AR – not a separate service

The components of aural rehabilitation treatment presented above are important for an on-going outpatient program of rehabilitation on behalf of adults who possess impaired hearing. However, as I have thought critically about the process over the years, I feel that what we generally call “aural rehabilitation,” (or “hearing rehabilitation”), is what we *should* be doing on behalf of our patients as we serve them and their hearing/communicative needs every time we see them! This boils down to the idea that aural rehabilitation should actually begin from the moment we meet our patients. Our aural rehabilitation efforts should not be divided between diagnostics and rehabilitation, but rather we should approach it holistically from the very beginning of our services on their behalf. It should be an *important part of the ongoing service* that we provide on their behalf. I believe that important aspects of aural (or hearing) rehabilitation should be intertwined within *everything* we do, including:

- the diagnostic testing in its various forms, and the discussions between audiologist and patient that take place as those testing sessions take place;
- the counseling that we provide as we discuss the audiogram and other test results with our patients, and our constructive responses and possible solutions to their questions regarding the difficult communicative situations that they face each day;
- the counseling that we provide as we discuss the benefits and limitations of hearing aids and other assistive listening devices;
- the counseling that we provide as we discuss the benefits of the use of vision to supplement impaired hearing;
- the counseling that we provide that stresses the need for the development of positive assertiveness on the part of our patients for the purpose of changing their difficult listening situations to their advantage;
- the counseling that we provide as we bring husband and wife or other significant others together with the patient to discuss ways in which support can be provided on their behalf in difficult listening environments;
- the counseling that we provide regarding the importance of hearing protection devices that can help to preserve our patient’s residual hearing;
- the counseling that takes place when patients are requested to return to our office to for follow-up and to see if they have further questions;
- the counseling we provide regarding other difficult listening situations that they may be facing, and to make sure their hearing aids or other assistive listening devices are assisting them as we expect they should be;
- and all of the other counseling, cajoling, encouraging, challenging that we engage in during our interactions with our patients.

That *is*, or should be, the essence of aural rehabilitation, hearing rehabilitation, or whatever we decide to call the service. Aural rehabilitation doesn’t have to be an extra add-on service. It is a critically important part of what we as audiologists *do*, or *should be doing* on behalf of our patients every time we see them. I think what I’m trying to say is that as audiologists we have the opportunity to form relationships with people (our patients and their significant others) that may extend for many years. Because of that, perhaps we need to think about how AR is a perfect approach to addressing the changing needs of individual patients across their lifespan. This means that aural rehabilitation should not be something that is confined to a series of “lessons”. Aural rehabilitation is a long-term process that spans the life of our patients as we

work to serve them and their communicative needs. I feel that as audiologists, that is our challenge and our mission.

The theme upon which the principles, or processes, within this article are designed is that we must remain continually mindful of the special needs of our individual patients, as consumers, that pertain to *their specific communicative environments and those with whom they communicate*. As audiologists, it should be an essential ongoing component of our services on behalf of our patients.

References

- Ackley, R.S (2014). Counseling adults with impaired hearing. In R. Hull (Ed). *Introduction to aural rehabilitation*. San Diego, CA: Plural Publishing.
- Boothroyd, A (2007). Adult aural rehabilitation: What is it and does it work? *Trends in Amplification*. 11, 63-71.
- Grenness, C., Hickson, L., Laplante-Levesque, A., & Davidson, B. (2014). Patient-centered care: A review for rehabilitative audiologists. *International Journal of Audiology*. 53, 60-67.
- Hull, R (1994). *WSU Communication Appraisal and Priorities Profile*. In R. Hull, (Ed). *Introduction to Aural Rehabilitation: Serving children and adults with hearing loss*. San Diego, CA: Plural Publishing.
- Hull, R (2012). *Hearing and aging*. San Diego, CA: Plural Publishing.
- Hull, R (2019). The process of aural rehabilitation for adults. In R. Hull (Ed.), *Introduction to aural rehabilitation; Serving children and adults with hearing loss (pp 281-316)*. San Diego, CA: Plural Publishing.
- Moody, H.R. (2006). *Aging: Concepts and controversies*. Thousand Oaks, CA: Pine Forge Press.